STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165614	A. BUILDING _____ B. WING _____	C 01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HAVEN NURSING HOME	1500 N FRANKLIN AVENUE MARENGO, IA 52301

(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 ✓ KK 1/31/17	INITIAL COMMENTS AMENDED 1/30/17 KK Correction date 1/13/17 The following information relates to the investigation of incident #61742 & #65019 and complaint #65018. (See Federal Code of Regulations (42-CFR) Part 483, Subpart B-C) Complaint #62437 was not substantiated.	F 000		
F 323 SS=K	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.	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/31/2017

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.

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	165614	A. BUILDING _____ B. WING _____	C 01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HAVEN NURSING HOME	1500 N FRANKLIN AVENUE MARENGO, IA 52301

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F 323	Continued From page 1 (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure the residents ' environment remained free from physical hazards as possible for 1 of 4 residents reviewed. (Resident #1). Resident #1 received burns from a base board heater. Two of three hallways had resident beds parallel to base board heaters. The west and south hallways had 30 residents with base board heaters in their rooms. On 1/12/17, the facility moved the remaining 3 beds from the base board heaters and disabled the west hallway unit under the handrail. The facility reported a census of 53 residents. Findings include: Resident #1 had a MDS (Minimum Data Set) assessment with a reference date of 12/18/16. The MDS identified Resident #1 had short and long term memory deficits and severely impaired cognitive abilities for daily decision making. Resident #1 required total dependence with bed mobility, transfers, dressing, eating, toilet use and personal hygiene needs. Resident #1's diagnosis included Alzheimer's disease, non-Alzheimer's dementia, diabetes mellitus and arthritis. The care plan dated 6/6/16, identified a problem with risk of falling related to Alzheimer's disease, increased confusion, weakness and occasional combative behavior. The care plan interventions directed the staff and included keeping the bed in the lowest position, bilateral side rails, a ditch mattress, and landing strips at bedside.	F 323		

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	165614	A. BUILDING _____ B. WING _____	C 01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HAVEN NURSING HOME	1500 N FRANKLIN AVENUE MARENGO, IA 52301

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F 323	Continued From page 2 On 1/11/17 at 2:42 p.m. Staff A, Certified Nurse Aide, was interviewed and stated she did final rounds at 11:00 p.m. on the evening of 1/6/17. Staff A stated she entered the room of Resident #1 who was incontinent and needed changed. Resident #1's bed was positioned parallel with the wall and the base board heating unit about a foot from the wall. Staff A stated she gathered her supplies and then grabbed the bed pad and pulled causing Resident #1 to roll onto his/her right side. Staff A removed the soiled brief and as she started to wipe the resident's bottom, without notice, Resident #1's legs flopped off the opposite side of the bed and Resident #1 went onto his/her knees between the bed and wall, with his/her hands grasping the side rail. Staff A came around to the other side of the bed and was able to get Resident #1 to release the side rail and lowered him/her onto the floor onto his/her left side. Staff A then ran out of the room to get help. Within seconds she and Staff B returned to the room. The nurse, Staff C arrived shortly after. Staff A stated when Resident #1 went to the floor she panicked and didn't recall whether Resident #1 was up against the base board heating unit or not. Staff A stated in hindsight she wished she would have had help with providing cares, but noted Resident #1 only required assistance of one staff person with perineal cares. On 1/11/17 at 3:10 p.m. Staff B, Certified Nurse Aide, was interviewed and stated she and Staff C were in a resident's room on the new wing at around 10:50 p.m. when she heard Staff A hollering her name in the dining room. Staff B immediately responded and followed Staff A into Resident #1's room. Resident #1 was lying up against the wall on his/her left side, between the	F 323		

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	165614	A. BUILDING _____ B. WING _____	C 01/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HAVEN NURSING HOME	1500 N FRANKLIN AVENUE MARENGO, IA 52301

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F 323	Continued From page 3	F 323		

bed and wall. Staff B instructed Staff A to move the bed as she lifted and slid Resident #1 away from the base board heating unit. Staff B then left the room to get the Hoyer (mechanical) lift and upon returning, Staff C and several other staff were attending to Resident #1. Staff B stated at that point, she left the room and allowed the other staff to deal with the situation. Staff B stated Resident #1 was typically just a one person assist with perineal cares and she has never known him/her to roll out of bed. Staff B stated Resident #1's bed had been positioned parallel with the wall and base board heating unit at the time of the incident, but has since been changed.

On 1/11/17 at 2:19 p.m. Staff C, Registered Nurse, was interviewed and stated at around 10:55 p.m. Staff A came to the nurse's station hollering for Staff B to come to Resident #1's room. Staff C stated she finished with the resident she was with and also went to Resident #1's room. Upon arriving, there were several staff in the room. Resident #1 was lying on the floor, on his/her left side in a fetal position. Resident #1's back was towards the heat register, but not in contact with it. Staff C assessed Resident #1 and then had him/her lifted into bed using the Hoyer lift. Once in bed, Resident #1 was rolled onto his/her side and at that time she noticed burns along his/her coccyx area. Staff C stated she began measuring the burns and then contacted the physician and administrative staff. Staff C then made arrangements to have Resident #1 sent to the emergency room. Staff C stated Resident #1's bed was usually positioned parallel with the base board heating unit.

The Nurse's Notes dated 1/6/17 at 10:25 p.m. and written by Staff C identified Resident #1 as

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being changed by one certified nurse aide (CNA). Resident #1 rolled off the opposite side of the bed, landed on the floor with his/her buttocks against the electrical wall heater.

The Resident Fall Assessment Sheet dated 1/6/17 at 10:55 p.m. indicated Resident #1 slid off the bed while being changed by Staff A. Lying on the left side in a fetal position. Staff B stated Resident #1 was up against the electric wall heater. Resident #1 was lifted by a Hoyer lift into bed. Wound #1 measured 18 centimeters by 3 centimeters, white burn and #2 area measured 16 centimeters by 1.5 centimeters white burn noted in sacral area. Some skin was peeling and the resident sent to the hospital.

On 1/11/17 at 3:30 p.m. the Administrator stated she was first notified of the incident involving Resident #1 on 1/6/17. The Administrator immediately initiated an investigation and began interviews. The following morning the Administrator and maintenance began evaluating the room and heating source noting concerns with the access to thermostats, the potential exposure to the heating units and positioning of the resident's bed. The Administrator had locked covers placed over room thermostats, ordered coverings for all base board units and began repositioning beds so they would not be parallel with the base board heating units.

Observations on 1/11/17 at 12:15 p.m. identified rooms S-01 through S-09 and rooms W-01 through W-10 all heated with electrical baseboard heating units. All protective coverings and shields were in place and could be touched without discomfort. However there were portions of the internal heating elements that were exposed and

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F 323	Continued From page 5	F 323		

when touched were extremely hot and within seconds of contact would cause burning. The temperature taken of the exposed heating element in Resident #1' room at 3:30 p.m. were in excess of 220 degrees Fahrenheit and the shields were too hot to maintain contact more than 2-3 seconds. There were three beds observed positioned parallel with the base board heating units. Two beds in room S-03 and one bed in room W-01. All three beds were in excess of three feet from the wall/base board heating units. All other beds were positioned with the head of the bed against the base board heating units. In the west hall, an electric heater was observed in the hallway below the hand rail. The facility turned the heater off.

The hospital records indicated the document titled Pertinent History identified the resident was transported to the burn unit and had burns involving less than 10 percent of body surface. On 1/9/17, a chest x-ray identified the resident had pleural effusions of both lungs, indicative of pneumonia or aspiration. The resident died on 1/11/17. The primary cause of death was respiratory failure. The conditions directly contributing to death, was an aspiration (inhalation of food, liquids, vomit, etc) event.

Note: At the time of the complaint investigation, the complaint was coded at a "K", immediate and serious jeopardy. By 1/12/17 the facility had implemented measures that adequately addressed the jeopardy and the grid placement was lowered to the "E" level. The facility moved all the beds in the rooms located in the south and west hall away from the electric base board heaters and not parallel to the bed. The facility ordered protective shields to completely cover the

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F 323	Continued From page 6 heaters and the heater located in the west hall way was disabled. As of the 1/12/17 exit conference the facility continued to need to: monitor the electric base board heaters to ensure the shields are covering the entire unit and the beds remain away from the heaters (not parallel).	F 323		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0659	A. BUILDING: _____ B. WING _____	C 01/12/2017

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ROSE HAVEN NURSING HOME	1500 N FRANKLIN AVENUE MARENGO, IA 52301

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N 101	50.7(1) 481- 50.7 (10A,135C) Additional notification. 481-50.7 (10A,135C) Additional notification. The director or the director ' s designee shall be notified within 24 hours, or the next business day, by the most expeditious means available (I,II,III): 50.7(1) Of any accident causing major injury. a. " Major injury " shall be defined as any injury which: (1) Results in death; or (2) Requires admission to a higher level of care for treatment, other than for observation; or (3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a " major injury " based upon the circumstances of the accident, the previous functional ability of the resident, and the resident ' s prognosis. b. The following are not reportable accidents: (1) An ambulatory resident, as defined in rules 481-57.1(135C), 481-58.1(135C), and 481-63.1(135C), who falls when neither the facility nor its employees have culpability related to the fall, even if the resident sustains a major injury; or (2) Spontaneous fractures; or (3) Hairline fractures. This Statute is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to notify the Department of Inspections and Appeals of an	N 101		

DIVISION OF HEALTH FACILITIES - STATE OF IOWA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/31/17

DEPARTMENT OF INSPECTIONS AND APPEALS

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	IA0659	A. BUILDING: _____ B. WING _____	C 01/12/2017

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N 101	Continued From page 1 accident causing major injury within 24 hours. (Resident #2) The facility census was 53 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 7/14/16, documented Resident #2 required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene needs and had diagnoses that included pancreatic cancer, diabetes mellitus and hypertension. During interview on 1/11/17 at 4:50 p.m., the Administrator stated the resident was admitted on 7/12/14 with end stage pancreatic cancer and had been on hospice. On 7/14/16, the resident fell and sustained a mild subdural hematoma and head laceration. Resident #2 returned to the hospital for observation and never returned to the facility. The Administrator stated she was on vacation at the time of the incident and was not informed of the incident until returning 7/20/16 at which time she reported.	N 101		

ROSE HAVEN
NURSING HOME

F 323

The facility states that it is the policy of Rose Haven Nursing Home to ensure and provide an environment that remains free from accident hazards as is possible. This facility denies that the alleged fact as set forth constitute a deficiency under 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 the State and Federal law required it.

With respect to Residents #1, the room was evaluated and bed moved on January 6 in relation to the floor heating unit. Regarding all other similarly situated residents, by January 8th every other room with the base board heating units were evaluated and rearranged for assure safety in regards to the bed position and the heating unit.

On January 6, 2017 available covers were placed over each individual room thermostat and locked. Additional thermostat covers were ordered and baseboard heater covers ordered to add further protection from the heat source. Covers began arriving Thursday January 12, 2017 and immediate installation began. A certified electrician was brought in to evaluate and check the units for proper functioning and found they were working as indicated by instruction manual.

On January 09-11, 2017 Re-education was provided to each CNA and Nurse employed at Rose Haven. The written training included two separate training forms. The first covered Resident Care and Safety regarding proper bed placement together with evaluating the environment for any potential hazards. Staff were re-educated to report any abnormal findings immediately. The second area of training covered Safety During an Incident. Upon identifying an incident staff were instructed to make sure the resident is in the safest position possible and follow the policy relating to proper reporting and requesting assistance for the situation. Each staff member went over the listed safety measures and signed off noting understanding.

Compliance will be monitored by the Maintenance supervisor through monthly checks of each individual thermostat and heating unit to ensure proper functioning and safety. Findings will be documented in a designated maintenance log. The Housekeeping Supervisor will perform weekly checks for each room to ensure proper bed and room placement. This will be documented in a designated log. Any concerns will be discussed with the administrator and immediate action will be taken for any corrections needed.

N 101

The facility states that it is the policy of Rose Haven Nursing Home to investigate and timely report accidents resulting in major injury per 50.7. This facility denies that the alleged fact as set forth constitute a deficiency under interpretations of State law.

1500 Franklyn Ave. Marengo, IA 52301
Phone: 319-642-5533
Fax: 319-642-3822

ROSE HAVEN
NURSING HOME

January 30, 2017

Kathy Kieler
Bureau Chief
Medicare/Medicaid Bureau III
Dear Ms. Kieler

Please find enclosed our plan of correction for our inspection on January 11-12, 2017.

We would like to thank Rob Reck for his courteous and professional conduct during the inspection. It was greatly appreciated by our staff and residents.

I hope you find everything in order. Please let me know if you have any further questions.

Sincerely,

Randi Roggentien, Administrator

Rose Haven Nursing Home

1500 Franklyn Ave. Marengo, IA 52301
Phone: 319-642-5533
Fax: 319-642-3822

ROSE HAVEN
NURSING HOME

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 the State law required it.

With respect to Residents #2 and all other similarly situated residents

upon return to facility on July 20, 2017 the administrator met with both the DON and ADON. At this time re-education was provided on the reporting guidelines. This involved the different categories of reporting, when reporting is necessary and the time frames in which a report must be made. The importance of notifying the administrator immediately of such events was also reiterated. Both the DON and ADON verbalized understanding.

Correction date; January 13, 2017

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