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 02/05/2020

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	INITIAL COMMENTS The following deficiency relates to the investigation of a Facility Self-Reported Incident #87002 which was substantiated. (See code of Federal Regulations (42 CFR) Part 483, Subpart B-C). The deficiency cited under F689 will be considered past non-compliance as the facility corrected the deficiency on October 23, 2019 prior to Surveyor entrance.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews the facility failed to appropriately supervise one of three residents reviewed to prevent a fall with injury (Resident #1). The facility reported a census of 54 residents. Findings include: According to the Minimum Data Set (MDS) dated 8/26/2019 and 9/19/2019, Resident #1 identified with no memory impairment, transferred and ambulated with limited assistance of one staff, and unsteady balance moving from a seated to standing position, walking, turning around,	F 689	Past noncompliance: no plan of correction required.	

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

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moving on and off the toilet, and surface to surface transfer. The resident with diagnoses including anemia, weakness, history of falling, pain and cancer. The resident had a history of falling prior to admission.

According to the MDS dated 11/6/2019, Resident #1 required extensive assistance to transfer and ambulate, after a fall with major injury, and experienced frequent pain.

The Care Plan initiated 8/26/2019 revealed Resident #1 with a fall risk related to diagnosis of progressing brain tumor, muscle weakness, pain in shoulder, history of falling, and corneal ulcer in right eye. The Care Plan directed staff to assist resident with all transfers and ambulation with the use of a gait belt and walker with limited assistance of one initiated 8/26/2019. On 10/23/2019 the Care Plan added, please assist with transfer assist times two due to recent arm fracture and arm is in a sling.

The October 2019 Plan of Care Kardex revealed Resident #1 transferred and ambulated with assist of one and a walker.

The Resident Fall Assessment Sheet dated 10/23/2019 revealed Resident #1 sustained a fall at 7:30 a.m.. The report documented the resident with risk factors including decline in functional status, acute condition making resident unstable, unsteady gait, decline in cognitive skills, depression, impaired hearing, impaired vision and dizziness. The resident's decline in functional status puts her at increased risk for falls and the resident used assistive devices including walker and wheel chair.

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The report states Staff A, Licensed Practical Nurse (LPN) called to the resident's bathroom and noted the resident sitting on buttocks on the bathroom floor and leaning against door frame with legs and arms extended. Resident denies bumping head. Neurological (Neuro's) checks initiated, walker upright in front of toilet, resident wearing pajamas and slipper socks. Resident ambulating to bathroom with walker and SBA (stand by assist) when she reported she got dizzy and lost balance and fell. Noted two small skin tears on right wrist and elbow without bruising. Skin sheet completed and order of antibiotic ointment and Band-Aid every day. Resident moved all extremities without difficulty or pain, assisted up to toilet, and without needs voiced.

The self report included: Staff assisted resident to the bathroom with walker. Resident wore slipper socks, pajama top and bottoms, and pull-up liner on. Resident became dizzy and lost balance and staff walked beside him/her. Staff thought resident only needed stand by assist. Resident started to turn towards the toilet and lost his/her balance, fell into the doorjamb and sat on the floor. Staff witnessed the fall and stated resident did not bump head. Legs were extended out in front and resident noted to have two small skin tears to right wrist and right elbow, able to move extremities without difficulty, and no bruising or pain with exam, Neuro's were intact at that time. After lunch the resident complained of pain to right arm and shoulder. The physician ordered an x-ray. The resident had a fracture to the head of the right humerus (upper arm bone). Resident walked out to breakfast and lunch without complaint. At 12:08 P.M. staff administered Tylenol for pain.

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The 10 Questions at the time of a fall included the following questions and responses:
1. Are you okay? "Yes"
2. What were you trying to do? "Going to bathroom"
3. What was different this time? "Aide without assistance"
4. Position of Resident: near toilet, on buttocks with legs and arms extended.
5. and 6. Poor lighting, and shiny, tile floor.
7. Resident wore non-skid slippers.
8. Assistive device: walker.
9. No glasses's or hearing aides.
10. Staff in the area when resident fell? Staff B, Certified Nurse's Aide (CNA).

The Emergency Room summary dated 10/23/2019 revealed Resident #1 with an arm injury and diagnoses including closed displaced fracture of proximal end of right humerus and acute cystitis (bladder infection) without hematuria (blood in the urine). The resident received an arm sling, and prescriptions for an antibiotic and pain medication and returned to the facility.

During an interview on 2/5/2020 at 2:30 p.m., Staff C, Administrator indicated staff had access to Care Plans in the front of resident charts. The Plan of Care Kardex is completed by the assigned CNA at the end of the shift. Assignment sheets are kept at the time clock. Staff B, CNA would have learned of the float assignment that day and should have picked up all the sheets. Staff use Walkie-talkies to communicate with one another, seek help and ask questions. The first time an Agency Staff works at the facility, they arrive an hour early for the shift and receive a tour, information and assignment sheets. Staff B

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indicated he/she thought Resident #1 ambulated with stand by assistance. Staff B received a discipline. Staff D, Director of Nursing (DON) handled the investigation. The facility had no prior concerns with Staff B. Per physical therapy, the resident always transferred with a minimum of one assist.

During an interview on 2/5/2020 at 2:45 p.m., Staff D, DON reported he/she did the investigation when Resident #1 had a fall with injury. Staff D arrived to work at approximately 8:30 a.m. that day and the resident walked to breakfast and lunch without complaint. After lunch the resident complained of pain and they sent the resident to the Emergency Room where the resident's x-ray revealed a fractured humerus. Staff D reported the incident to DIA (Department of Inspections and Appeals) and the Agency Staffing Company. Staff B seemed upset about the incident and thought Resident #1 ambulated with stand by assist. The resident wanted to do more for him/her self and worked with therapy. Staff B worked as a float that day, had no assignment sheets but did have a Walkie-talkie. Stand by assist means staff needs to be present but not assisting with a gait belt. The facility had no gait belt policy but expectation is it is to be used with assistance of one or greater. Staff B worked at the facility prior and they had no prior concerns. The Agency Staffing Company reported they direct staff to use a gait belt always when in doubt. After the incident they did a "fall huddle" and discussed the event. Staff D communicated to staff via the Walkie talkie and reminded them to use a gait belt. Staff B chose not to return to the facility.

During an interview on 2/5/2020 at 10:30 a.m.,

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Staff A, LPN reported working the day Resident #1 fell. Staff B summoned Staff A to Resident #1's bathroom and found the resident sitting on the floor leaning up against the door frame with a gait belt on. The resident denied hitting his/her head, had two small lacerations on the right arm and complained of right shoulder pain. The resident said the Aide did not have a hold of him/her and the Aide had just put the gait belt on. Staff A wrote the Staff B,CNA a warning and he/she has not worked at the facility since. The resident ate breakfast and lunch and then complained of right arm pain. They sent the resident to the emergency room and he/she returned with an arm sling. The resident had a right humerus fracture. The resident transferred to another facility to be closer to family. CNA's have wing sheets that reveal resident's needs. Staff B did not have an excuse as to why he/she did not have sheets. Staff A had no prior concerns with Staff B. The resident had a history of a brain tumor and had a history of dizzy spells.

During an interview on 2/5/2020 at 12:15 p.m., Staff B, CNA revealed he/she worked for the Agency Staffing Company for one year and worked at the facility quite a bit. When Resident #1 fell, Staff B assisted the resident in the morning to get ready for the day. Staff B walked with the resident to the bathroom without a gait belt, though Staff B had a gait belt available. The resident tried to turn towards the toilet and fell. Staff B thought the resident had the walker. Staff B stated did not put the gait belt on the resident because he/she had been told prior the resident a stand by assist. That day, Staff B worked as a float and covered the entire building. Staff B reported worked with the resident 6-12 times prior, usually as a float, and unaware the resident

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transferred and ambulated with assist of one. As the resident turned, Staff B stood by him/her. Staff B unaware of the resident's brain tumor or history of dizziness. Staff B asked other staff as needed, but did not ask anyone the day the resident fell because he/she thought she was told the resident ambulated with stand by assist. Stand by assist means you are with the resident and guide them without a gait belt.

Staff receive morning report from the nurse letting them know any changes and appointments. Staff B did not recall of any mention of anything reported regarding Resident #1. Staff B indicated he/she put a gait belt on the resident after the fall because he/she knew they would need it to get the resident up off of the floor, and the resident complained of right arm pain. Staff B reported he/she ambulated the resident to meals, never put a gait belt on him/her, and never saw any staff use a gait belt, so he/she believed the resident was a stand by assist. The Agency Staffing Company wrote Staff B up for not using a gait belt after the incident. Staff B had no other disciplines.

Record review revealed Staff A, LPN issued a Warning Notice to Staff B, CNA dated 10/23/2020 for violation of Policies/Procedures. Description of violation: resident assisted to bathroom without a gait belt and fell.

During an interview on 2/5/2020 at 1:50 p.m.., Staff E, CNA reported working full time at the facility. Staff E recalled Resident #1 returned from the emergency room with an arm sling and said the Agency Aide did not put a gait belt on the resident and he/she lost his/her balance. Staff E reported the resident had dizzy spells, but could

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F 689	Continued From page 7 use the call light and make his/her needs known. Staff is to use a gait belt with every resident who requires one assist. Resident #1 always required assist of one. Staff has Daily Assignment Sheets with list of residents and assistance needed to review. The float staff could take Daily Assignment Sheets from all halls. The facility corrected the deficient practice on October 23,2019 prior the Incident investigation by contacting the Agency Staffing Company who educated the staff employed and the facility did education with facility CNA's to utilize gait belts on all transfers with residents who needed one person assist. Because the facility corrected the deficient practice, the situation identified as past non-compliance.	F 689		