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	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Haven Nursing Home	1500 N Franklin Avenue Marengo, IA 52301

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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 34821 Based on observation, clinical record review, staff and resident interviews and facility policy review the facility failed to treat one out of four residents reviewed in a dignified manor (Resident#5). The facility reported a census of 49 residents. Finding include: The Significant Minimum Data Set (MDS) assessment for Resident #5 dated 2/18/25, included diagnoses of neurogenic bladder, pressure ulcer, diabetes mellitus (DM), anxiety, and depression. The MDS reflected Resident#5's Brief Interview for Mental Status score of 15 (intact cognition). The MDS listed Resident#5 dependent on staff for toilet transfers and toilet hygiene. The Care Plan for Resident#5 dated 2/18/25, directed Staff to assist her with toileting upon her request, Resident#5 often preferred to utilize the commode. Staff assist with peri cares (procedure to clean and maintain the genital and anal areas) every AM, PM and as needed with incontinence episodes. On 3/6/35 at 8:30 AM, Resident#5 sat in her room in her wheelchair and she confirmed Staff B, Certified Nurses Aid (CNA) told her to go to the bathroom in her bed if she needed to have a bowel movement (BM) right now. On 3/6/25 at 5:47 AM, Staff G, Registered Nurse (RN) reported Resident#5 told her Staff B, directed Resident#5 to go the the bathroom in her bed. Staff G revealed her shock over that direction from staff. She reported she wrote up Staff B and slid it under the office door for the Director of Nursing to follow up on. On 3/10/25 at 3:16 PM, the Director of Nursing (DON) confirmed she knew that Staff B told Resident#5 to go to the bathroom in her bed. The DON reported she provided verbal education on dignity and explained that is an unacceptable practice. She stated the staff are expected to take the resident to the bathroom. The facility provided documentation of a Five Minute Meeting for Employees dated 1/4/25, that covered the Resident's [NAME] of Rights. Staff G, signed she received the education. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided the Residents' [NAME] of Rights dated 11/2016, it directed facility staff as follows: A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source.

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NAME OF PROVIDER OR SUPPLIER Rose Haven Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N Franklin Avenue Marengo, IA 52301	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34821 Based on clinical record review, resident interviews, and facility policy review the facility failed to report an allegation of abuse in a timely manner for 1 out of 4 residents reviewed for abuse (Resident#2). The facility reported a census of 49 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment for Resident#2 dated 1/24/25, listed diagnoses of respiratory failure, heart failure, and diabetes mellitus. The BIMS reflected a score of 12 (moderate cognitive impairment). The MDS reflected Resident#2 required substantial/maximal assistance with toileting hygiene and partial/ moderate assistance to transfer off the toilet. The Care Plan for Resident#2 dated 8/8/24 directed assist of one staff for transfers, ambulation with walker and toileting. A facility document titled #408 Alleged Abuse dated 3/4/25, Resident#2 reported one of the CNA slammed her down on the toilet over the weekend. The document showed the facility asked eight residents about the care staff provided at the facility. During an interview on 3/4/25 at 12:52 PM, Resident#2 reported one CNA slammed her down on the toilet a few days ago. Resident#2 stated her bottom hurt when it happened. Resident#2 explained she goes in the bathroom with the walker and the wheelchair (w/c). During an interview on 3/6/25 at 09:16 AM, Staff M, CNA/Rehabilitation aid pushed Resident#2 into her room, applied the Gait Belt (GB) above the breasts, assisted her to Stand Pivot Transfer (SPT) with her walker to the recliner in her room. During an interview on 3/10/25 at 11:06 AM Staff O, CNA said she went to get Resident#2's light after lunch last Sunday 3/2/25. She reported Resident#2 told her that someone there threw her on the toilet. Staff O reported she worked with Staff P, CNA on that day. Staff O reported Staff P's tone can seem harsh and short at times. She thought she reported Resident#2's complaint to the nurse right after it happened, but she may not have listened to her. During an interview on 3/10/25 at 11:20 AM, Staff N, CNA, stated She said Staff O, CNA told her that Resident#2 told her that someone slammed her on the toilet on 3/2/25. During an interview on 3/10/25 at 3:24 PM, the Director of Nursing (DON) reported any concerns the staff needed to report and make sure the nurses listened to them. During an interview on 3/10/25 at 3:44 PM, the Administrator stated she expected each staff to report any concerns to the nurse and make sure the nurse listened or report the concern to the DON independently. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided a policy undated titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, the policy directed Investigation Protocols: Should an incident or suspected incident of Resident abuse (as defined above) be reported or observed, the administrator or his/her designee will designate a member of management to investigate the alleged incident. The administrator or designee will complete documentation of the allegation of Resident abuse and collect any supporting documents relative to the alleged incident. Review documentation in resident record (including review of assessment if resident injury). Assess the resident for injury if the allegation involves physical or sexual abuse; Provide proper notifications to primary care provider, responsible party, etc. Attempt to obtain witness statements (oral and/or written) from all known witnesses. If there is physical evidence that can be preserved, attempt to do so, and maintain in a safe location to minimize risk of evidence being tampered with. The facility will establish and enforce an environment that encourages individuals to report allegations of abuse without fear of recrimination or intimidation. Following investigation, the Administrator or designated agent will be responsible for forwarding the results of the investigation to the State Agency. This written report shall be forwarded to the Department within five days of the initial report.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34821 Based on clinical record review, resident interviews, and facility policy review the facility failed to do a thorough investigation into an allegation of abuse for 1 out of 4 residents reviewed Resident#2). The facility reported a census of 49 residents. Findings include: The Quarterly Minimum Data Set (MDS) assessment for Resident#2 dated 1/24/25, listed diagnoses of respiratory failure, heart failure, and diabetes mellitus. The BIMS reflected a score of 12 (moderate cognitive impairment). The MDS reflected Resident#2 required substantial/maximal assistance with toileting hygiene and partial/ moderate assistance to transfer off the toilet. The Care Plan for Resident#2 dated 8/8/24 directed assist of one staff for transfers, ambulation with walker and toileting. A facility document titled #408 Alleged Abuse dated 3/4/25, Resident#2 reported one of the CNA slammed her down on the toilet over the weekend. The document showed the facility asked eight residents about the care staff provided at the facility. During an interview on 3/4/25 at 12:52 PM, Resident#2 reported one CNA slammed her down on the toilet a few days ago. Resident#2 stated her bottom hurt when it happened. Resident#2 explained she goes in the bathroom with the walker and the wheelchair (w/c). During an interview on 3/10/25 at 3:42 PM, the Administrator reported the residents she interviewed after the first incident failed to report further concerns about staff treatment and after the second incident she the resident failed to identify staff mistreatment. The facility provided a list of the current resident's BIMS dated 3/4/25, that included 20 cognitively intact residents. The facility interviewed 13 in reference to staff treatment. The facility failed to provide evidence that an alleged allegation of abuse related to Resident#2 was thoroughly investigated. For example the investigation notes lacked documentation that the discription of the staff member Resident#2 discribed was followed up on. The facility provided a policy undated titled Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, the policy directed Investigation Protocols: Should an incident or suspected incident of Resident abuse (as defined above) be reported or observed, the administrator or his/her designee will designate a member of management to investigate the alleged incident. The administrator or designee will complete documentation of the allegation of Resident abuse and collect any supporting documents relative to the alleged incident. Review documentation in resident record (including review of assessment if resident injury). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident for injury if the allegation involves physical or sexual abuse; Provide proper notifications to primary care provider, responsible party, etc. Attempt to obtain witness statements (oral and/or written) from all known witnesses. If there is physical evidence that can be preserved, attempt to do so, and maintain in a safe location to minimize risk of evidence being tampered with. The facility will establish and enforce an environment that encourages individuals to report allegations of abuse without fear of recrimination or intimidation. Following investigation, the Administrator or designated agent will be responsible for forwarding the results of the investigation to the State Agency. This written report shall be forwarded to the Department within five days of the initial report.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34821 Based on observation, resident and staff interviews and facility policy review the facility failed to transfer 3 out of 4 residents safely Resident#1, #2, and #5). The facility reported a census of 49 residents. Findings include: 1. The Quarterly Minimum Data Set (MDS) assessment for Resident#1 dated 12/10/24, listed diagnoses of pulmonary hypertension (blood pressure in the arteries of the lungs is abnormally high), hyperthyroidism and insomnia. The MDS reflected a Brief Interview for Mental Statues score of 15 (intact cognition). The MDS identified Resident#1 independent with sit to stand and ambulation up to 150 feet. The MDS reflected she needed partial/moderate assistance with toileting hygiene. The Care Plan for Resident#1 dated 9/30/24, identified Resident #1 independent in the facility with her walker, and independent with toileting. Staff assist her as needed upon her request. The Progress Notes for Resident#1 dated 1/4/25 at 9:43 AM, reflected Resident#1 went to the nurse's station and showed Staff I, Licensed Practical Nurse (LPN) a bruise on her left forearm, 3 centimeters (cm) by 2.5 cm, maroon in color. Resident#1 reported that Staff C, Certified Nurses Aid (CNA), caused the bruise by applying to much pressure to her arm. A facility document titled #363 Alleged Abuse dated 1/4/25, revealed Resident#1 reported Staff C, gripped her left forearm hard enough to bruise her, and it hurt her. The document reflected staff member educated on gait belt use for transfers. On 3/6/25 at 11:48 AM, Staff P, CNA placed a gait belt on Resident#1 and walked her out of the dining room, down her hall. On 3/4/25 at 12:23 PM, Resident#1 reported Staff C, CNA walked her out of the bathroom back to her bed. Resident#1 stated Staff C grabbed her arm and squeezed. On 3/5/25 at 10:44 AM, Staff K, Licensed Practical Nurse (LPN) revealed when the CNAs need to boost Resident#1 to stand they go under her arm, when she's up they walk with her Stand By Assist (SBA) they don't need a Gait Belt (GB). On 3/6/25 at 2:35 PM, Staff C, reported the day of the incident she went right to Resident#1's room to get her call light. Staff C said she normally helped Resident#1 sit up on the side of the bed. She wound uncovered her, puts her left arm under legs, her right over legs and pull her legs off the edge of the bed. Resident#1 took her hands to sit up. Staff C revealed she reached her left arm out, Resident#1 reached up with her left arm and took a hold of Staff C's left arm by her elbow. Staff C stated she grabbed Resident#1 arm near her elbow. She revealed she reached her other arm behind her back and pulled Resident#1 up. She confirmed Resident #1 called out in pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The Quarterly Minimum Data Set (MDS) assessment for Resident#2 dated 1/24/25, listed diagnoses of respiratory failure, heart failure, and diabetes mellitus. The BIMS reflected a score of 12 (moderate cognitive impairment). The MDS reflected Resident#2 required substantial/maximal assistance with toileting hygiene and partial/ moderate assistance to transfer off the toilet. The Care Plan for Resident#2 dated 8/8/24 directed assist of one staff for transfers, ambulation with walker and toileting. On 3/6/25 at 09:16 AM, Staff M, CNA/Rehabilitation aid pushed Resident#2 into her room, applied the GB above the breasts, assisted her to Stand Pivot Transfer (SPT) with her walker to the recliner in her room. On 3/4/25 at 12:52 PM, Resident#2 reported one CNA slammed her down on the toilet a few days ago. Resident#2 stated her bottom hurt when it happened. Resident#2 explained she goes in the bathroom with the walker and the wheelchair (w/c). She said she gets up out of the w/c and wiggled herself to the stool. She reported she's not sure why the CNA came in there to bother her. On 3/5/25 at 11:14 PM, Staff A, CNA, said if the transfer is a stand pivot transfer (SPT) he doesn't always use the GB. Staff A reported Resident#2 needed SPT to the toilet, he said he will clean her up, she stood and sat on her own. On 3/10/25 at 11:06 AM, Staff O reported she doesn't normally a use GB during transfers with Resident#2. 3. The Quarterly MDS assessment for Resident#6 dated 2/18/25, listed diagnoses of heart failure, diabetes mellitus, and respiratory failure. The MDS included a BIMS score of The MDS reflected Resident#6 dependent on staff for chair/bed/toilet transfers. The Care Plan dated 2/20/25, directed transfers with staff assistance of two using a stand lift for all transfers. The facility document titled #397Fall During Staff Assist dated 2/13/25 at 8:45 PM, described two CNAs were in Resident#6's room lifting her up in EZ-stand, and she passed out and fell to the floor. The report reflected Resident#6 failed to remember the fall. The Progress Note dated 2/02/25 at 8:30 PM, revealed staff reported that when they lifted resident up with stand lift, resident slumped forward with her eyes closed and became unresponsive. After lowering resident back down into her recliner, resident began to open her eyes and spook to staff. On 3/10/25 at 12:34 PM, Staff O reported Resident#6 fell to the floor through the stand lift during a transfer. She clarified they grabbed her arms as she fell through the strap and lowered her to the floor. She reported the strap sat at Resident#6's waist or near her breasts she failed to know, she revealed it happened so fast. It was just like how she fell before she went to the hospital. On 3/10/25 at 1:00 PM, the Physical Therapy Assistant reported a resident shouldn't fall from a stand lift if it's all hooked up correctly. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/10/25 at 3:21 PM, the Director of Nursing (DON) reported she felt the bruise to Resident#1's left arm resulted from Staff C's lack of gait belt use. The DON stated a resident may fall from the stand lift if they fainted and went limp. On 3/10/25 at 3:44 PM, the Administrator stated she expected Staff to use the gait belt with transfers. Reported Resident#6 failed to fall to the floor she said the staff lowered her to the floor. The facility provided a policy titled Gait Belts dated 12/5/24, identified the purpose: All employees providing direct resident care are required to utilize a gait belt whenever hands on assistance is needed for resident transfer and/or ambulation unless otherwise contraindicated. The facility provided the Stand Lift Operating Instruction dated 1/01, directed the resident needed to bear weight.

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F 0865 Level of Harm - Potential for minimal harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 34821 Based on staff interview, facility record review and facility policy review the facility failed to address previously cited deficiencies in the Quality Assessment and Performance Improvement (QAPI) program. The facility reported a census of 49 residents. Findings include: The Centers for Medicare and Medicaid Services (CMS) Statements of Deficiencies 2567 dated 10/24/24, included violation at F609 and F610. The current survey dated 3/4/25 through 3/10/25 identified the same violation at F609 and F610. Form CMS-2567 dated of 11/13/24, reflected acceptance of your credible allegation of substantial compliance and Plan of Correction. On 3/10/25 at 3:44 PM, the Administrator reported the facility followed up on other previous deficiencies cited. The facility Quality Assessment and Performance Improvement (QAPI) policy undated, that identified: The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process included developing and implementing corrective action or performance improvement activities; and monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.