**Iowa Department of Inspections and Appeals**
**Health Facilities Division**
**Citation**

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|---|---|---|---|---|
| **FC#6425** | | | | **Date: January 27, 2017** |
| **Rose Haven Nursing Home** | | **Survey dates: January 11-12, 2017** | | |
| **1500 N. Franklin Ave.** | | | | |
| **Marengo, Iowa 52301** | **Ds/pc/kk** | | | |
| | | **Class** | **Fine Amount** | **Correction Date** |
| **58.28(3)f**<br><br>**+**<br><br>**58.35(4)i,j** | **481—58.28 (135C) Safety.** The licensee of a nursing facility shall be responsible for the provision and maintenance of a safe environment for residents and personnel. (III)<br>**58.28(3)** *Resident safety.*<br>*f.* Residents shall be protected against physical or environmental hazards to themselves. (I, II, III).<br><br>**481-58.35(135C) Buildings, furnishings, and equipment.**<br>**58.35(4)** *Bedrooms.*<br>i. Beds shall not be placed with the head of the bed in front of a window or radiator. (III)<br>j, Beds should not be placed in such a manner that the side of the bed is against the radiator or in close proximity to it unless it is covered so as to protect the resident from contact with it or from excessive heat. (III)<br><br>**DESCRIPTION:**<br><br>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. The facility reported a census of 53 residents. | **I** | **$10,000**<br>**Held in suspension** | **Upon Receipt** |



Facility Administrator Date

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| | Findings include:<br><br>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.<br><br>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.<br>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.<br><br>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 | | | |



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| | 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.<br><br>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 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 | | | |



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| | 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.<br><br>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.<br><br>The Nurse's Notes dated 1/6/17 at 10:25 p.m. and written by Staff C identified Resident #1 as 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.<br><br>The Resident Fall Assessment Sheet dated 1/6/17 | | | |



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| | 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.<br><br>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.<br><br>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 when touched were extremely hot and within seconds of contact would cause burning. The temperature taken of the | | | |



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| | 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.<br><br>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.<br><br>**FACILITY RESPONSE:** | | | |



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