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	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Green Village Care Center	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on clinical record review, family interview, staff interviews and policy review, the facility failed to immediately notify and inform a family member (Resident #1) and the resident's physician (Resident #2) of a change in status for 2 of 3 residents reviewed for notification. The facility reported a census of 48 residents.Findings include: 1. The Minimum Data Set (MDS) assessment, dated 3/30/26, documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The resident had diagnoses to include medically complex conditions, heart failure, arthritis and respiratory failure. The Care Plan initiated 3/24/26, included a Focus that indicated Resident #1 required assistance with Activities of Daily Living (ADL's). The goal listed Resident #1 would receive assistance with ADLs as required. The interventions included:a. Encourage participation on ADL's. b. Gait belt with transfers and ambulation. c. Provide sufficient time for completion of ADL tasks.d. Staff will allow resident independence to the best of their ability with ADL task completion. The Incident Report Note dated 3/30/26 at 3:48 AM, written by Staff A, Registered Nurse (RN), reflected Resident #1 fell during an assisted transfer in her bathroom. The note reflect Staff A notified Resident #1's daughter and physician. Resident #1 Clinical Resident Profile reviewed 4/13/26 listed her daughter as her emergency contact #1. During an interview on 4/13/26 at 12:00 PM, Resident #1's daughter, emergency contact, stated she received a call from Staff A on 3/30/26 at 11:00 AM advising her of a fall Resident #1 sustained earlier that morning around 8:00 AM. Staff A advised her the facility was sending Resident #1 to the hospital due to unmanaged pain. Resident #1's daughter stated she asked Staff A why they didn't notify her right after the fall happened that morning and Staff A replied they were trying to manage her pain. During an interview on 4/14/26 at 11:30 AM, Staff A recalled the morning of 3/20/26 when she learned Resident #1 fell in the bathroom, hitting her head on the wall. Staff A stated Resident #1 sustained a skin tear on her leg and complained of pain in her back. Staff A notified the on-call physician right away, around 8:00 AM, and obtained an order for pain medication and orders to treat the skin tear. Staff A reported she contacted the on-call physician again around 11:00 AM due to Resident #1 still complained of pain in her back. They gave an order to send Resident #1 to the hospital. Staff A explained she didn't call the daughter, until around 11:00 AM. Staff A stated she contacted the family approximately 3 hours after the fall. She acknowledged they are supposed to contact the family, emergency contact, as soon as they can. 2. The MDS assessment, dated 3/16/26, documented Resident #2 had a BIMS score of 12, indicating moderate cognitive impairment. The MDS included diagnoses of fractures and other multiple trauma, renal insufficiency, arthritis, osteoporosis and other fracture. The Care Plan initiated 3/10/26 included the following Focuses:a. Resident #2 had complaints of pain related to osteoporosis, bursitis of both knees and history of wedge compression fracture of T11-T12 (area of the middle of the back protecting the spine) vertebra. The goal listed Resident #2 stated their level of pain is tolerable at (0) or has relief with interventions. The interventions included: i. Notify MD (doctor of medicine) if inadequate pain relief as indicated. ii. Notify the physician if interventions are unsuccessful or if current complaint is a significant change from past experience of pain. b. Resident #2 had a risk for falls and had an actual fall. The goal listed (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to minimize risk for falls throughout next review. The interventions included: i. Assist resident with ambulation and transfers as needed. ii. 3/12/26: Urinary Analysis (UA), labs, x-ray of right knee. The Physical Therapy (PT) report dated 3/12/26 documented Resident #2 reported a fall in the night. Resident #2 stated she couldn't complete PT that morning due to pain in her knees related to the fall. The PT report documented Resident #2 had x-rays ordered that day. The General Progress Note dated 3/12/26 at 4:25 PM indicated the mobile x-ray company arrived at 4:00 PM to take x-rays of Resident #2's bilateral (both) knees. The X-Ray Report dated 3/12/26, listed Critical, significant findings for the right knee x-ray. Under the Impression section: There is an apparent comminuted fracture (a severe injury where a bone breaks into three or more pieces) involving the central patella (kneecap). The x-ray report was faxed to the facility with a date stamp of 3/13/26 at 00:36 AM (12:36 AM). During an interview on 4/14/26 at 7:50 AM, Staff B, Licensed Practical Nurse (LPN), stated she worked the overnight shift on 3/12/26, beginning at 10:00 PM and ending at 6:00 AM on 3/13/26. Staff B recalled they received the fax from the mobile x-ray company a little after midnight. She read the fax and noted the fracture to Resident #2's right knee. Staff B explained she sent a text to the management phone number; however, she didn't call the on-call provider/physician. Staff B reported they have a provider on-call at all times and acknowledged she didn't call the on-call provider to notify them of the fracture to Resident #2's right knee to get direction for treatment. Staff B acknowledged she should have contacted the provider. During an interview on 4/14/26 at 10:35 AM, the Director of Nursing (DON) reported being the management staff on call during the night of 3/12/26 into the morning of 3/13/26. The DON stated Staff B sent her text message on 3/13/26 around 2:30 AM and again at around 5:30 AM regarding the x-ray result. The DON explained she only responded to the 5:30 AM text, however she couldn't recall what she said. The DON stated she arrived at the facility around 7:00 AM and didn't know no one notified the provider of the x-ray result indicating Resident #2 had a fracture to her right knee. The DON acknowledged she didn't notify the provider upon arrival to the facility and not until approximately 9:40 AM by the Administrator. The Communication with Physician Note dated 3/13/26 at 9:41 AM, completed by the Administrator documented they called the provider regarding the x-ray results for Resident #2. The provider requested to see if an ortho doctor could immediately see Resident #2. If they couldn't, the provider directed to Resident #2 to the emergency room for evaluation and treatment of their right knee fracture. During an interview on 4/15/26 at 1:15 PM, the Administrator stated she expected the staff to call the family as soon as possible, within an hour, of Resident #1's fall and change in status. Additionally, the Administrator expected the staff to notify the on-call provider immediately of a significant change in condition. The facility should have immediately notified the on-call provider of the fracture to Resident #2's right knee. The Administrator acknowledged this didn't happen. Review of the facility policy Notification for Change of Condition, revised June 2023, instructed the facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is: a. An accident involving the resident which results in injury and has the potential for requiring physician intervention; b. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); c. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or d. A decision to transfer or discharge the resident from the facility as specified in S483.12(a).

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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. Based on clinical record review, written staff statement, staff interviews and policy review, the facility failed to provide adequate nursing supervision related to a fall and failed to ensure appropriate steps were taken after a fall to ensure resident safety for 1 of 3 residents reviewed for falls (Resident #2).The facility corrected the noncompliance prior to the start of the survey on 3/13/26 by completing the following:3/13/26: The facility started educating their employees on falls.3/13/26: The facility started educating their employees on the fall occurrence policy. 3/13/26: The facility started educating their employees on abuse prevention.3/13/26: The facility began using the audit tool on new falls to ensure the staff followed the occurrence policy and understood the fall policy.The facility reported a census of 48 residents.Findings include:Resident #2's Minimum Data Set (MDS) assessment, dated 3/16/26, documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate impaired cognition. Resident #2 had diagnoses to include fractures, multiple trauma, renal insufficiency, arthritis, and osteoporosis.The Care Plan for Resident #2, initiated 3/10/26, included a focus area for complaints of pain related to osteoporosis, bursitis of both knees, and a history of a wedge compression fracture. The goal was for Resident #2 to state that the pain level's tolerable at a score of 0 or that she had relief with interventions. Interventions included notifying the Medical Doctor (MD) if pain relief's inadequate or if the complaint's a significant change from past experiences. An additional focus area noted Resident #2's at risk for falls. Interventions included assisting Resident #2 with ambulation and transfers, using a gait belt, and using a standard walker. The plan required a substantial or maximum assist of two staff members for walking.The Fall Occurrence policy, dated February 2024, instructed staff to ensure residents are evaluated for fall risks and to implement interventions to minimize injury. The policy directed a nurse needed to complete an incident report each time a resident fell. It further required a licensed nurse assess residents prior to being moved after a fall. The nurse must notify the physician and the resident's representative.Review of the Electronic Health Record (EHR) revealed a Physical Therapy (PT) report dated 3/12/26. Staff D, Physical Therapist (PT), documented that after he explained the agenda, Resident #2 stated, I cannot, my knees are so painful. Resident #2 reported she fell the previous night while a staff member changed her brief. Staff D asked the charge nurse, Staff C, Registered Nurse (RN), about the fall, but Staff C explained no one told them about a fall in report. When Staff D notified the Administrator, they reported Resident #2 would have x-rays that day. They documented pain with movement as a 7 out of 10 in both knees, indicating severe pain level.Review of a facility investigation report, completed 3/20/26, outlined the investigation into the fall. The facility determined Staff E, Certified Nursing Aide (CNA), worked the overnight shift on 3/11/26. Camera monitors showed Staff E entered Resident #2's room at 4:46 AM and exited at 5:04 AM. Staff E told the Administrator she observed Resident #2 sitting in a lift chair and used a gait belt to assist her to the floor because of her sliding out. Staff E stated she didn't view this as a fall and didn't report it to the nurse. When the Administrator follow-up with Resident #2 told them the staff member assisted her to the floor and she landed on her knees. Resident #2 stated the staff member helped her up alone without equipment. She didn't believe the nurse knew of her fall.A written statement from Staff F, Human Resources (HR) Director, dated 3/12/26, documented an interview with Staff E. Staff E stated it wasn't a fall, but that she lowered Resident #2 to the floor because she wasn't in a safe position. Staff E confirmed she didn't report the incident to the nurse because she assisted Resident #2 the entire time.The General Progress Notes dated 3/12/26 at 4:25 PM confirmed a mobile X-ray company arrived at 4:00 PM to x-ray both of Resident #2's knees. The X-Ray Report dated 3/12/26, identified Critical, significant findings for the right knee x-ray. The Impression indicated Resident #2 had an apparent comminuted fracture (a severe injury where a bone breaks into three or more pieces) involving the central patella (kneecap). The x-ray report listed a faxed date stamp of 3/13/26 at 12:36 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	AM. The Diagnostic Test Result Note dated 3/13/26 at 12:36 AM indicated the left knee x-ray showed arthritic changes but no fracture.The Physical Therapy Treatment Encounter Note dated 3/13/26, signed at 1:41 PM by Staff D. The Note reflected Staff D informed Resident #2, the staff would transfer her with a full-body mechanical lifting device due to a fracture and non-weight bearing status. Additionally, he documented educating Staff J about the lift. Resident #2 rated their pain at a 6 out of 10, indicating moderate pain. She described the pain as constant and intermittent (coming and going) to her right knee, adding it ached and felt dull.On 4/13/26 at 4:07 PM, the Administrator stated Staff B, Licensed Practical Nurse (LPN), received the fax and sent a text message with a screenshot of the fracture result to the on-call management phone at 2:01 AM. The Administrator reported she thought she was the person on-call that night. She explained she didn't hear the text at 2:01 AM as she was sleeping and needed her sleep. The Administrator noted Staff B didn't call the on-call provider to inform them of the fracture. The Administrator called the provider at 9:41 AM on 3/13/26 and received an order to send Resident #2 to the Emergency Department (ED). The facility didn't send Resident #2 to the hospital until 3:15 PM.Review of text messages to the on-call phone revealed Staff B sent a picture of the results at 2:01 AM and another text at 5:37 AM asking, did you see this? The response, saw this now, was followed by Staff B asking if she should chart it in the nurses' notes or wait for them to arrive. The on-call manager asked if Staff B did an incident report, and Staff B responded no one told her Resident #2 fell.The hospital report dated 3/13/26 for the ED visit documented Resident #2 fell onto her knees while a staff member helped her out of a recliner. The hospital confirmed Resident #2 had a comminuted fracture of the patella with a new x-ray and placed her in a knee immobilizer. The hospital directed to follow-up with orthopedics.On 4/14/26 at 7:50 AM, Staff B stated she went into the room at 5:00 AM on 3/12/26. Resident #2 asked for pain medication and said her legs hurt, but didn't mention a fall. Staff B remembered giving her something for pain, but couldn't remember when. Staff B confirmed Staff E didn't report a fall. Staff B admitted she should've called the on-call provider after receiving the fracture results on 3/13/26 but didn't. She documented the fracture in a communication book but didn't recall telling the oncoming shift in person.On 4/14/26 at 8:15 AM, Staff G, Occupational Therapist (OT), stated she performed a toileting session with Resident #2 on the morning of 3/13/26. Staff G assisted Resident #2 out of her chair with a gait belt and Resident #2 walked to the bathroom, placing weight on her right knee. Resident #2 complained of pain in her back as 8 out of 10 on the pain scale, indicating severe pain but described it as an ache. Resident #2 didn't mention any pain in her knees. Staff G stated she didn't know Resident #2 had a fractured knee. Staff H, RN, came into the room during the session but didn't mention a fracture. Staff G noted the Director of Nursing (DON) didn't email her about the fracture until 9:45 AM, after completion of the session. Staff G reported if she knew about the fracture, she wouldn't have walked her due to her impaired cognition and difficulty reporting pain or events.The Treatment Encounter Note, completed by Staff G, OT on 3/13/26 identified they walked Resident #2 to the bathroom using a 2-wheeled walker (2WW) with contact guard assistance (CGA). Resident #2 rated her pain with movement at an 8 out of 10. Staff G notified Staff H of Resident #2's pain. Resident #2 had constant pain in her bad that she described as an ache. Resident #2's March 2026 Medication Administration Record (MAR) included orders for acetaminophen (over the counter pain medicine) and hydrocodone-acetaminophen (prescription pain medication). On 3/12/26, Resident #2 rated their pain at dinner a 7. On 3/13/26 at 5:28 AM, Resident #2's received as-needed pain medication for a pain rating of 4 with movement.On 4/14/26 at 9:55 AM, Staff H stated she didn't get a report of the fracture when her shift started at 6:00 AM on 3/13/26. She didn't see the report in the chart and didn't tell the staff not to transfer Resident #2. She stated a resident shouldn't put weight on a fracture.On 4/14/26 at 10:10 AM, Staff D stated Resident #2's hesitant to say what happened because she didn't want to get staff in trouble. He stated Resident #2 eventually reported she fell on her knees near the recliner and a staff member lifted her up alone. Staff D confirmed he notified Staff C, who stated she knew nothing about a fall. Staff D didn't do a session with Resident #2 because of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	her knee pain. She reported her pain as a 7 with movement, but none at rest. On 4/14/26 at 10:35 AM, the DON explained she was the person on-call the night the results came in but didn't hear the 2:30 AM text. She heard the 5:30 AM text and spoke with Staff B at 7:00 AM. The DON acknowledged she didn't immediately call the provider or notify therapy. She confirmed Resident #2 shouldn't have put weight on her knee.The Communication with Physician Note dated 3/13/26 at 9:41 AM, completed by the Administrator documented they called the provider regarding the x-ray results for Resident #2. The provider requested to see if an ortho doctor could immediately see Resident #2. If they couldn't, the provider directed to Resident #2 to the emergency room for evaluation and treatment of their right knee fracture. On 4/14/26 at 11:15 AM, Staff C stated when she started her shift at 6:00 AM on 3/13/26 no one reported Resident #2 fell in the night. After Staff D asked her about Resident #2 falling, she tried to figure out what happened as she didn't have any documentation of a fall. Staff C confirmed she texted Staff B, who replied later in the day that she didn't know about a fall.On 4/14/26 at 11:45 AM, Staff I, Certified Medical Assistant (CMA), reported she worked 3/12/26 at 6:00 AM, no one reported Resident #2 fell in the night. On 3/13/26 when started at 6:00 AM, no one reported Resident #2 had fracture. She the staff transferred Resident #2 that morning and she put weight on her knee before and after breakfast. Staff I explained if a resident fell, they are supposed to call the charge nurse right away so they can assess the resident and document the fall. She noted the staff aren't supposed to pick residents up alone after a fall.On 4/14/26 at 1:45 PM, Staff K, CNA, reported she worked on 3/13/26 starting at 6:00 AM, but she didn't care for Resident #2 that day. No one reported about Resident #2 having a fracture that day. She stated the facility sent a message in their application about Resident #2's non-weight bearing status but not until 9:44 AM.On 4/14/26 at 2:00 PM, Staff L, CNA/CMA, stated no one advised her that Resident #2 fell in the night when she started on 3/12/26. The PT asked her about it and explained the situation. She heard Resident #2 had an x-ray but no one reported she had a fracture when she started her restorative shift on 3/13/26.The review of the facility's message application sent on 3/13/26 at 9:44 AM instructed Resident #2 couldn't bear weight on her right leg.On 4/14/26 at 2:15 PM, Staff J, CNA, stated she saw Resident #2 early in the shift around 10:40 PM on 3/11/26. After Staff E made it to work, she didn't ask Staff J for help with a fall on the night of 3/11/26. She didn't work again until 3/13/26 and when she returned no one reported Resident #2 had a fracture and attempted to transfer her for lunch with full weight-bearing. Staff D walked by and stopped her before she transfer her. Staff D informed her of Resident #2's injury.On 4/15/26 at 6:00 AM, Staff M, CNA, stated she worked Resident #2's hall on 3/12/26 on the overnight shift. She did hear she fell, but no one told her about Resident #2's right knee fracture during her overnight shift on 3/12/26. Staff M explained she did call for Resident #2 but didn't have to get her up as she slept. She only learned of the injury a day or two later.On 4/15/26 at 10:24 AM, Staff D stated he saw Staff J in the room and warned her not to put weight on Resident #2's knee. Staff J told him she didn't know about the fracture. Staff D reported the facility administration never emailed him about Resident #2's x-ray results or her non-weight bearing status on the morning of 3/13/26. He explained he only saw the hospital x-ray with their discharge instructions. Staff D stated that placing weight on a patella fracture could cause significant separation of the bone and increased pain.