STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165357	A. BUILDING _____ B. WING _____	C 12/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE VISTA HOME, INC.	1109 NORMAL STREET WOODBINE, IA 51579

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction date 12/28/16 Complaints # 64604-C and # 64614-C were substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

POC accepted 1/17/17 SS

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F 323	Continued From page 1 Based on record review and staff interviews, the facility failed to provide adequate supervision to ensure against hazards when providing assistance with bathing for 1 of 4 residents (Resident #3) who needed assistance with transfer and ambulation. The facility reported a census of 59 residents. Findings include: According to the quarterly Minimum Data Set (MDS) assessment dated 9/7/16, Resident #3 had diagnoses of peripheral vascular disease, non-Alzheimer's dementia, macular degeneration, traumatic amputation of the left shoulder-arm and right leg between the hip and knee. The resident needed extensive assistance of 2 staff with bed mobility, transfers and bathing. According to the MDS the resident had impairments on both sides of the lower extremity and utilized a wheelchair for mobility. The test for balance identified the resident could not stabilize/balance him/herself without staff assistance when moving from seated to standing position, when moving on or off the toilet and when moving from surface to surface transfer. A Brief Interview for Mental Status (BIMS) identified a score of 4. A score of 4 identified the resident had severe cognitive problems. The resident's updated care plan dated 9/15/16 indicated a focus area of self-care performance deficit related to dementia, left upper shoulder and right lower leg amputation. The interventions dated 4/4/15 and 9/13/16 respectively directed staff to provide shower/bed baths 1-2 times weekly if south tub not available; and 10/28/16, noted the resident may bath in the north tub.	F 323		

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F 323	Continued From page 2 An incident report dated 11/8/16 at 8:50 a.m. revealed staff had given the resident a bath in the north tub room. Staff A, a certified nursing assistant released the tub door and didn't realize the resident had been leaning against the inside door. Upon opening the door the resident fell out onto the floor, hitting his/her head. The resident sustained a 5 inch circular area on the top left side of the head with a laceration measuring 1.5 centimeters (cm) x .5 cm. The resident complained of pain after the incident and the physician would be notified. The intervention after the incident was to closely monitor residents when releasing tub door and no more tubs baths. The incident report noted 11/11/16, computed tomography (CT) scan identified fractured clavicle/scapula. On 11/14/16, the physician determined there was not a major injury. Progress notes dated 11/8/16 at 9:39 a.m. indicated there resident fell out of the bathtub and hit the left side of the head, sustained a laceration and complained of left shoulder pain. A clinic note dated 11/8/16 at 9:08 a.m. indicated the resident had been seen by his/her physician due to fall after his/her bath. The resident fell less than 3 feet and struck his/her head on the tile floor and left shoulder at the same time. A small scrape to the scalp with the resident reporting his/her head felt fine and did not lose consciousness. The resident reported left shoulder pain. A 3 cm superficial laceration to the left side of the scalp in the occipital region. The physician ordered a left should x-ray. Radiology report dated 11/8/16 revealed the bones osteopenic (bone loss).	F 323		

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F 323	Continued From page 3	F 323		

A physician telephone order dated 11/8/16 ordered Hydrocodone/Acetaminophen 5 milligrams (mg)/325 mg - 1 tablet every six hours as needed (prn) for pain.

A computerized tomography (CT) scan taken 11/11/16 indicated an acute fracture of the medial aspect of the left clavicle, non-displaced. The CT showed there is a poorly visualized fracture involving the scapula extending into the base of the glenoid (socket of shoulder). The fracture appears to extend into the coracoid (shoulder).

Progress notes dated 11/12/16 at 6:32 a.m. indicated the resident had much difficulty during the evening meal, unable to swallow liquids and spits out into a napkin. The resident is only able to verbalized one word at a time and difficulty following directions. The facility notified the resident's family member; suggesting the resident's condition could be from the medication Hydrocodone. A physician's telephone order dated 11/11/16 ordered to change Vicodin (similar to Hydrocodone) 5mg/325 mg - 1 tablet every 4 hours prn for pain.

Progress notes dated 11/13/16 at 8:27 a.m. revealed the resident had been restless, moaning and groaning and wouldn't take a medication orally. A physician's telephone order dated 11/13/16 ordered Morphine 10 mg - 1 tablet every 4 hours prn for pain and oxygen per nasal cannula to keep oxygen saturation levels greater than 90%.

A patient report dated 11/15/16 revealed a chest x-ray of the chest indicated hypoxia (shortness of breath). A telephone order dated 11/14/16 ordered the initial order of Morphine 10 mg be

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F 323	Continued From page 4 discontinued with a new order for Morphine 2.5 mg - 1 tablet every 4 hours prn for pain. A telephone order dated 11/16/16 admitted the resident to hospice care. During an interview dated 8:58 a.m. on 12/21/16 Staff A, a certified nursing assistant (CNA) reported she had been employed at the facility for 3 years and assists residents with bathing. On 11/8/16 she gave the resident a bath; as it was the resident's normal bath day. The resident is normally given a bath in the South Hall tub room but it wasn't available as it was under repair. Staff had to give baths in the North Hall tub room. She and another CNA (she doesn't remember who) brought the resident into the tub room and transferred the resident into the tub and the staff helping her left the room. Staff A reported she gave the resident a bath and when finished she drained the tub, placed towels over the resident's upper torso and at the same time, pushed the button that releases the side door to the tub. As the door lowered the resident slid out of the tub and fell onto the floor, hitting his/her head and left shoulder. The resident cried out in pain and held his/her left shoulder. She reported she hadn't realized the resident had leaned against the door when she lowered the door. Staff A reported she had been alone during the bath and when the incident occurred. She reported the South Hall tub had a security belt that is used to secure residents during a bath, but the North Hall tub didn't have such a device. Staff A reported that after this incident the facility requires 2 staff to be present at all times with bathing. During an interview dated 12/21/16 at 8:50 a.m. Staff B, a registered nurse (RN) reported she had been called to the North Hall tub room. When	F 323		

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F 323	Continued From page 5 she entered she saw the resident on the floor lying on h/her left side/shoulder and the left side of the resident's head bleeding. The resident's physician had been in the building at the time and evaluated the resident. Staff transferred the resident from the floor to a wheelchair and taken to his/her room. Staff B reported she had been a CNA and recently became an RN. She reported as a CNA and now as an RN she expected 2 staff to assist with bathing and to be present at all times. During an interview dated 12/21/16 at 9:15 a.m., Staff C, RN and MDS coordinator reported the resident had been given bed baths because he/she had reported staff had been too rough with transfer. She recalled family or someone else wanted the resident to resume a tub bath (whirlpool). She reported the MDS dated 9/76/16 reflected the resident needing 2 staff to physically help with bathing and two staff to provide continuous support with the task of bathing. During an interview dated 12/21/16 at 10:07 a.m., Staff D, LPN and restorative nurse stated the section of the MDS indicating extensive assist of two staff with bathing meant that only 2 staff were needed to transfer the resident and not to assist with bathing. During an interview dated 12/21/16 at 9:30 a.m., the Director of Nursing reported the resident needed 2 staff assist with transfer to the tub and the second staff need not be present during the bath. She reported that after the resident's fall from the tub the facility procedure is for 2 staff be present before the tub door is opened. In a typed statement dated 12/21/16, the Director	F 323		

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F 323	Continued From page 6 of Nursing stated when the MDS indicated two staff assist with bathing, it is expected that 2 staff will assist with transfer and not for 2 staff to remain in the tub room for the entire bath, but be present for the transfer in and out of the tub. Since the resident's fall of 11/8/16 the facility had begun requiring 2 staff to be present before the tub door is lowered. The operating instructions for the tub used by the facility titled "Operating Instructions" directs staff to secure the security belt firmly around the individual's chest by inserting the attachment knob located behind the individual's back through the appropriate hole at the end of the belt. Adjust the belt and comfort pads as necessary for the individual's security and comfort. At the end of the bath cycle, open the drain and allow the tub to drain. After the water is completely drained, open the tub door by pushing down on the open button and allow the door to rotate to a fully open position until it stops. Dry as much of the individual as possible. When completed remove the chest belt from the individual and transfer the individual out of the bath seat. During a follow-up interview dated 12/26/16 at 6:30 a.m., Staff A reported the South tub had security belt to place around the resident but the North tub did not have the same safety device. During an interview dated 12/27/16 at 8:13 a.m., the resident's physician reported the computerized tomography taken 11/11/16 revealed a non-displaced fracture to the left clavicle and a fracture to the clavicle. The resident had increased pain and health decline. The resident had been prescribed increased doses of Hydrocodone/Acetaminophen and	F 323		

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F 323	Continued From page 7 Morphine.	F 323		

F 000 Correction Date: 12/28/2016

F 323

This facility denies that the alleged facts as set forth constitute a deficiency under the interpretations of Federal and State law.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.

The plan of correction prepared for this deficiency was executed solely because provisions of State and Federal law require it.

Without waiving the foregoing statement, with respect to Resident #3 and all similarly situated residents, the facility immediately amended the policy requiring two staff members to be present to assist with all transfers for residents identified as two-person assist into and out of the whirlpool tub, adding the requirement that two staff members must be present prior to the whirlpool tub door being lowered. Staff members have been educated regarding this policy. The DON will monitor this plan of correction weekly for the next three months, and then will monitor monthly for three additional months. This plan of correction (correction date) will be in effect on or before 12/28/2016.