

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER The Friendly Home		STREET ADDRESS, CITY, STATE, ZIP CODE 303 Rhodes Avenue Woonsocket, RI 02895	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure that services provided meet professional standards of quality and practices relative to 1 of 1 resident reviewed for a fall resulting in a fracture, Resident ID #32, 1 of 1 resident observed for the use of geri-sleeves (protective arm wear) during a transfer, Resident ID #111, and 1 of 1 resident reviewed for off-loading booties, Resident ID #88. Findings are as follows: 1. Review of a facility reported incident submitted to the Rhode Island Department of Health on 11/24/2025 revealed that Resident ID #32 fell while ambulating to the bathroom. Additionally, it was determined that s/he fractured his/her femur (thigh bone) and was admitted to the hospital. Record review revealed Resident ID #32 was readmitted to the facility in November of 2025 with a diagnosis including, but not limited to, displaced fracture of the medial condyle of the right femur (inner part of the lower thigh bone). Review of a care plan focus area dated 9/29/2025 revealed that s/he is at risk for falls due to vertigo (dizziness) and impaired mobility. Record review of the progress notes revealed that s/he had a fall on 11/17/2025. 1a. Review of a progress note dated 11/21/2025, authored by the resident's Physician, Staff F, revealed that the resident's blood pressure is low and to check orthostatic blood pressure (a type of low blood pressure that occurs when moving from a sitting to a standing position. The drop in blood pressure can result in dizziness, lightheadedness, and/or fainting. Orthostatic blood pressure measurements are recorded when an individual is lying, sitting, and standing to assess for drops in blood pressure related to positional changes). Record review failed to reveal evidence that orthostatic blood pressure monitoring was obtained on or after 11/21/2025. Record review revealed that the resident had another fall two days after the request to check orthostatic blood pressures on 11/23/2025, and was found in his/her room on the floor between the bed and bathroom. Additionally, s/he was determined to have a right femur fracture and was transported and admitted to the hospital for surgical repair of the fracture. Record review revealed that the s/he was readmitted on [DATE] following surgical repair of his/her right femur fracture. 1b. Review of a document titled, Orthopaedic Surgery Discharge Instructions dated 11/25/2025 revealed that s/he was to follow up with the surgeon in 10-14 days. Record review failed to reveal evidence that a follow up appointment was made until it was brought to the facility's attention by the surveyor. During a surveyor interview on 12/17/2025 at 12:22 PM with Licensed Practical Nurse (LPN), Staff A, she acknowledged the physician's note indicating to check the resident's orthostatic blood pressure and that s/he was supposed to have a follow up appointment scheduled. She was unable to provide evidence that a follow up appointment was scheduled or that his/her orthostatic blood pressures were taken. During a surveyor interview on 12/18/2025 at 10:35 AM with the Scheduler, Staff B, she revealed that she is the person responsible for making appointments. She indicated the nursing staff will message her to make her aware of appointments that need to be scheduled. She revealed that she was unaware that the resident required a follow up appointment until staff first made her aware on 12/17/2025, after it was brought to the facility's attention by the surveyor. During a surveyor interview on 12/18/2025 at 11:20 AM with the Director of Nursing Services (DNS), she was unable to provide evidence that Resident ID #32 received services that meet professional standards of quality and practices. During a surveyor interview on 12/19/2025 at 10:40 AM with the resident's Physician, he revealed that he would expect orthostatic blood pressure monitoring to be completed within 24 hours and that his/her follow appointment would have been scheduled. 2. According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients. Record review revealed Resident ID #88 was admitted to the facility in January of 2025 with a diagnosis including, but not limited to, need for assistance with personal care. Review of Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 out of 15 indicating intact cognition. Review of a care plan focus area dated 12/16/2025 revealed an alteration in skin integrity due to impaired skin integrity with an intervention for bilateral off-loading foot booties as ordered. Review of a physician's order dated 12/15/2025 revealed bilateral booties to feet off in mornings and on at bedtime. Review of the December 2025 Treatment Administration Record revealed that the resident's booties were documented by the morning shift nurse as no or off, indicating that they were not applied at bedtime, as ordered, on the following dates: -12/15-12/16-12/17-12/18-12/19 During a simultaneous surveyor observation and interview on 12/19/2025 at 8:58 AM with the resident s/he was observed in bed without his/her booties in place. S/he</p>		