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	12/11/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, clinical record review, policy review, and staff interviews, the facility failed to determine that it was clinically appropriate and safe for a resident to self-administer medications for 1 of 1 residents reviewed for the self-administration of medications(Resident #13). The facility reported a census of 45 residents. Findings included: The Quarterly Minimum Data Set(MDS) assessment tool, dated 9/30/25, listed diagnoses for Resident #13 which included chronic obstructive pulmonary disease(COPD), a disease which caused symptoms such as shortness of breath), heart failure, and diabetes. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The 2022 facility policy Self-Administration of Medications stated residents had the right to self-administer medications if the interdisciplinary team determined that it was clinically appropriate and safe for the resident to do so. The December 2025 Medication Administration Record(MAR) listed a 7/21/25 order for Ipratropium-Albuterol Solution(a medication used to treat COPD) 0.5-2.5 milligrams(mg)/milliliters(ml) 3 ml inhale orally four times a day related to COPD.2/20/24 Care Plan entries stated the resident was at risk for altered respiratory status and difficulty breathing related to COPD, a history of respiratory failure, and a history of pneumonia. The entries directed staff to administer medications as ordered and monitor for effectiveness.On 12/11/25 at 1:00 p.m. Staff A Licensed Practical Nurse(LPN) stated that she would administer the resident's nebulizer(a medical device that turns liquid medicine into a fine, inhalable mist) treatment. She retrieved a 3 ml vial of Ipratropium-Albuterol Solution 0.5-2.5 mg/ml from the medication cart and went to the resident's room. When she arrived, the resident was putting the cap on his nebulizer's medicine cup and stated he already added the medication from a vial he had in his pocket. The facility lacked documentation of an assessment carried out to show the resident was safe to self-administer his medication.On 12/10/25 at 1:05 p.m. Staff A stated Resident #13 was not supposed to carry out his nebulizer treatments on his own. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated residents who did not have an assessment completed for the self-administration of medications should not keep medications in their rooms. She stated the nurses should administer the resident's nebulizer treatment.On 12/11/25 at 11:51 a.m., the Director of Nursing(DON) stated residents should not keep albuterol vials in their rooms for self-administration.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, clinical record review, policy review, and staff interviews, the facility failed to ensure residents were free from physical abuse for 1 of 1 residents reviewed for abuse(Resident #35). The facility reported a census of 45 residents. Findings:The Minimum Data Set(MDS) assessment tool, dated 9/2/25, listed diagnoses for Resident #35 which included unspecified intellectual disabilities, hearing loss, and coronary artery disease. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 6 out of 15, indicating severely impaired cognition. The facility Abuse Policy, dated 7/1/25, stated all residents had the right to be free from abuse and neglect. The policy stated assault of a dependent adult was the commission of any act which was generally intended to cause pain or injury or which was generally intended to result in physical contact considered by a reasonable person to be insulting or offensive or any act intended to place another in fear of immediate physical contact which would be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act.Care Plan entries, dated 4/4/25, stated the resident had impaired cognitive function, intellectual disability, and hearing loss impeding communications. The entries directed staff to orient the resident as needed, keep his routine consistent, and engage him in simple structured activities that avoided overly demanding tasks. An Unwitnessed Fall report, dated 10/28/25 at 1:46 p.m., stated the resident sat on the floor after he slid out of bed. The resident did not have any observable injuries. A 10/28/25 2:59 p.m. Nurses Note stated the resident sat on the floor in front of the bed. He denied injuries and stated he slipped out of bed. The facility applied slide strips in front of his bed for safety. An untitled facility investigation, dated 12/8/25, stated that the staff notified the Administrator on 10/28/25 that Staff A Licensed Practical Nurse(LPN) yelled and poked the resident in the chest. The resident reported that no one poked him in the chest or yelled at him. The resident denied being fearful or afraid of the nursing staff. A 10/28/25 statement, written by Staff B Certified Nursing Assistant(CNA), stated she went into the resident's room to help him up and Staff A came in and asked what happened. Staff A started poking him in the chest and stated that she was sicker than him and this was not funny, she didn't feel good, and was stuck here until 4:00 p.m. because you(the resident) couldn't stay off the floor.A 10/28/25 statement, written by Staff F CNA, stated she was in the room after Resident #35 fell. Staff A came in and started to get stern with him and told him this wasn't funny and he should stay off the floor. She then cried and got in his face and told him that she was sicker than you(the resident) and she could not deal with this. A 10/28/25 statement, written by Staff C CNA, stated the resident fell out of bed around 1:30 p.m. and Staff A came in and was upset because this was the second fall of the day. Staff A yelled and said that she felt worse than the resident did and now she had to stay until 4:00 pm. to keep an eye on him. While she said this, she poked the resident's chest kind of roughly. A 10/28/25 statement, written by Staff D CNA stated Resident #35 was on the floor and Staff A came in and almost cried and said he was the second person on the floor and she wouldn't be able to finish work until 4:00 p.m. and she didn't feel good. Staff D stated she did not see Staff A poke the resident and stated this was blown up for nothing.A 10/28/25 statement, written by Staff A, stated staff called her to the room and the resident sat on the floor and leaned against his bed. Staff A stated she felt overwhelmed by the number of aides in the room and tried to finish her assessment. She spoke very loudly to the resident due to his hearing loss. She stated she did not feel well today and was upset about not being able to leave on time due to another fall. She wrote that she did become visually frustrated in the room and teared up during her assessment. She stated she did not yell at the resident or poke at him in any way. She stated she did feel frustrated with the CNAs at the time. On 12/8/25 at 2:13 p.m., Resident #35 sat in his recliner in his room. The resident did not answer when spoken to by the State Agency. On 12/8/25 at 12:21 p.m., via phone, Staff B stated she received a page that the resident was on the floor. The resident sat on the floor and Staff A asked why he was (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	still on the floor. Staff A stated she wasn't worried about the resident's vitals. She walked up to him and poked him in the chest because she had to work late. The resident was standing at the time she jabbed him. Staff B stated after this occurred, she and Staff F told the Administrator and wrote out statements. She stated she did not see Staff A be physical before this but it was normal for her to be rude. On 12/10/25 at 10:57 a.m., Staff F stated on the day Resident #35 fell, Staff A had a rough day. She had had surgery and was feeling under the weather. She stated when the resident fell, she, Staff B CNA, Staff C CNA and another CNA entered the room and then Staff A came in. She stated another resident had just fallen prior to this and Staff A was overwhelmed and crying and this was toward the end of the shift. Staff F stated Staff A entered the room and said why did you fall on the floor, what are you doing?. Staff F stated the resident was on the floor but leaned against the bed. Staff F stated Staff A completed an assessment including obtaining vitals and looking over his legs. Staff F stated they stood him up and he was walking and Staff A tapped his left shoulder one time and stated why did you do that?. Staff F demonstrated on the table how hard she thought Staff A tapped the resident. Staff F tapped the table in a manner that did not appear to be with any force. She stated after the incident, she went to the Administrator to report this and filled out a statement.On 12/10/25 at 1:50 p.m., Staff F stated after the resident fell, he was startled and overwhelmed but was not crying and did not appear scared. On 12/11/25 at 8:08 a.m., Staff F stated Staff A already had her vital equipment with her when she walked in the resident's room. On 12/10/25 at 11:08 a.m., via phone Staff C stated the day Resident #35 fell was chaotic and another resident had also fallen. She stated she and other staff entered the room after he fell and Staff A followed. Staff C stated Staff A was pretty angry and wanted them to get him up but she hadn't taken his vitals. They got him off the floor and Staff A didn't check him at all. Staff A told them to get him off the floor. After they assisted him to stand, Staff A obtained his vitals and started yelling that she felt worse than you referring to the resident and now she had to stay later because you had to fall. Staff C stated she poked him in his chest and sternum. She stated she poked him 3-4 times in a rough manner. Staff C stated that Staff A was mean to the residents but could not give an example of which residents or further details. She stated she wrote out a statement for the Administrator related to this incident. On 12/10/25 at 1:54 p.m., via phone, Staff C stated after the fall, the resident seemed confused like he didn't understand what was happening or why Staff A was upset with him but he was not crying. On 12/10/25 at 1:05 p.m. Staff A stated on the day the resident fell, she was sick and had just returned from the facility after surgery. She stated 20 minutes before the end of her shift, she had another resident fall. She had just gotten the other resident to the nursing station to continue neurological checks when staff notified her that Resident #35 was on the floor. Staff A stated she was tearful and disappointed with her staff. She stated when she walked into the resident's room, she was tearful and disappointed that the staff were not watching the residents but instead stood at the nursing station waiting for their shift to end. Staff A stated she said to Staff B that she was sick and didn't feel good and now had to stay longer. Staff A stated she told staff to back away from the resident and admitted she was terse at this time. She assessed the resident on the floor. She stated she is sure she raised her voice but did not change her tone. She stated she had to talk to the resident into his left ear. She stated she did not ask the resident why he fell and did not poke him. She stated none of her comments were directed to the resident but were directed to Staff B. She stated the resident did not cry during this event. Staff A stated she immediately implemented the intervention of placing strips in his room and sat with the resident after the fall. She stated she would not ask the resident why he fell because this would hurt his pride. She stated after the incident, the office called her in and she told them the same thing. Staff A stated she should have never said anything to Staff B(regarding being sick or having to work later). On 12/10/25 at 2:16 p.m. via phone, Staff D stated when the resident fell, Staff A assessed him before they got him up. On 12/10/25 at 2:53 p.m., the Administrator stated that 2 CNAs approached her and said that Resident #35 fell and Staff A was in his face and yelled at him. They stated Staff A and the resident were both crying so she said she would look at that. She interviewed the resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Staff A. On 12/11/25 at 9:53 a.m., Staff A stated staff called her down to Resident #35's room and she was tearful. She stated to Staff B that she didn't feel good and just wanted to go home. She stated she already had her vitals equipment with her as well as a neurological sheet. She completed an assessment on the resident including obtaining vital signs and checking range of motion. She asked the aides if this was the third time the resident had a fall to verify this. She stated after the fall they placed strips on his floor. After she assessed him, she asked them to assist him into a wheelchair and bring him to the nursing station so she could carry out 15 minute neurological checks. She stated she did not poke the resident's shoulder or his chest. She stated she had asked staff to back away while she assessed the resident and they were behind her so she didn't know how they would have seen her poke his chest. She stated the resident's assessment was normal and he did not have any injuries or bruises. She stated she did not ask the resident why he fell and did not say that she was sicker than the resident. She stated she did say that now she had to stay late but did not say it to the resident but to the staff in the room. She stated she did not say that she didn't care about the vital signs and to just get him up. She stated she regretted that she said she was sick and wanted to go home. She stated after the fall, she stayed at the facility to complete assessments. She stated the resident was fine and had a soft drink and she sat with him. She stated the resident did not cry during or after this incident. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated staff should treat residents with respect and dignity. On 12/11/25 at 11:51 a.m., the Director of Nursing(DON) stated staff should report allegations of abuse to the administrator and they would remove the staff member(from resident care) and notify the State Agency. On 12/11/25 at 12:45 p.m., the Administrator stated the facility should report all allegations of abuse to the State Agency. She stated she trusted the previous DON's judgement regarding this and she shouldn't have. She stated the facility would suspend the staff member pending an investigation.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review, policy review, and staff interviews, the facility failed to carry out a gradual dose reduction(GDR) or ensure the provider documented why the reduction would be clinically contraindicated for 1 of 5 residents reviewed for psychotropic medications(Resident #35). The facility reported a census of 45 residents. Findings included:The Minimum Data Set(MDS) assessment tool, dated 9/2/25, listed diagnoses for Resident #35 which included unspecified intellectual disabilities, hearing loss, and coronary artery disease. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 6 out of 15, indicating severely impaired cognition. The December 2025 Medication Administration Record(MAR) listed the following:A 3/27/25 order for Trazodone(an antidepressant) 100 milligrams(mg) daily.A 3/28/25 order for Duloxetine(an antidepressant) 120 mg daily. As of 12/8/25, the facility lacked documentation of an attempted GDR for the above medications or provider documentation as to why the reduction would be clinically contraindicated.On 12/11/25, the Administrator provided a 9/26/25 Pharmacist's Recommendation to Prescriber form. On 12/10/25, the provider checked the form's boxes which stated a reduction of the medications was contraindicated but did not provide documentation as to why the reductions were contraindicated. The facility lacked provider documentation related to the GDRs prior to 12/10/25, after the State Agency requested information. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated within the first year of a resident starting a psychotropic medication, they needed to make two attempts at a GDR in 2 separate quarters or have supporting documentation from the provider as to why the GDR would be contraindicated. She stated they faxed the provider multiple times and they did not get a response.The undated facility policy Psychotropic Drug Monitoring stated all psychotropic medication use would be appropriate and given in the lowest effective dose to help minimize the risk of side effects. The policy stated that the facility should carry out a GDR twice in 2 separate quarters during the first year of the medication's usage.

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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. Based on clinical record review, policy review, and staff interviews, the facility failed to report an allegation of abuse to the State Agency for 1 of 1 residents reviewed for abuse(Resident #35). The facility reported a census of 45 residents. Findings:The Minimum Data Set(MDS) assessment tool, dated 9/2/25, listed diagnoses for Resident #35 which included unspecified intellectual disabilities, hearing loss, and coronary artery disease. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 6 out of 15, indicating severely impaired cognition. The facility Abuse Policy, dated 7/1/25, stated the facility would report all allegations of abuse to the State Agency within 2 hours.Care Plan entries, dated 4/4/25, stated the resident had impaired cognitive function, intellectual disability, and hearing loss impeding communications. The entries directed staff to orient the resident as needed, keep his routine consistent, and engage him in simple structured activities that avoided overly demanding tasks. An Unwitnessed Fall report, dated 10/28/25 at 1:46 p.m., stated the resident sat on the floor after he slid out of bed. The resident did not have any observable injuries. A 10/28/25 2:59 p.m. Nurses Note stated the resident sat on the floor in front of the bed. He denied injuries and stated he slipped out of bed. The facility applied slide strips in front of his bed for safety. An untitled facility investigation, dated 12/8/25, stated that the staff notified the Administrator on 10/28/25 that Staff A Licensed Practical Nurse(LPN) yelled and poked the resident in the chest. The resident reported that no one poked him in the chest or yelled at him. The resident denied being fearful or afraid of the nursing staff. A 10/28/25 statement, written by Staff B Certified Nursing Assistant(CNA), stated she went into the resident's room to help him up and Staff A came in and asked what happened. Staff A started poking him in the chest and stated that she was sicker than him and this was not funny, she didn't feel good, and was stuck here until 4:00 p.m. because you(the resident) couldn't stay off the floor.A 10/28/25 statement, written by Staff F CNA, stated she was in the room after Resident #35 fell. Staff A came in and started to get stern with him and told him this wasn't funny and he should stay off the floor. She then cried and got in his face and told him that she was sicker than you(the resident) and she could not deal with this. A 10/28/25 statement, written by Staff C CNA, stated the resident fell out of bed around 1:30 p.m. and Staff A came in and was upset because this was the second fall of the day. Staff A yelled and said that she felt worse than the resident did and now she had to stay until 4:00 pm. to keep an eye on him. While she said this, she poked the resident's chest kind of roughly. A 10/28/25 statement, written by Staff D CNA stated Resident #35 was on the floor and Staff A came in and almost cried and said he was the second person on the floor and she wouldn't be able to finish work until 4:00 p.m. and she didn't feel good. Staff D stated she did not see Staff A poke the resident and stated this was blown up for nothing.A 10/28/25 statement, written by Staff A, stated staff called her to the room and the resident sat on the floor and leaned against his bed. Staff A stated she felt overwhelmed by the number of aides in the room and tried to finish her assessment. She spoke very loudly to the resident due to his hearing loss. She stated she did not feel well today and was upset about not being able to leave on time due to another fall. She wrote that she did become visually frustrated in the room and teared up during her assessment. She stated she did not yell at the resident or poke at him in any way. She stated she did feel frustrated with the CNAs at the time. The facility lacked documentation they reported the allegation of abuse to the State Agency.On 12/8/25 at 2:13 p.m., Resident #35 sat in his recliner in his room. The resident did not answer when spoken to by the State Agency. On 12/8/25 at 12:21 p.m., via phone, Staff B stated she received a page that the resident was on the floor. The resident sat on the floor and Staff A asked why he was still on the floor. Staff A stated she wasn't worried about the resident's vitals. She walked up to him and poked him in the chest because she had to work late. The resident was standing at the time she jabbed him. Staff B stated after this occurred, she and Staff F told the Administrator and wrote out statements. She stated she did not see Staff A be physical (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	before this but it was normal for her to be rude. On 12/10/25 at 10:57 a.m., Staff F stated on the day Resident #35 fell, Staff A had a rough day. She had had surgery and was feeling under the weather. She stated when the resident fell, she, Staff B CNA, Staff C CNA and another CNA entered the room and then Staff A came in. She stated another resident had just fallen prior to this and Staff A was overwhelmed and crying and this was toward the end of the shift. Staff F stated Staff A entered the room and said why did you fall on the floor, what are you doing?. Staff F stated the resident was on the floor but leaned against the bed. Staff F stated Staff A completed an assessment including obtaining vitals and looking over his legs. Staff F stated they stood him up and he was walking and Staff A tapped his left shoulder one time and stated why did you do that?. Staff F demonstrated on the table how hard she thought Staff A tapped the resident. Staff F tapped the table in a manner that did not appear to be with any force. She stated after the incident, she went to the Administrator to report this and filled out a statement.On 12/10/25 at 1:50 p.m., Staff F stated after the resident fell, he was startled and overwhelmed but was not crying and did not appear scared. On 12/11/25 at 8:08 a.m., Staff F stated Staff A already had her vital equipment with her when she walked in the resident's room. On 12/10/25 at 11:08 a.m., via phone Staff C stated the day Resident #35 fell was chaotic and another resident had also fallen. She stated she and other staff entered the room after he fell and Staff A followed. Staff C stated Staff A was pretty angry and wanted them to get him up but she hadn't taken his vitals. They got him off the floor and Staff A didn't check him at all. Staff A told them to get him off the floor. After they assisted him to stand, Staff A obtained his vitals and started yelling that she felt worse than you referring to the resident and now she had to stay later because you had to fall. Staff C stated she poked him in his chest and sternum. She stated she poked him 3-4 times in a rough manner. Staff C stated that Staff A was mean to the residents but could not give an example of which residents or further details. She stated she wrote out a statement for the Administrator related to this incident. On 12/10/25 at 1:54 p.m., via phone, Staff C stated after the fall, the resident seemed confused like he didn't understand what was happening or why Staff A was upset with him but he was not crying. On 12/10/25 at 1:05 p.m. Staff A stated on the day the resident fell, she was sick and had just returned from the facility after surgery. She stated 20 minutes before the end of her shift, she had another resident fall. She had just gotten the other resident to the nursing station to continue neurological checks when staff notified her that Resident #35 was on the floor. Staff A stated she was tearful and disappointed with her staff. She stated when she walked into the resident's room, she was tearful and disappointed that the staff were not watching the residents but instead stood at the nursing station waiting for their shift to end. Staff A stated she said to Staff B that she was sick and didn't feel good and now had to stay longer. Staff A stated she told staff to back away from the resident and admitted she was terse at this time. She assessed the resident on the floor. She stated she is sure she raised her voice but did not change her tone. She stated she had to talk to the resident into his left ear. She stated she did not ask the resident why he fell and did not poke him. She stated none of her comments were directed to the resident but were directed to Staff B. She stated the resident did not cry during this event. Staff A stated she immediately implemented the intervention of placing strips in his room and sat with the resident after the fall. She stated she would not ask the resident why he fell because this would hurt his pride. She stated after the incident, the office called her in and she told them the same thing. Staff A stated she should have never said anything to Staff B(regarding being sick or having to work later). On 12/10/25 at 2:16 p.m. via phone, Staff D stated when the resident fell, Staff A assessed him before they got him up. On 12/10/25 at 2:53 p.m., the Administrator stated that 2 CNAs approached her and said that Resident #35 fell and Staff A was in his face and yelled at him. They stated Staff A and the resident were both crying so she said she would look at that. She interviewed the resident and Staff A. On 12/11/25 at 9:53 a.m., Staff A stated staff called her down to Resident #35's room and she was tearful. She stated to Staff B that she didn't feel good and just wanted to go home. She stated she already had her vitals equipment with her as well as a neurological sheet. She completed an (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment on the resident including obtaining vital signs and checking range of motion. She asked the aides if this was the third time the resident had a fall to verify this. She stated after the fall they placed strips on his floor. After she assessed him, she asked them to assist him into a wheelchair and bring him to the nursing station so she could carry out 15 minute neurological checks. She stated she did not poke the resident's shoulder or his chest. She stated she had asked staff to back away while she assessed the resident and they were behind her so she didn't know how they would have seen her poke his chest. She stated the resident's assessment was normal and he did not have any injuries or bruises. She stated she did not ask the resident why he fell and did not say that she was sicker than the resident. She stated she did say that now she had to stay late but did not say it to the resident but to the staff in the room. She stated she did not say that she didn't care about the vital signs and to just get him up. She stated she regretted that she said she was sick and wanted to go home. She stated after the fall, she stayed at the facility to complete assessments. She stated the resident was fine and had a soft drink and she sat with him. She stated the resident did not cry during or after this incident. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated staff should treat residents with respect and dignity. On 12/11/25 at 11:51 a.m., the Director of Nursing(DON) stated staff should report allegations of abuse to the administrator and they would remove the staff member(from resident care) and notify the State Agency. On 12/11/25 at 12:45 p.m., the Administrator stated the facility should report all allegations of abuse to the State Agency. She stated she trusted the previous DON's judgement regarding this and she shouldn't have. She stated the facility would suspend the staff member pending an investigation.

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	12/11/2025

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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(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. Based on clinical record review, policy review, and staff interviews, the facility failed to separate an alleged perpetrator of abuse from residents for 1 of 1 residents reviewed for abuse(Resident #35). The facility reported a census of 45 residents. Findings:The Minimum Data Set(MDS) assessment tool, dated 9/2/25, listed diagnoses for Resident #35 which included unspecified intellectual disabilities, hearing loss, and coronary artery disease. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 6 out of 15, indicating severely impaired cognition. The facility Abuse Policy, dated 7/1/25, stated the facility would separate the employee accused of abuse from all residents.Care Plan entries, dated 4/4/25, stated the resident had impaired cognitive function, intellectual disability, and hearing loss impeding communications. The entries directed staff to orient the resident as needed, keep his routine consistent, and engage him in simple structured activities that avoided overly demanding tasks. An Unwitnessed Fall report, dated 10/28/25 at 1:46 p.m., stated the resident sat on the floor after he slid out of bed. The resident did not have any observable injuries. A 10/28/25 2:59 p.m. Nurses Note stated the resident sat on the floor in front of the bed. He denied injuries and stated he slipped out of bed. The facility applied slide strips in front of his bed for safety. An untitled facility investigation, dated 12/8/25, stated that the staff notified the Administrator on 10/28/25 that Staff A Licensed Practical Nurse(LPN) yelled and poked the resident in the chest. The resident reported that no one poked him in the chest or yelled at him. The resident denied being fearful or afraid of the nursing staff. A 10/28/25 statement, written by Staff B Certified Nursing Assistant(CNA), stated she went into the resident's room to help him up and Staff A came in and asked what happened. Staff A started poking him in the chest and stated that she was sicker than him and this was not funny, she didn't feel good, and was stuck here until 4:00 p.m. because you(the resident) couldn't stay off the floor.A 10/28/25 statement, written by Staff F CNA, stated she was in the room after Resident #35 fell. Staff A came in and started to get stern with him and told him this wasn't funny and he should stay off the floor. She then cried and got in his face and told him that she was sicker than you(the resident) and she could not deal with this. A 10/28/25 statement, written by Staff C CNA, stated the resident fell out of bed around 1:30 p.m. and Staff A came in and was upset because this was the second fall of the day. Staff A yelled and said that she felt worse than the resident did and now she had to stay until 4:00 pm. to keep an eye on him. While she said this, she poked the resident's chest kind of roughly. A 10/28/25 statement, written by Staff D CNA stated Resident #35 was on the floor and Staff A came in and almost cried and said he was the second person on the floor and she wouldn't be able to finish work until 4:00 p.m. and she didn't feel good. Staff D stated she did not see Staff A poke the resident and stated this was blown up for nothing.A 10/28/25 statement, written by Staff A, stated staff called her to the room and the resident sat on the floor and leaned against his bed. Staff A stated she felt overwhelmed by the number of aides in the room and tried to finish her assessment. She spoke very loudly to the resident due to his hearing loss. She stated she did not feel well today and was upset about not being able to leave on time due to another fall. She wrote that she did become visually frustrated in the room and teared up during her assessment. She stated she did not yell at the resident or poke at him in any way. She stated she did feel frustrated with the CNAs at the time. Staff A's Archived Time Card Report documented she continued to work at the facility from the date of the allegation of abuse on 10/28/25 until 12/10/25.On 12/8/25 at 2:13 p.m., Resident #35 sat in his recliner in his room. The resident did not answer when spoken to by the State Agency. On 12/8/25 at 12:21 p.m., via phone, Staff B stated she received a page that the resident was on the floor. The resident sat on the floor and Staff A asked why he was still on the floor. Staff A stated she wasn't worried about the resident's vitals. She walked up to him and poked him in the chest because she had to work late. The resident was standing at the time she jabbed him. Staff B stated after this occurred, she and Staff F told the Administrator and wrote out statements. She stated she did not see Staff A be physical before this but it was (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	normal for her to be rude. On 12/10/25 at 10:57 a.m., Staff F stated on the day Resident #35 fell, Staff A had a rough day. She had had surgery and was feeling under the weather. She stated when the resident fell, she, Staff B CNA, Staff C CNA and another CNA entered the room and then Staff A came in. She stated another resident had just fallen prior to this and Staff A was overwhelmed and crying and this was toward the end of the shift. Staff F stated Staff A entered the room and said why did you fall on the floor, what are you doing?. Staff F stated the resident was on the floor but leaned against the bed. Staff F stated Staff A completed an assessment including obtaining vitals and looking over his legs. Staff F stated they stood him up and he was walking and Staff A tapped his left shoulder one time and stated why did you do that?. Staff F demonstrated on the table how hard she thought Staff A tapped the resident. Staff F tapped the table in a manner that did not appear to be with any force. She stated after the incident, she went to the Administrator to report this and filled out a statement.On 12/10/25 at 1:50 p.m., Staff F stated after the resident fell, he was startled and overwhelmed but was not crying and did not appear scared. On 12/11/25 at 8:08 a.m., Staff F stated Staff A already had her vital equipment with her when she walked in the resident's room. On 12/10/25 at 11:08 a.m., via phone Staff C stated the day Resident #35 fell was chaotic and another resident had also fallen. She stated she and other staff entered the room after he fell and Staff A followed. Staff C stated Staff A was pretty angry and wanted them to get him up but she hadn't taken his vitals. They got him off the floor and Staff A didn't check him at all. Staff A told them to get him off the floor. After they assisted him to stand, Staff A obtained his vitals and started yelling that she felt worse than you referring to the resident and now she had to stay later because you had to fall. Staff C stated she poked him in his chest and sternum. She stated she poked him 3-4 times in a rough manner. Staff C stated that Staff A was mean to the residents but could not give an example of which residents or further details. She stated she wrote out a statement for the Administrator related to this incident. On 12/10/25 at 1:54 p.m., via phone, Staff C stated after the fall, the resident seemed confused like he didn't understand what was happening or why Staff A was upset with him but he was not crying. On 12/10/25 at 1:05 p.m. Staff A stated on the day the resident fell, she was sick and had just returned from the facility after surgery. She stated 20 minutes before the end of her shift, she had another resident fall. She had just gotten the other resident to the nursing station to continue neurological checks when staff notified her that Resident #35 was on the floor. Staff A stated she was tearful and disappointed with her staff. She stated when she walked into the resident's room, she was tearful and disappointed that the staff were not watching the residents but instead stood at the nursing station waiting for their shift to end. Staff A stated she said to Staff B that she was sick and didn't feel good and now had to stay longer. Staff A stated she told staff to back away from the resident and admitted she was terse at this time. She assessed the resident on the floor. She stated she is sure she raised her voice but did not change her tone. She stated she had to talk to the resident into his left ear. She stated she did not ask the resident why he fell and did not poke him. She stated none of her comments were directed to the resident but were directed to Staff B. She stated the resident did not cry during this event. Staff A stated she immediately implemented the intervention of placing strips in his room and sat with the resident after the fall. She stated she would not ask the resident why he fell because this would hurt his pride. She stated after the incident, the office called her in and she told them the same thing. Staff A stated she should have never said anything to Staff B(regarding being sick or having to work later). On 12/10/25 at 2:16 p.m. via phone, Staff D stated when the resident fell, Staff A assessed him before they got him up. On 12/10/25 at 2:53 p.m., the Administrator stated that 2 CNAs approached her and said that Resident #35 fell and Staff A was in his face and yelled at him. They stated Staff A and the resident were both crying so she said she would look at that. She interviewed the resident and Staff A. On 12/11/25 at 9:53 a.m., Staff A stated staff called her down to Resident #35's room and she was tearful. She stated to Staff B that she didn't feel good and just wanted to go home. She stated she already had her vitals equipment with her as well as a neurological sheet. She completed an assessment on the resident including obtaining (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vital signs and checking range of motion. She asked the aides if this was the third time the resident had a fall to verify this. She stated after the fall they placed strips on his floor. After she assessed him, she asked them to assist him into a wheelchair and bring him to the nursing station so she could carry out 15 minute neurological checks. She stated she did not poke the resident's shoulder or his chest. She stated she had asked staff to back away while she assessed the resident and they were behind her so she didn't know how they would have seen her poke his chest. She stated the resident's assessment was normal and he did not have any injuries or bruises. She stated she did not ask the resident why he fell and did not say that she was sicker than the resident. She stated she did say that now she had to stay late but did not say it to the resident but to the staff in the room. She stated she did not say that she didn't care about the vital signs and to just get him up. She stated she regretted that she said she was sick and wanted to go home. She stated after the fall, she stayed at the facility to complete assessments. She stated the resident was fine and had a soft drink and she sat with him. She stated the resident did not cry during or after this incident. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated staff should treat residents with respect and dignity. On 12/11/25 at 11:51 a.m., the Director of Nursing(DON) stated staff should report allegations of abuse to the administrator and they would remove the staff member(from resident care) and notify the State Agency. On 12/11/25 at 12:45 p.m., the Administrator stated the facility should report all allegations of abuse to the State Agency. She stated she trusted the previous DON's judgement regarding this and she shouldn't have. She stated the facility would suspend the staff member pending an investigation.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review, policy review, and staff interview, the facility failed to administer insulin in a timely manner with respect to the obtainment of the resident's blood sugar(BS) for 1 of 2 residents(Resident #2) reviewed for insulin(an injectable medication used to lower blood sugars). The facility reported a census of 45 residents.Findings included:The Minimum Data Set(MDS) assessment tool, dated 11/2/25, listed diagnoses for Resident #2 which included diabetes(a disease which causes irregularities in blood sugars), arthritis, and anxiety, and listed his Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The resident's Blood Sugar Summary included the following blood sugar readings:11/23/25 5:20 a.m. 110 mg/dl(milligrams(mg)/deciliter(dl) and 8:11 a.m. 110 mg/dl11/24/25 5:25 a.m. 150 mg/dl and 9:18 a.m. 150 mg/dl11/25/25 5:30 a.m. 225 mg/dl and 6:50 a.m. 225 mg/dl11/26/25 6:23 a.m. 222 mg/dl and 8:58 a.m. 222 mg/dl11/29/25 5:37 a.m. 188 mg/dl and 8:28 a.m. 188 mg/dl11/30/25 5:19 a.m. 253 mg/dl and 826 a.m. 253 mg/dlThe November 2025 Medication Administration Record(MAR) listed an 11/21/25 order for humalog(a type of insulin) per sliding scale as follows: 20 units for BS between 60 and 150 mg/dl and 40 units for BS between 151 and 400 mg/dl. The order directed staff to call the provider for BS under 60 or over 400 mg/dl. The MAR documented nurses utilized the above blood sugars obtained on the night shift to determine the resident's breakfast sliding scale insulin amount. On 12/10/25 at 10:50 a.m., Staff E Registered Nurse(RN) stated the third shift nurses obtained blood sugars and the day shift nurses utilized that reading to determine the amount of sliding scale insulin to administer.On 12/10/25 at 1:05 p.m. Staff A Licensed Practical Nurse(LPN) stated that third shift staff obtained most blood sugars and the day shift nurses utilized those to determine the amount of sliding scale insulin to give. She stated the day shift nurses entered the third shift blood sugars into the electronic record when they administered the sliding scale insulin. Staff A stated breakfast used to be at 7:00 a.m. but was now later so this needed discussed. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated the night nurse carried out blood sugars but stated best practice would be to check it within 30 minutes of the administration of sliding scale insulin. On 12/11/25 at 11:51 a.m., the Director of Nursing(DON) stated staff should carry out blood sugars around 30 minutes prior to the administration of sliding scale insulin, or as close as they could get. The undated facility policy Insulin Pen Administration did not provide guidelines for staff with regard to the obtainment of blood sugars in relation to the administration time of sliding scale insulin.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review, policy review, and staff interview, the facility failed to assess and intervene in a timely manner after a resident complained of signs and symptoms of an infection for 1 of 2 residents reviewed for a change in condition(Resident #26). The facility reported a census of 45 residents. Findings included:The Minimum Data Set(MDS) assessment tool, dated 9/23/25, listed diagnoses for Resident #26 which included diabetes(a disease which caused irregularities in blood sugars), non-Alzheimer's dementia, and depression. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. On 12/8/25 at 1:42 p.m., Resident #26 stated it took the facility a week before they obtained medication for her yeast infection. She stated she had burning and itching and it was very, very uncomfortable.A 11/25/25 5:11 AM Nurses Note documented that the facility sent a fax to the resident's provider related to a possible yeast infection. The resident's vaginal area was red and she had discomfort when using the bathroom and sitting. The resident requested an order for Diflucan(an antifungal medication). A 12/2/25 Nurses Note stated the facility received an order for Diflucan 150 milligrams(mg) x 1 dose. The facility lacked documentation of a follow-up to the fax sent between 11/25/25 and 12/2/25 and lacked documentation of assessments carried out related to the resident's concern between 11/25/25 and 12/7/25.On 12/10/25 at 1:05 p.m. Staff A Licensed Practical Nurse(LPN) stated if a resident had signs and symptoms of an infection, she would assess them and notify the doctor. She stated if they didn't get a response to a provider's fax in 24 hours, they would call them. She stated the nurses had a clipboard and should check it every shift. She stated this may be where the communication breakdown occurred. She stated if nurses didn't go through the clipboard, they wouldn't know what needed followed up on. She stated if a resident started a medication, the nurses would complete follow-up assessments. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated if a resident complained of signs and symptoms of infection, they would obtain vitals and complete an assessment. She stated they would call or fax the provider. She stated nurses had a clipboard to follow up on the faxes. She stated she was gone on vacation and had inquired as to what happened with regard to Resident #26's complaints. On 12/11/25 at 11:51 a.m., the Director of Nursing(DON) stated staff should follow up on a fax to a provider within 24 hours. The undated facility policy Documentation Assessment Guidelines stated the facility should facilitate accurate assessments of residents when the resident had physical changes.