STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385151	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Haven Nursing Center	740 NW Hill Roseburg, OR 97471

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34703 Based on interview and record review it was determined the facility failed to develop an individualized plan of care for 1 of 1 sampled resident (#77) reviewed for medications. This placed residents at risk for unmet care planned needs. Findings include: Resident 77 was admitted to the facility in 2/2025 with diagnoses including colostomy (opening in large intestine to divert stool from the colon to an external bag), necrotizing fasciitis (flesh eating disease) and utilized a wound vac (vacuum assisted closure for healing of wounds). Resident 77's care plan last revised 2/10/25 did not address Resident 77's care and services for her/his colostomy or wound vac. On 2/25/25 at 10:10 AM Staff 11 (CNA) stated she was not aware of care and services for the colostomy or the wound vac, and acknowledged this was not on the care plan. On 1/25/25 at 12:03 PM Staff 30 (CNA) stated he was not aware of what care and service he was to provide for the resident's colostomy or wound vac. Staff 30 acknowledged care and services for both were not on the care plan. On 2/27/25 at 11:51 AM Staff 2 (DNS) acknowledged Resident 77's care plan needed more on the care plan related to the colostomy and the wound vac. Staff 2 acknowledged the care plan was not person centered.

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: 385151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 35855 Based on observation, interview, and record review it was determined the facility failed to provide care and services for a fall, infection, and skin wound for 4 of 11 residents (#6, 35, 55, and 77) reviewed for skin, accidents, medications. This placed residents at risk for delayed treatment and unmet needs. Findings include: 1. A review of the facility's Skin and Wound Management Guidelines revealed the following: The following alterations in skin integrity would be assessed, measured, photographed, and documented in the Skin and Wound Module: -All vascular-related wounds, venous or arterial. -Scabs which have not healed for four weeks. Resident 6 was admitted to the facility in 4/2021 with diagnoses including heart failure, and chronic kidney disease. A 1/29/25 Wound Evaluation indicated Resident 6 had a venous wound on the left lateral calf. The Area was 1.02 cm, with a length of 1.84 cm and a width of .83 cm. There was a light amount of exudate serous with progress of resolved. The photo on the evaluation showed a red area with two dark scabbed areas and two small, scabbed areas. No documentation was found in Resident 6's clinical record of any additional Wound Evaluations of her/his left lateral calf venous wound. A 2/2025 TAR instructed staff to treat Resident 6's venous wound to the left outer leg area by applying skin prep over the area every day shift on Monday, Wednesday, and Friday, with a start date of 12/20/24. On 2/26/25 at 12:23 PM, Resident 6 was sitting in her/his wheelchair in her/his room. On Resident 6's left lateral calf, a scabbed area approximately the size of a nickel was observed. On 2/27/24 at 7:22 AM, Staff 22 (LPN Unit Manager) stated the facility did not complete evaluations on scabs until they fell off. In an interview on 2/27/25 at 10:03 AM with Staff 1 (Administrator), Staff 2 (DNS), and Staff 12 (Regional Care Nurse). Staff 2 confirmed Resident 6's wound should continue to have weekly wound assessments when the wound was not fully healed. 2. Resident 35 was readmitted to the facility in 8/2021 with diagnoses including stroke, muscle weakness, and difficulty walking. A review of Nursing Notes revealed the following occurred with Resident 35: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-2/2/25 at 3:25 PM was found sitting on the floor beside her/his bed. Resident 35's vitals were completed. -2/3/25 at 9:13 PM vitals monitored with no signs or symptoms of pain or discomfort regarding this mornings fall. -2/4/23 at 3:41 PM vitals were monitored at 3:32 PM -2/4/25 at 3:32 PM vitals monitored. -2/6/25 at 3:09 PM vitals monitored. -2/7/25 at 12:12 PM vitals monitored. -2/9/25 at 11:24 PM vitals monitored. -2/11/25 at 1:56 PM vitals monitored. -2/12/25 at 5:25 PM was found sitting on the floor beside the bed. At 6:25 PM, vitals were monitored. -2/13/25 at 5:24 PM vitals monitored. -2/14/25 at 11:37 AM vitals monitored. -2/15/25 at 5:15 PM vitals monitored. -2/16/25 at 1:33 AM vitals monitored. -2/16/25 at 5:06 PM vitals monitored. -2/18/25 at 10:45 AM vitals monitored. -2/21/25 at 10:42 PM fell in the dining area. -2/25/25 at 2:29 PM vitals monitored. A review of Neurological Observation reports revealed the following for Resident 35: -2/2/25 at 3:53 PM for unwitnessed fall 15-minute check number one was completed with no concerns documented. -2/3/25 at 9:21 PM for unwitnessed fall four-hour check number four was completed with no concerns documented. -2/12/25 at 5:28 PM for unwitnessed fall initial check. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/27/25 at 8:04 AM, Staff 18 (RN) stated after a resident sustained an unwitnessed fall, the staff should complete neurological checks every 15 minutes three times, then every 30 minutes two times, then every hour four times, then every four hours four times then every eight hours three times and document in the resident's clinical records. In an interview on 2/27/25 at 10:03 AM with Staff 1 (Administrator), Staff 2 (DNS), and Staff 12 (Regional Care Nurse), Staff 2 confirmed no documentation was found for additional neurological checks for Resident 35 after her/his unwitnessed falls. 34703 3. Resident 77 was admitted to the facility in 2/2025 with diagnoses including necrotizing fasciitis (flesh eating disease) and utilized a wound vac (vacuum assisted closure for healing of wounds). The 2/2025 MAR indicated for staff to premedicate the resident with diazepam (for anxiety) and percocet (narcotic pain medication) one hour prior to the resident's dressing change. On 2/23/25 Resident 77 was administered percocet and diazepam at 2:00 PM. Resident 77's dressing change was completed at 2:40 PM, less than an hour after the prescribed medication was administered. Resident 77 was observed moaning and making painful expressions during the dressing change. On 2/27/25 at 11:52 AM Staff 2 (DNS) acknowledged Resident 77 was not premedicated one hour prior to the 2/23/25 dressing change and should have been due to the large wound and pain. 41455 4. Resident 55 was admitted to the facility in 5/2024 with diagnoses including severe obesity and diabetes. A 2/6/25 Quarterly MDS revealed Resident 55 was cognitively intact. A 2/14/25 revised care plan indicated Resident 55 had the potential for impaired skin integrity related to impaired mobility and other conditions. Resident 55 was to avoid scratching and keep her/his body parts from excessive moisture. A 2/18/25 Nursing Note indicated Resident 55 complained of severe itching in her/his genital area. The area was very red and itchy with heavy, clumpy, yellow discharge. The provider was notified with a request for new orders. A 2/18/25 Nurse/MD Request sent to Resident 55's provider indicated fluconazole (yeast infection treatment) was ordered and to wait for urine results if the resident had UTI symptoms. The orders were acknowledged and entered on 2/25/25 (seven days after symptom onset). A 2/21/25 Nursing Note indicated Resident 55 had a red area on her/his right thigh area as well as redness to her/his abdominal folds and antifungal cream was applied. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2/2025 TAR indicated Resident 55 required a urine sample starting on 2/21/25 and to attempt during each shift until the specimen was collected. The final nursing entry was documented on 2/24/25 during the evening shift (three days after the order was received). A 2/22/25 Late Entry Note indicated an attempt to obtain a urine sample from Resident 55 was unsuccessful and the oncoming nurse would attempt again. The 2/2025 TAR did not indicate orders were in place for any topical antifungal treatment for Resident 55. On 2/23/25 at 12:56 PM and 2/27/25 at 8:15 AM Resident 55 stated over the last week she/he felt like something was eating her/him from the inside and only the topical antifungal treatment provided some relief which was inconsistently provided. Resident 55 indicated staff even tried pillowcases to absorb moisture a few times but the attention to her/his care related to skin moisture and itching was inconsistent. Resident 55 stated the staff excuse for the lack of care and treatment was because she/he did not use the facility provider. On 2/24/25 at 3:19 PM Staff 1 (Administrator) stated Resident 55's use of antifungal cream was ineffective and Staff 3 (Unit Manager-LPN) reported to Staff 1 the use of pillowcases around Resident 55's skin to keep her/him dry. On 2/25/25 at 3:05 PM Staff 38 (CNA) indicated Resident 55 needed assistance for proper daily hygiene, Staff 38 acknowledged Resident 55 had a yeast infection and Staff 38 used antifungal cream on Resident 55's skin because the resident had no other option for relief or treatment. Staff 38 stated updates for Resident 55's care were verbally communicated between CNAs because the resident's care plan was not accurate. On 2/26/25 at 7:58 AM Staff 6 (LPN) stated she was aware of Resident 55's yeast infection and that a second urine catch was completed for Resident 55, but no information or results were found. Staff 6 stated she often called providers within hours of sent communication to ensure a resident's treatment was not delayed and acknowledged Resident 55 had ongoing issues with delay in her/his treatment. On 2/26/25 at 3:42 PM Staff 3 acknowledged follow-up by nursing to ensure timely treatments and implementation of physician orders for Resident 55's yeast infection was lacking and confirmed there was an opportunity for improved yeast infection management for Resident 55. Staff 3 confirmed orders for the antifungal powder Resident 55 needed were not in place and orders for fluconazole started on 2/25/25. On 2/27/25 at 10:53 AM Staff 2 (DNS) stated Resident 55's change of condition communication to Staff 2 related to her/his yeast infection should have occurred earlier than 2/27/25. Staff 2 stated standing orders for antifungal powder were available for Resident 55 but not implemented timely.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34703 Based on observation, interview and record review it was determined the facility failed assess, implement, follow and maintain pressure ulcer treatments and care plans for 1 of 4 sampled residents (# 3) reviewed for pressure ulcers. Findings include: Resident 3 was admitted to the facility in 2/2025 with diagnoses including pressure ulcer and paraplegia. The 2/2/25 Admission Assessment revealed Resident 3 had a coccyx (tailbone) pressure wound and a wound to the left gluteal fold, but did not mention the purple area to the resident's right anterior ankle. The 2/13/25 care plan revealed Resident 3 had two Stage IV (full thickness tissue loss which extend to muscle, tendon, or bone) pressure ulcers to the sacrum (triangle shaped bone at the base of the spine) and left ischial tuberosity (lower part of the pelvis) but did not mention the wound to the right anterior ankle. On 2/17/25 Staff 2's (DNS) Progress Note revealed Resident 3 was admitted to the facility with a red/purple discoloration to both ankles. On 2/19/25 the 2/2025 TAR revealed Resident 3's right anterior ankle wound opened and treatment was intiated. A 2/21/25 Skin and Wound Evaluation indicated Resident 3 had a Stage 2 pressure wound to the right medial malleolus (bony prominence to the side of the ankle). On 2/27/25 at 8:53 AM Staff 2 acknowledged the pressure wound to the right anterior ankle was not captured on the Admission Assessment, and was not treated until 2/19/25 when the wound opened.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49676 Based on observation, interview and record review it was determined the facility failed to ensure residents remained free from accident hazards for 2 of 3 sampled residents (#s 25 and 283) reviewed for accidents. Due to Staff 42 (CNA) not following the care plan, Resident 25 fell and broke her/his hip which required surgery. Findings include: 1. Resident 25 was admitted to the facility on ,d+[DATE] with acute embolism of the right lower extremity and difficulty walking. A 10/2019 Annual MDS revealed Resident 25 had a BIMS score of 7. She/he was not able to provide an interview due to impaired cognition. A review of the comprehensive care plan revised 2/3/25, indicated the resident's bed was to be in a lowered position due to her/his documented fall risk. A 7/26/24 incident investigation revealed: -Resident 25 had a fall with injury. -Resident 25 required an x-ray of her/his spine due the fall. -Resident 25 was crying out in pain complaining of her/his right buttock/hip hurting. No visible signs of bruising were noted. Resident 25 was unable to tolerate any range of motion of her/his right lower extremity. - RN on duty medicated Resident 25 with two narcotics per orders. - X-ray results revealed Resident 25 had a broken hip and was transferred to Emergency Department for surgical evaluation. A 7/31/24 History and Physical Summary indicated Resident 25 had a right femoral neck fracture. An 8/1/24 Operate Report revealed Resident 25 received surgery for her/his hip fracture and was taken to the post anesthesia care unit in stable condition. In an interview on 2/25/25 at 11:47 AM, Staff 42 (CNA) stated Resident 25 needed a bed change, she left the room to try and get help, and told her/him to roll onto her/his back. Staff 42 heard the resident fall, got the nurse, did her vitals, a neuro check, and completed the bed change. Staff 42 said she called the DNS and found out Resident 25 broke her hip. Staff 42 stated I know [the resident] was a two person everything. On 2/25/25 at 11:17 AM, Staff 1 (Administrator) acknowledged the resident was unsupervised, fell , and required surgery for a broken hip. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	41455 2. Resident 283 was admitted to the facility in 2/2025 with diagnoses including nicotine dependence and paraplegia (paralysis of the legs). A 2/14/25 Nursing Smoking Screen indicated Resident 283 smoked five to 10 times each day, had a history of using her/his smoking equipment in non-designated areas, was unable to demonstrate safe smoking practices and was to utilize her/his electronic cigarettes during monitored smoke breaks. A 2/15/25 care plan indicated Resident 283 signed a facility smoking agreement and the resident's smoking materials were to be stored at the nurses station. On 2/23/25 at 2:13 PM Resident 283 said she/he did not sign any safety agreement related to smoking at the time of her/his admission and continued to use her/his electronic cigarettes outside at various places during the day and night. On 2/24/25 at approximately 9:40 AM Resident 283 was observed seated in a non-smoking area on the grounds of the facility. Resident 283 stated this is where I sit when she/he was outside for fresh air and to smoke. Electronic cigarettes were observed with Resident 283. Resident 283 stated staff were aware of the use of her/his electronic cigarettes at the observed location and assisted her/him in and out of the building. On 2/24/25 at 4:15 PM Staff 27 (CNA) stated Resident 283 smoked independently and often went outside on her/his own to use her/his electronic cigarettes. On 2/25/25 at 12:25 PM Staff 1 (Administrator) acknowledged the facility's Smoking Contract was not clear about electronic cigarette safety and the Smoking Contract and Smoking Fire Hazard Awareness Form applied to both smoking and electronic cigarettes. On 2/25/25 at 1:06 PM Staff 2 (DNS) acknowledged smoking contracts were needed and not completed timely for Resident 283 to ensure smoking safety.

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	385151	A. Building B. Wing	02/27/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 40774 Based on observation, interview and record review it was determined the facility failed to monitor, assess and document signs and symptoms of dehydration for 1 of 1 sampled resident (#21) reviewed for limited range of motion and depression. This placed residents at risk for dehydration. Findings include: Resident 21 was admitted to the facility in 2019 with diagnoses including a stroke affecting her/his left side, muscle weakness, and dysphagia (difficulty swallowing). A 7/25/23 diet order indicated Resident 21 received regular liquids and required a two-handled cup with all meals. Resident 21's 11/26/24 annual MDS indicated the resident was cognitively intact, she/he was at risk for malnutrition and had dysphagia. No CAAs were documented related to dehydration/fluid maintenance. A 12/22/24 Nutritional Evaluation indicated Resident 21 was on a regular diet and fluids. Staff were to provide Resident 21 with a two-handed cup. Resident 21's estimated daily fluid requirements were 1450 to 1550 cc. Resident 21's goal was to maintain or improve nutritional status. Staff were to ensure Resident 21 met her/his nutritional intake and maintained adequate hydration status with no signs/symptoms of dehydration. A 2/17/25 revised care plan indicated Resident 21 would be hydrated and nourished as her/his condition allowed. Resident 21 had potential for decline in daily fluid intake related to impaired mobility, relying upon staff to provide her/him with fluids. Staff were to ensure Resident 21 was free of symptoms of dehydration, maintained moist mucous membranes, and had good skin turgor. Resident 21's Fluid Monitor dated 1/30/25 through 2/27/25 revealed:the resident's fluid intake fell below the registered dietitian's fluid recommendation for 26 out of 29 days: 1/30/25-917 cc for all shifts 1/31/25-1060 cc for all shifts 2/1/25-1030 cc for all shifts 2/2/25-507 cc for all shifts 2/3/25-1000 cc for all shifts 2/4/25-860 cc for all shifts 2/5/25-910 cc for all shifts 2/6/25-1210 cc for all shifts (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Rose Haven Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 740 NW Hill Roseburg, OR 97471	

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/7/25-1620 cc for all shifts 2/8/25 830 cc for all shifts 2/9/25-1270 cc for all shifts 2/10/25-1200 cc for all shifts 2/11/25-960 cc for all shifts 2/12/25-1227 cc for all shifts 2/13/25-910 cc for all shifts 2/14/25-1865 cc for all shifts 2/15/25-740 cc for all shifts 2/16/25-450 cc for all shifts 2/17/25-1250 cc for all shifts 2/8/25-1100 cc for all shifts 2/19/25-1055 cc for all shifts 2/20/2 5-1230 cc for all shifts 2/21/25-720 cc for all shifts 2/22/25-865 cc for all shifts 2/23/25-1340 cc for all shift 2/24/25-1350 cc for all shifts 2/25/25-2610 cc for all shifts 2/26/25-1330 cc for all shifts 2/27/25-960 cc for all shifts On 2/23/25 at 2:18 PM Resident 21 was sitting upright in bed with a two-handed cup of water on her/his bed side table. The resident exhibited signs of dry mouth, dry lips, and had difficulty speaking. The resident's face appeared pale and gray in color. The resident's tongue was coated with a white film residue. Resident 21 stated multiple times that she/he was thirsty and asked for water. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/24/25 between 7:48 AM and 2:42 PM Resident 21 was observed multiple times sitting upright in bed with little to no fluid in her/his two-handed cup. At times, the resident was unable to speak when spoken to. On 2/24/25 at 2:47 PM Staff 28 (CNA) indicated Resident 21 was dependent on staff for care and stated she checked on the resident every hour to ensure fluids were available at her/his bedside table. Resident 21 stated they wanted water. Staff 28 was unsure how to determine if the resident's mouth was dry. Staff 28 did not return to provide fluids at any time in the next hour. On 2/24/25 at 4:11 PM Staff 29 (LPN) assessed Resident 21 and stated the residents mouth looked better than yesterday, and her/his mouth appeared dry. Staff 29 stated she was not concerned about the layer of white, chunky film on her/his tongue. Staff 29 stated Resident 21's skin tone was fair. Resident 21 again stated that she/he was thirsty and asked for water. Staff 29 stated she was not concerned about the resident's hydration status. On 2/25/25 at 8:06 AM Staff 30 (CNA) stated his shift started at 6:00 AM and Resident 21 was dependent on staff for care. He reported providing water every two hours and the resident required a special cup but he had not seen the cup since the start of his shift, assuming the kitchen was washing it. Staff 30 stated Resident 21 expressed thirst and requested water 45 minutes earlier and noted 45 minutes was a long wait for water, the resident's mouth appeared dry, and if the wait continued, he would request the resident's two-handed cup from the kitchen. He also stated Resident 21 typically drank a lot of water during the day and did not usually have a dry mouth. Resident 21 was observed on 2/25/25 9:01 AM sitting up in bed with three empty cups on her/his bed side table. Resident 21 asked for more water. Resident 21's tongue appeared dry and was covered in a white film. On 2/25/25 at 9:05 AM Staff 18 (RN) was asked to assess Resident 21 for concerns related to hydration. Staff 18 performed a skin turgor test on Resident 21 and her/his skin stayed tented. Staff 18 stated this was indicative of dehydration. Staff 18 confirmed Resident 21's mouth had build up and had three empty cups on her/his bedside table. Resident 21 told Staff 18 that she/he was thirsty and asked for water. A Nursing Note dated 2/25/25 at 11:50 AM indicated Resident 21 exhibited signs of dehydration, including dry mouth, dry lips, and poor skin turgor. A 2/25/25 at 2:38 PM Administration Note revealed the resident's doctor requested a full assessment, instructed staff to encourage fluids, and Resident 21 did not void during the shift. On 2/26/25 at 8:33 AM Resident 21 was observed sitting upright in bed with three half empty cups sitting on her/his bedside table. Resident 21 stated she/he was thirsty, and her/his mouth and lips appeared dry. On 2/26/25 at 8:35 AM Staff 39 (CNA) stated Resident 21 did not void during the last shift. Staff 39 stated Resident 21 did not typically ask for fluids, but staff offer and provide fluids every couple hours. Staff 39 stated Resident 21 usually drank six to eight cups of fluid during a shift. (continued on next page)

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	385151	A. Building B. Wing	02/27/2025

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 8:23 AM Staff 22 (LPN/UM) confirmed Resident 21 was placed on alert charting on 2/25/25 for five days related to signs and symptoms of dehydration. Staff 22 confirmed the required documentation was not completed as expected. Staff 22 further stated I would definitely show that to the DNS. On 2/27/25 at 8:58 AM Staff 36 (Facility Nurse Practitioner) stated Resident 21 had mild skin turgor. Staff 36 noted Resident 21 did not like water and that he did not believe it was uncommon for Resident 21 to go eight hours without voiding. He indicated concerns would arise only if the resident went longer than eight hours without voiding. On 2/27/25 at 9:48 AM Staff 2 (DNS) confirmed the facility failed to thoroughly monitor, assess and document signs and symptoms of dehydration for Resident 21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Rose Haven Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 740 NW Hill Roseburg, OR 97471	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 35855 Based on observation, interview, and record review, it was determined the facility failed to provide physician-ordered respiratory care for 1 of 1 sampled resident (#6) reviewed for respiratory services. This placed residents at risk for unmet respiratory needs. Findings include: Resident 6 was admitted to the facility in 4/2021 with diagnoses including heart failure and chronic obstructive pulmonary disease (a lung condition caused by damage to the lungs). A review of Resident 6's Vitals Report for oxygen (O2) saturation levels (how much oxygen was in the lungs) indicated on 9/4/24 and 9/5/24 her/his O2 levels were received while she/he was on a continuous positive airway pressure ((CPAP) takes room air then filters and pressurizes it and delivers it through a tube to a facial mask to keep a continuous flow of air). A 9/6/24 signed physician order instructed staff to provide Resident 6 with a bilevel positive airway pressure (BiPAP), a non-invasive ventilation therapy used to treat sleep apnea, respiratory failure, and other breathing disorders. It delivers two levels of pressure, a higher pressure during inhalation to support breathing) with five liters of oxygen with a start date of 12/19/23. A 9/22/24 Nursing Note indicated Resident 6's oxygen saturation was 63 percent, and when she/he was switched from a CPAP mask to a nasal cannula, oxygen saturations increased to 95 percent. On 10/14/24, the State Survey agency received a public complaint that indicated Resident 6 had orders for a BiPAP machine since her/his admission. Around 10/1/24, Resident 6 was discovered to have a CPAP machine instead of a BiPAP machine. A 12/13/24 Annual MDS revealed Resident 6's BIMs was 15, indicating she/he was cognitively intact. The MDS also indicated Resident 6 was on a non-invasive mechanical ventilator but did not indicate if it was a BiPAP or CPAP. On 2/24/25 at 5:50 AM, 7:00 AM, and on 2/26/25 at 8:00 AM, Resident 6 was observed in bed with a facial mask with tubing going to a small machine on the bedside table. On 2/25/25 at 8:19 AM, Witness 4 (Complainant) stated Resident 6 had the wrong equipment and was on a CPAP instead of a BiPAP. On 2/26/25 at 8:52 AM, Staff 20 (RN) stated Resident 6 had a CPAP and was switched to a BiPAP. On 2/26/25 at 12:23 PM, Resident 6 stated she/he did have the CPAP for a while and believed when she /he was readmitted to the facility from the hospital, they gave her/him the wrong machine. In an interview on 2/27/25 at 10:03 AM with Staff 1 (Administrator), Staff 2 (DNS), and Staff 12 (Regional Care Nurse), Staff 2 stated the respiratory company delivered a CPAP instead of a BiPAP, so Resident 6 had the wrong machine.

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NAME OF PROVIDER OR SUPPLIER: Rose Haven Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 740 NW Hill, Roseburg, OR 97471	

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 41455 Based on interview and record review the facility failed to accurately assess pain, develop person centered plans and provide pain medications as ordered for 2 of 3 sampled residents (#s 24 and 55) reviewed for pain management. This placed residents at risk for increased pain. Findings include: 1. Resident 24 was admitted to the facility in 1/2025 with diagnoses including chronic pain and fusion of the spine. A 1/23/25 Admission MDS indicated Resident 24's pain was frequent, occasionally impacted her/his sleep and therapy, and her/his pain reached a level of 10 (worse pain imagined) on a scale of of one through 10 during the last five days. A 1/20/25 Nursing Pain Evaluation for Resident 24 revealed her/his pain was best managed by repositioning and receiving scheduled pain medications. A 1/21/25 revised care plan indicated to anticipate Resident 24's need for pain relief and respond immediately to any complaint of pain. The 2/2025 MAR indicated Resident 24 was to receive gabapentin (nerve pain treatment) twice during the day and once at bedtime for the relief of pain to her/his spinal region: -On 2/14/25 at 10:00 PM the facility was waiting for delivery of the medication and the medication was not provided. -On 2/15/25 at 7:00 AM the facility was waiting for the delivery of the medication and the medication was not provided. -On 2/19/25 and 2/22/25 at 10:00 PM the medication was not provided and no nursing notes were found. The 2/2025 TAR indicated to apply Biofreeze (topical menthol pain relief) once every four hours for Resident 24's pain relief. Resident 24 was not provided the medication as ordered because she/he was sleeping during the following times: -2/3/25 at 10:00 PM -2/12/15 at 2:00 AM -2/16/25 at 10:00 AM as documented by Staff 19 (RN) -2/16/25 at 10:00 PM On 2/24/25 at 9:08 AM Resident 24 stated her/his Biofreeze was a big solution for her/his pain management. Resident 24 indicated she/he believed at times her/his Biofreeze was unavailable because of the lack of consistent application of the medication. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Rose Haven Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 740 NW Hill Roseburg, OR 97471	

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/25 at 3:38 PM Staff 4 (Medication Tech) stated he was aware Resident 24 did not receive her/his Biofreeze as ordered. On 2/26/25 at 4:27 PM Staff 3 (Unit Manager-LPN) confirmed Resident 24's pain medication should be administrated as ordered even if the resident was asleep and the physician should be notified if orders were not followed. On 2/26/25 at 4:40 PM Staff 9 (LPN) confirmed Resident 24's missed gabapentin medication was not available in the reserve medication system on 2/14/25. The pharmacy indicated the medication was in the building on 2/15/25. Staff 9 indicated Staff 19 was the nurse on duty on 2/14/25. On 2/26/25 at 12:14 PM and 2/27/25 at 10:38 AM attempts to reach Staff 19 were unsuccessful. On 2/27/25 at 10:53 AM Staff 2 (DNS) stated a system change to improve missed or lacking medications for Resident 24 was necessary. 2. Resident 55 was admitted to the facility in 5/2024 with diagnoses including diabetes with neuropathy (nerve pain) and kidney disease. A 5/6/24 Admission MDS indicated Resident 55 was at risk to decline due to frequent levels of moderate to severe pain. Staff were to assess Resident 55's pain, treat the resident's pain as ordered and provide non-pharmacological pain interventions. The 2/2025 MAR indicated Resident 55 received oxycodone-acetaminophen (opioid pain medication) as needed for pain every six hours. From 2/1/25 through 2/24/25 Resident 55 was administered the medication 44 times with no pain level indicated. The 2/2025 MAR indicated Resident 55 received acetaminophen as needed every six hours for pain. From 2/1/25 through 2/23/25 Resident 55 was administered the medication 20 times with no pain level indicated. A 2/5/24 Progress Note indicated Resident 55's pain was managed through the use of PRN pain medications. A 2/6/25 Quarterly MDS did not indicate Resident 55 received opioid medications. A 2/14/25 revised care plan indicated Resident 55 had low back pain, was administered pain medication and staff were to monitor for side effects of the medication. The care plan did not indicate any non-pharmacological pain interventions. Review of Resident 55's clinical record revealed no monitor for the use of pain medication side effects. On 2/25/25 at 3:05 PM Staff 38 (CNA) reviewed Resident 55's care plan, indicated the resident's care plan lacked details related to her/his pain management, and the resident had pain everywhere. On 2/26/25 at 7:58 AM Staff 6 (LPN) stated Resident 55's PRN pain medications were to have her/his pain levels documented at the time the pain medication was administered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 12:33 PM Resident 55 indicated her/his pain rarely went below a pain level of three on a pain scale of zero to 10 (highest pain level imagined). On 2/26/25 at 3:42 PM Staff 3 (Unit Manager-LPN) confirmed Resident 55's pain care plan lacked details especially for non-pharmacological interventions. The PRN pain medication monitor and side effect monitor were also not in place as expected.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 35855 Based on interview, and record review, it was determined the facility failed to provide care and services for dementia for 1 of 5 sampled residents (#35) reviewed for medications. This placed residents at risk for unmet needs. Findings include: Resident 35 was readmitted to the facility in 12/2024 with diagnoses including dementia and borderline personality disorder. A 12/26/24 Admission MDS revealed Resident 35 was rarely understood. Resident 35 did not have any physical, verbal, or behavioral symptoms. Resident 35 had rejection of care behavior. A 1/28/25 care plan indicated Resident 35 had the potential to be physically and verbally aggressive. Interventions included administering medications as ordered, anticipating her/his needs, and providing physical and verbal cues to communicate. Give Resident 35 as many choices as possible about care and activities. Monitor, document, and report if she/he was posing a danger to self or others. When Resident 35 was agitated, intervene before the agitation escalates. A Documentation Survey Report from 2/1/25 through 2/25/25 revealed Resident 35 demonstrated the following behavioral symptoms: -Two times on day shift rejection care, yelling, and kicking or hitting. -Three times on evening shift yelling, kicking of hitting, and abusive language. -Three times on night shift rejection of care, abusive language, and kicking or hitting. A review of the TAR from 2/1/25 through 2/25/25 instructed staff to complete a progress note regarding behaviors, including but not limited to rejection of cares, abusive or inappropriate language, kicking or hitting, and yelling. The TAR referred the reader to progress notes 14 times on the evening shift and five times on the night shift. A review of Nursing Notes revealed the following occurred with Resident 35: -2/4/25 at 3:41 PM anxious, frustrated, cursing, and hitting out at nursing staff at times. -2/10/25 at 9:03 AM today cheerful but mood and reality changes quickly. No documentation was found in Resident 35's clinical record to indicate what interventions to reduce her/his behaviors were attempted or if the intervention attempts were successful. On 2/26/25 at 9:33 AM, Staff 16 (CNA) stated Resident 35 had behaviors; if she/he was incontinent, she/he may grab the blanket. Resident 35 usually liked to sleep until lunchtime and had behaviors if woken up when she/he wanted to sleep in. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 12:37 PM, Staff 23 (CNA) stated Resident 35 had behaviors when she/he was incontinent and she/he would get irritated. Staff 23 stated when she spoke to her/him, she/he started to calm down. In an interview on 2/27/25 at 10:03 AM with Staff 1 (Administrator), Staff 2 (DNS), and Staff 12 (Regional Care Nurse), Staff 2 confirmed staff needed to offer and document interventions provided for the behaviors of Resident 35.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34703 Based on interview and record review it was determined the facility failed to ensure narcotic drug records were in order, accurate, and maintained for all controlled drugs for 5 of 5 medication carts reviewed for medication administration and failed to provide accurate and timely pharmaceutical services for 2 of 2 sampled residents (#s 77 and 131) reviewed for medications and pressure wounds. This placed residents at risk for drug diversion and unmet pharmaceutical needs. Findings include: The 3/2023 the Reconciliation and Destruction of Controlled Substances Policy Statement indicated The facility regularly reconciles controlled substances and conducts thorough investigation of identified irregularities. Controlled substances are disposed of in a manner that reduces the risk of exposure, ingestion, misuse, abuse, or diversion. 1. On 2/25/25 at 8:00 AM the 100 hall medication cart narcotic log book for 1/2025 through 2/2025 revealed the facility staff did not sign the log book to verify the narcotic count was accurate for 44 out of 336 counting opportunities. On 2/25/25 at 8:15 AM the 200 hall medication cart narcotic log book for 2/25/25 revealed facility staff did not sign the log book to verify the narcotic count was accurate for 17 out of 144 counting opportunities. On 2/25/25 at 8:30 AM the 300 hall medication cart narcotic log book for 1/2025 through 2/24/25 revealed facility staff did not sign the log book to verify the narcotic count was accurate for 62 out of 336 counting opportunities. On 2/25/25 at 8:40 AM the 400 hall medication cart narcotic log book for 1/2025 through 2/24/25 revealed facility staff did not sign the log book to verify the narcotic count was accurate for 65 out of 330 counting opportunities. On 2/25/25 at 8:55 AM the 500 and 700 hall medication cart narcotic log book for 1/2025 through 2/24/25 revealed facility staff did not sign the log book to verify the narcotic count was accurate for 58 out of 330 counting opportunities. On 2/25/25 at 9:05 AM Staff 2 (DNS) acknowledged two staff members needed to count the narcotics, sign the log books and verify the narcotic count was correct. Staff 2 verified the missing signatures and stated the narcotic count was not correct. 2. Resident 77 was admitted to the facility in 2/2025 with diagnoses including depression. A 2/6/25 Care plan indicated Resident 77 had depression and insomnia with interventions which included to administer antidepressant medications as ordered by the physician. A 2/2025 MAR instructed staff to administer Burpropion and Lexapro once a day for depression with a start date of 2/12/25. On 2/21/25, 2/22/25, 2/23/25, and 2/24/25 at 8:00 AM the MAR referred the reader to review Progress Notes. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Progress Notes indicated Burpropion and Lexapro were not administered to Resident 77 because the medications were unavailable. On 2/27/25 at 11:45 AM Staff 2 (DNS) acknowledged Resident 77 did not receive her/his antidepressants for the above dates and staff should have alerted her the medication was unavailable. 3. Resident 131 was admitted to the facility in 2/2024 with diagnoses including Stage 4 pressure wound, Unstageable left heel wound, Unstageable buttocks wound and infection. A 8/20/24 Care Plan indicated Resident 131 had a nutritional problem or potential nutritional problem related to pressure injuries with increased demand for wound healing. Interventions included to administer medications by the physician. A 8/2024 MAR instructed staff to administer B-Complex-C (supplement) once a day and Juven (supplement) two times a day for wound healing with a start date of 8/21/24. The MAR referred the reader to review Progress Notes. The Progress Notes indicated B-Complex-C was unavailable from 8/25/25 through 8/30/24 and Juven was unavailable from 8/22/24 through 8/27/24 and 8/31/24 and were not administered to Resident 131. On 2/27/25 at 11:45 AM Staff 2 (DNS) acknowledged Resident 131 did not receive her/his B-Complex-C and Juven for the above dates and staff should have alerted her the medication was unavailable.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 35855 Based on interview and record review it was determined the facility failed to provide adequate indication for use of medications for 2 of 4 sampled residents (#s 6 and 131) reviewed for pressure ulcers. This placed residents at risk for unnecessary medications. Findings include: 1. Resident 6 was admitted to the facility in 4/2021 with diagnoses including heart failure and shortness of breath. A 9/23/24 physician order instructed staff to administer Doxycycline Hyclate (an antibiotic to treat various conditions, including UTI, sinus infection, and acne) two times a day for infection for 10 days. A review of signed physician orders dated 9/29/24 instructed staff to administer Augmentin (an antibiotic to treat bacterial infections) twice a day. No diagnosis was documented for the Augmentin on the physician's orders. A 9/2024 MAR instructed staff to administer the following: -Augmentin two times a day for ABX (medical abbreviation for antibiotics) with a start date of 9/29/24. -Doxycycline Hyclate two times a day for infection with a start date of 9/23/24. A 10/31/24 physician order instructed staff to administer Linezolid (an antibiotic that stops the growth of bacteria) every 12 hours for infection with a start date of 10/31/24. A 10/2024 MAR instructed staff to administer Linezolid every 12 hours for infection with a start date of 10/31/24. No documentation was found in Resident 6's clinical record for the indication for use for Augmentin, Doxycycline Hyclate, and Linezolid. In an interview on 2/27/25 at 10:03 AM with Staff 1 (Administrator), Staff 2 (DNS), and Staff 12 (Regional Care Nurse), Staff 2 stated the expectation was to have the diagnosis documented for the use of antibiotics. 34703 2. Resident 131 was admitted to the facility in 8/2024 with diagnoses including Stage 4 pressure wound, Unstageable left heel wound, and Unstageable buttocks wound. The August 2024 MAR indicated Cephalexin (an antibiotic) was given for antibiotic. No diagnostic indication of use was documented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/27/25 at 12:02 Staff 2 (DNS) acknowledged the Cephalexin did not have a documented indication of use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34703 Based on observation, interview and record review it was determined the facility failed to follow infection control standards for 4 of 4 halls observed and 2 of 4 sampled residents (#77 and 43) reviewed for pressure ulcers. This placed residents at risk for exposure and contraction of infectious diseases. Findings include: 1. Resident 77 was admitted to the facility in 2/2025 with diagnoses including necrotizing fasciitis (flesh eating disease), utilized a wound vac (vacuum assisted closure for healing of wounds) and a colostomy (a surgical opening in the abdominal wall to divert stool). The CDC indicated EBP (enhanced barrier precautions) involve gown, and gloves during high contact resident care. Resident 77 was not on EBP. On 2/24/25 at 8:30 AM Staff 41 (RN/Unit Manager) stated the resident should be on EBP due to the resident's wound and colostomy. Staff 41 observed the opened dressing packages in the resident's dresser drawer and stated the dressings have to be thrown away if they are all the way opened and need to be dated and these dressings were not. On 2/23/25 at 2:40 PM a dressing change for Resident 77 was performed by Staff 40 (LPN). -Staff 40 washed her hands and donned gloves but no gown. -Staff 40 placed all clean dressing supplies including bandage scissors on Resident 77's bed which had a dirty blanket and sheets. Staff 40 began touching dressing packages. -Staff 40 removed the resident's wound vac dressing and wiped wound and surrounding area with wound cleanser. -Surveyor reminded Staff 40 to change her gloves but she did not. -Staff 40 opened black sponge for the wound vac and began cutting the sponge with scissors on the resident's bed. -Staff 40 inserted the black sponge into the resident's wound but did not change gloves or sanitize hands. -Staff 40 grabbed the tape to seal the wound with dirty gloves. -Staff 40 continued to touch the inside of the large wound along with the resident's genitals trying to get the black sponge into the wound. -Staff 40 held the black sponge in the wound while reaching for the tape to cover the black sponge with dirty gloves. -Staff 40 finished dressing change and wiped blood from between the resident's legs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Staff 40 placed dirty dressings containing blood and left them in the garbage can by the resident's bed. On 2/23/25 at 3: 30 PM Staff 40 stated she should have donned a gown, set-up a clean field for the dressing change, change her gloves and sanitize her hands like she should have. On 2/23/25 at 3:45 PM Staff 41 stated she had gone over how to complete the dressing change with Staff 40 and told her to make sure she had a clean field for the dressings and change her gloves. 40774 2. On 2/23/25 at 10:47 AM Staff 33 (Agency CNA) was observed in the 300 Hall entering a room with signage on the door indicated Enhanced Barrier Precautions (EBP) and Droplet Precautions, with specific instructions for PPE use. Staff 33 did not sanitize her hands before donning gloves then proceeded to enter the room. Staff 33 left the room without sanitizing her hands or removing her face mask and walked to the linen closet to retrieved towels without sanitizing her hands beforehand. Staff 33 then delivered the towels and a cup of coffee to the same room while still not sanitizing her hands prior to donning PPE. Additionally, Staff 33 continued to enter other resident rooms and the linen closet without proper hand hygiene. On 2/23/25 at 11:17 AM Staff 34 (CNA) was observed in the 300 Hall entering a room without sanitizing her hands. Staff 34 closed the door and later exited with a bag of soiled linen, which she transported down the hall. Staff 34 did not sanitize her hands after handling the bag of soiled linen. On 2/23/25 at 12:30 PM Resident 43 was observed in the 500-dining room eating her/his lunch. An unidentified staff member was observed taking Resident 43's blood sugar at the table. Resident 43 stated she/he had previously expressed discomfort with staff multiple times about taking her/his blood sugar in the dining room. Resident 43 further stated it grossed her/him out thinking about blood near her/his food. On 2/26/25 at 9:02 AM Staff 35 (Agency LPN) entered a room on the 400 Hall that was on Enhanced Barrier Precautions. The room had signage posted on the door indicating EBP with specific instructions for PPE use. Staff 35 did not don a gown before touching the residents tube feeding supplies. Staff 2 (DNS) was standing next to Staff 35 and instructed Staff 35 to don a gown before providing care. On 2/26/25 at 5:57 PM Staff 35 was asked about the process for (EBP) prior to providing care related to resident on a feeding tube. Staff 35 stated she was confused about the process, and she did not notice the signage posted on the resident's door before entering the room and did not know she was supposed to wear a gown. On 2/27/25 at 10:33 AM Staff 2 was informed of the above staff observations, and she confirmed staff were expected to follow proper infection control precautions before and after entering resident rooms and before and after handling clean linen. Staff 2 also confirmed staff should have been aware of the infection control expectations prior to handling resident feeding tubs and obtaining blood sugars. 41455 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Rose Haven Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 740 NW Hill Roseburg, OR 97471	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. On 2/24/25 at 8:38 AM a sign on the door of room [ROOM NUMBER] indicated Enhanced Barrier Precautions (EBP) were in place in the room. Staff were directed to perform hand hygiene before entering, when leaving the room and to wear gloves and gowns during direct care or contact with the resident. On 2/24/25 at 8:39 AM Staff 11 (CNA) entered room [ROOM NUMBER] from another room with EBP and did not perform hand hygiene prior to the donning of gloves and gown. Staff 11 transferred the resident while in the room. On 2/24/25 at 8:49 AM Staff 11 confirmed hand hygiene was not performed as needed prior to the resident's transfer in room [ROOM NUMBER]. On 2/24/25 at 9:21 AM Staff 7 (LPN) was observed to enter room [ROOM NUMBER] with only gloves when a pain patch was applied to the skin of the resident. Staff 7 stated he was not aware room [ROOM NUMBER] was on EBP. On 2/26/25 at 3:35 PM Staff 10 (IP) confirmed staff should perform hand hygiene prior to the donning of gowns and gloves and wear gowns and gloves during close contact of residents on EBP. 49676 4. On 2/26/25 at 9:41 AM, Staff 24 (Housekeeping) was observed cleaning residents' rooms. Staff 24 took off PPE after cleaning room with signage indicating enhanced barrier precautions and placed the soiled gown into the bottom of the plastic bin outside the residents' room mixing it with clean gowns. When asked where he should remove the gown Staff 24 stated he gets confused and doesn't know which one is clean or dirty. I've only worked here two weeks. On 2/26/25 at 10:43 AM, Staff 25 (Housekeeping Manager) stated staff receive training online and are also trained by a seasoned housekeeper. All gowns when removed are placed in a plastic bin inside residents' rooms and do not get placed in plastic bin outside residents' room. On 2/26/25 at 10:20 AM, Staff 10 (Infection Preventionist) Stated the brown inside residents' room with blue liner inside is where staff are to discard gown and should never come out of resident room with gown on. On 2/27/25 at 10:42 AM, Staff 1 (Administrator) stated staff are supposed to wear PPE appropriately and discard of it in the resident's room. Staff should also not put soiled gown in the plastic three drawer bin outside residents' room with clean PPE.