STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165361	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Green Village Care Cen	100 Sixth Street Nevada, IA 50201

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on observation, interviews, record reviews and policy the facility failed to assess and treat a pressure ulcer for 2 of 2 residents observed with pressure ulcers (Residents #9 and #50). Resident #50 documentation indicated the facility found their pressure wound on 11/1/24. Interviews determined hospice found the pressure wound before that date. The facility, hospice staff, and Resident #50's family had a meeting before the facility documented the pressure ulcer. At the meeting, hospice reported the got an order for heel protectors for Resident #50. Resident #50's clinical record lacked documentation of the order. When the facility reported the concern to the physician, the directed to monitor the wound. Resident #50 reported she didn't like the boots because they made her feet hot. Resident #50's heel pressure ulcer declined and the facility failed to intervene to prevent the decline. Resident #9 had a pressure ulcer to their buttock. The nurse failed to provide clean technique while completing the wound treatment. The facility reported a census of 47 residents. Findings included: 1. Resident #50's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of anemia (low iron levels in the blood), atrial fibrillation (abnormal heart rate), hypertension, and demyelinating disease of the central nervous system (protective tissue surrounding special cells are damaged and disrupting the transmission of signals). The MDS indicated Resident #50 had a risk for a pressure ulcer, but didn't have one at the time of assessment. The Care Plan Focuses with a target date of 1/16/25 indicated: a. Resident #50 elected hospice services. The Interventions directed the following: i. Coordinate her care with hospice services to keep her as comfortable as possible. ii. May experience expected skin breakdown due to terminal disease process, poor nutrition, weight loss and decreased mobility, may be diagnosed with a Kennedy ulcer (occurs is some near final weeks of life) due to my terminal diagnosis. Skin issues are not expected to heal due to terminal disease process, poor nutrition, perfusion and decreased mobility. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	b. Resident #50 had a risk for alteration in skin integrity related to falls from terminal restlessness, altered skin integrity related to a terminal diagnosis of demyelinating disease, limited mobility and the use of a mechanical lift. Updated 11/8/24 Left calf medial aspect 4.0 by 2.0 centimeters (cm), left cheek bruising 5.0 by 5.0 cm extends down along left jawline, bruising is yellow and fading, and right medial heel measures 4.0 by 5.0 cm dark red center stage 2 pressure ulcer - hospice notified. Resident #50 had heel boots present but she often removed them. The Goal indicated Resident #50 would not develop skin alterations out of her disease process and skin impairment would heal without complications. The Interventions directed to use pillows/position devices as needed. The Skin Condition Note dated 11/1/24 indicated Staff E, Licensed Practical Nurse (LPN) completed Resident #50's weekly skin check, which revealed a right medial heel stage 2 pressure ulcer measuring 2.5 by 2.0 cm. The physician responded to continue to monitor. The Skin Condition Note dated 11/8/24 reflected Staff E completed the weekly skin check which revealed Resident #50's right heel stage 2 pressure ulcer measured 4.0 x 5.0 cm with a dark red center. Resident #50 remained on hospice level of care, heel boot present but she removed them often. Staff E placed a mepilex (dressing) to her right heel for protection and she alerted hospice to provide more. The Physician responded on 11/11/24 to continue to monitor. On 11/13/24 at 3:05 PM Staff C, Registered Nurse, reported they checked the Treatment Administration Record (TAR), and remarked it didn't have a treatment for Resident #50's right heel pressure ulcer. During an interview on 11/13/24 at 3:24 PM Resident #50's Power of Attorney (POA) voiced they had a meeting about two weeks before (10/30/24) with family, hospice, and the facility staff. They discussed the heel concern and hospice brought heel protectors. The POA reported she understood they had something new on order since Resident #50 wouldn't wear the heel protectors. On 11/13/24 at 3:25 PM Resident #50 acknowledged she didn't like to wear the heel protectors, as they made her feet hot. Resident #50 added that it would be nice if a doctor looked at her heel. She couldn't recall if it had a covered dressing or treatments. During an observation on 11/13/24 at 3:30 PM Staff C, Registered Nurse (RN), measured Resident #50's heel wound and reported it measured 1.5 by (x) 2.2 x 0.1 cm depth. They cleansed the wound and covered it with a mepilex dressing. Staff C said the TAR should include the heel boots, but it didn't. Staff C stated the previous Sunday they recalled the heel as dry with a darkened area, flat and reported the measurements in the skin book are much larger. They didn't appear accurate from their recalled comparison. Staff C explained the wound opened, they didn't have a treatment order and they should. During an interview on 11/14/24 at 1:35 PM Staff E stated they first saw the heel wound on 11/1/24. At that time, they measured, documented left medial heel, 2.5 x 2 cm stage 2, indicated the wound as open, notified the physician via fax, and alerted Staff D, Hospice RN, verbally. Staff E reported they didn't get any treatment orders and the Physician, directed to continue to monitor. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Further interview, record review and discussion on 11/14/24 at 1:38 PM with LPN, Staff E included review of weekly skin record. LPN, Staff E acknowledged had measured the wound again on 11/8/24 noted increased size, stage II (two) measured 4.0 x 5.0 centimeters, dark red center, recorded placed mepilex (dressing) on for protection and alerted hospice to provide more direction. LPN, Staff E relayed, should not of staged the wound, is not qualified to do so as an LPN, relayed had staged as two since wound was open. Relayed updated Physician, Staff F and responded again to the updated measurements on 11/11/24 continue to monitor. During an interview on 11/14/24 at 3:00 PM, Staff D reported they documented in her hospice notes and acknowledged the following: a. On 10/29/24 suspected deep tissue injury, deep purple, obtained a physician order for the protective heel boots. b. On 10/31/24 met with family, the heel was intact, reddened, ensured a written order to the facility nurse for the heel protectors that didn't get transcribed to the TAR. c. On 11/11/24 obtained an order to cover wound with mepilex dressing, gave the order to the nursing facility staff, and again not transcribed to the TAR, and the order couldn't be located. d. On 11/12/24 measure the heel wound at 3 x 2.5 x .0.2 cm depth. e. On 11/14/24 at 3:05 PM, Staff D acknowledged the wound depth increased. They thought the facility should have transcribed the orders to the TAR. During an interview on 11/13/24 at 3:50 PM the Assistant Director of Nursing (ADON) acknowledged they only monitored the Stage 2 pressure ulcer weekly per the weekly skin book. The ADON verified Resident #50 had heel boots in her room, but no treatment orders. During an interview on 11/13/24 at 3:50 PM the Administrator acknowledged Resident #50 had a stage 2 pressure ulcer to her heel. They added the physician ordered to just monitor the wound and they wouldn't override a doctor's order. On 11/14/24 at 3:13 PM the ADON stated they have a process, when hospice got an order they give the written note to a facility nurse. Two nurses verify the order and add it to the electronic TAR. The ADON couldn't explain why the orders didn't get transcribed for the heel protectors or the mepilex dressing. The ADON expressed she trusted Staff D gave the orders to the facility nurse. The facility didn't provide a policy for pressure ulcer treatments. 2. Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of heart disease, respiratory failure, metabolic encephalopathy (brain dysfunction due to problems with the metabolism) and depression. The MDS documented Resident #9 had a pressure ulcer. Resident #9 November 2024 TAR included an order dated 11/13/24 apply a Hydrofiber (soft, absorbent material that transforms into a gel on contact with wound fluid) with bordered foam dressing to change on Monday, Wednesday and Friday for skin healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 11/13/24 at 9:40 AM, observed Resident #9 lying on her side. Staff C explained they sanitized their hands, put on gloves, and removed the coccyx dressing. Staff C cleansed the coccyx wound with dermal (skin) cleanser, cut the hydro fiber, and placed it on the wound, labeled the dressing with a pen and applied it to Resident #9's coccyx. During the treatment, Staff C didn't complete hand hygiene between removing the old dressing and applying the ordered treatment. In an interview on 11/13/24 at 10:32 AM following Resident #9's coccyx wound treatment, Staff C reiterated the treatment process and verified they should have sanitized their hands before placing the new dressing on. In an interview on 11/13/24 at 3:00 PM the ADON acknowledged hand hygiene is standard practice after removing an old dressing, after taking off gloves, and prior to putting on gloves. The Infection Prevention and Control policy revised 7/31/24 instructed staff to perform hand hygiene before and after direct patient contact and after each situation that necessitates hand hygiene. To complete the hand hygiene, they will use an alcohol -based hand rub or hand washing for 20 seconds.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44972 Based on observation and staff interview, the facility failed to discard expired stock medications to avoid compromising the integrity of the medications. The facility reported a census of 47 residents. Findings include: On 11/13/24 at 2:35 PM observed the medication room across from the nurses' station with Staff B, Licensed Practical Nurse (LPN). The room contained the following expired items: a. 1 unopened bottle of Rubbing Alcohol 70%, 16 fluid ounces with an expiration date of March 2024. b. 1 unopened box of Assure Prism Blood Glucose Monitoring System with an expiration date of 8/25/24 c. 2 unopened bottles of Geri Dryl (similar to Benadryl) Allergy Relief with an expiration date of September 2024. In an interview on 11/13/24 at 3:10 PM, the Assistant Director of Nursing (ADON) stated she didn't know if they had a facility policy related the prevention of expired stock medications in the medication storage area but she would implement one if they didn't. She stated she expected the staff to discard all expired medications, so the staff didn't use or give them to the residents. On 11/14/24 at 11:44 AM, the Administrator reported the facility didn't have a policy relating to expired medications.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 46875 Based on clinical record review, menu review, observations, staff interviews, and policy review the facility failed to provide residents food in a form to meet the needs of 2 of 6 residents (Resident #51 and #50). The facility reported a census of 47 residents. Findings include: A Physician diet order dated 10/24/24 for Resident #51 directed staff to administer a mechanical soft, ground meat diet. A Physician diet order dated 11/6/24 for Resident #50 directed staff to administer a mechanical soft texture diet. A facility menu titled Week 3 Wednesday documented the noon meal for a mechanical soft diet included a ground steak sandwich with grilled onion, potato salad with no raw vegetables, cooked broccoli cuts and maraschino cherry cake. On 11/13/24 at 11:20 AM, prior to the start of the noon meal service, observed the steam table didn't contain ground steak meat. The observation of the steak meat revealed various sizes of cut up meat. On 11/13/24 observations during the noon meal service revealed Staff A, Cook, prepared a steak sandwich with cut up meat for Resident #51. They served Resident #51 the non ground steak sandwich on a room tray. During the middle of the meal service, Staff A took several servings of the cut-up steak meat out of the steam table, grounded the meat using a robot coupe and returned the ground meat to the steam table. As the meal service continued, Staff A prepared and plated a steak sandwich with cut up meat (non ground) for Resident #50. Staff A placed it on a tray on the food cart. At 12:22 PM, the Dietary Manager intervened and stated she couldn't let the food trays leave the kitchen. She stated Resident #50's sandwich wasn't prepared with ground meat. Staff A removed Resident #50's plate from the food cart and acknowledged Resident #50's sandwich as prepared with cut up meat and not ground meat. Staff A prepared a new sandwich with ground meat for Resident #50. The Dietary Manager agreed if she didn't intervene Resident #50 would have received non ground meat. On 11/13/24 at 12:30 PM, the Dietary Manager reported she expected the staff to follow the menu and grind the meat as indicated on the menu. On 11/13/24 at 12:40 PM, Staff A reported she forgot to prepare the ground meat prior to the start of meal service. Staff A said when she prepared Resident #51's food tray she chopped up the food into small pieces in the pan before serving it. Staff A reported she made a mistake and overlooked the ground meat for Resident #50. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 12:45 PM, Resident #51 and her husband reported she had a sandwich with meat pieces for lunch. Resident #51's husband reported his wife shouldn't have a mechanically soft diet, as his wife could chew her meat with no problems. Resident #51 said she could chew her meat without difficulty. Resident #51's husband said he took his wife to a local restaurant the previous night and she ate chicken on the bone without difficulty. Resident #51 said she ate the chicken off the bone and didn't have any problems with chewing or swallowing. Resident #51 said she hasn't choked on her food. Resident #51 and her husband said a staff member comes to the room and provides supervision while she eats. Resident #51 and her husband said the meat was in smaller pieces that day for lunch. Resident #51 reported she ate all of her lunch, stating it was good and she had no difficulty swallowing or chewing. On 11/13/24 at 2:30 PM, the Dietary Manager provided a counseling form signed by Staff A on 11/13/24. The form indicated the problem was ensuring proper diets are prepared before meal service and to double check the correct diets are served. The form documented Human Resources would assign an online course to Staff A regarding proper food service procedures. The Altered Textured Diet Orders policy revised April 2012 instructed diet orders for residents requiring altered textures for chewing and swallowing problems, be written in a standardized language to specify the appropriate consistency of food and fluids to meet residents' safety, tolerance, and preferences.