STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365559	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Rehab and Care Ctr	68222 Commercial Drive Bridgeport, OH 43912

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, interview, record review, facility investigation review and policy review the facility failed to ensure residents were free from staff physical abuse. This affected two residents (#38 and #56) of three residents reviewed for abuse. The facility census was 57. Finding include: 1. Review of the medical record for Resident #56 revealed an admitted [DATE]. Diagnoses included Asperger syndrome (a developmental disorder affecting ability to effectively socialize and communicate), bipolar disorder, anxiety disorder, and Wernicke's encephalopathy (an acute neurological condition characterized by a clinical triad of ophthalmoplegia, ataxia, and confusion). Review of Resident #56's admission Minimum Data Set (MDS) assessment, dated 01/31/24, revealed the resident had impaired cognition and a memory problem. The resident was dependent on staff for bed mobility and transfers. Review of Resident #56 care plan dated 02/04/24 revealed the resident has impaired cognitive function or impaired thought processes related to developmentally delayed, difficulty making decisions, and Asperger's. Interventions included asking yes and no questions to determine the resident's needs. Communicate with the resident/family/caregivers regarding resident's capabilities and needs. Identify yourself at each interaction. Face the resident when speaking and make eye contact. The resident understands consistent, simple, directive sentences. Provide the resident with necessary cues- stop and return if agitated. Present just one thought, idea, question, or command at a time. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Self-Reported Incident (SRI) dated 03/15/24 and timed 8:31 P.M. revealed a State tested Nursing Assistant (STNA) alerted the nursing staff Resident #56 reported STNA #101 for whacking her back and cussing at her during incontinence care. The resident reported it was only STNA #101 and the resident was in the room with no other witnesses present. The nurse on duty reported to the Director of Nursing (DON) of the accusations. STNA #101 was immediately escorted out of the building and suspended pending investigation. A head-to-toe assessment of the resident was completed with findings of light blue markings on the left shoulder with scattered petechiae. The resident reported that STNA #101 whacked me on my back maybe four times. The resident stated the STNA told her to hold explicit still during care. She reports that she was rolled to her right-side during incontinence care. The resident is a Hoyer transfer and dependent on care. The resident was incontinent bowel and bladder and her shirt got wet with urine. The resident's clothing was bagged up, which the resident believed was being thrown away. During the investigation the resident's clothing was found in the laundry. On follow up with the resident, she reports additional allegations that STNA #101 threw her on the bed and bounced her head on the headboard. Another skin check was completed with resolved skin areas. The mother of the resident reports that she has sensory processing disorder and may be making allegations because she wants to return home. STNA #101 was interviewed and denied all allegations. STNA #101 reports that she was providing incontinence care and resident was resisting and rolling back into her hands during care. The Medical Director (MD) was notified, the residents family notified, and authorities were notified as indicated. Review of STNA #120's witness statement dated 03/15/24 revealed the STNA walked into Resident #56 room to start her last rounds and (the resident) stated crying saying, I didn't pee on her The STNA asked what she was talking about, and she said STNA #101 called me a dumb explicit and hit me in my back. The STNA continued in her statement that she rolled her over and the resident reached behind her shoulders and said, right here on my Spine. STNA #120 stated she saw two blue marks on her shoulder and went and reported the incident. Review of Resident #56's nurse practitioner (NP) progress note dated 03/16/24 at 12:09 P.M. NP #100 revealed Resident #56 claims, the night before (03/15/24) one of the aides moving her had punched her in the back. When NP #100 went to assess her, she was crying over the ordeal, and she did not want to see the STNA again. It was very hard to assess the patient; she would not roll over on her side for me. Even with her mother helping. Assessment of her back revealed the NP could not see any bruising as far as I could look and was very tender her whole back on palpation. Review of the facility's investigation revealed STNA #101 completed incontinence care by herself without assistance on Resident #56. There were no witnesses to the incident and no other residents reported negative incidents with STNA #101. The STNA was suspended from the facility from 03/15/24 to 03/21/24 but was brought back after the incident was unable to be substantiated. A phone interview on 04/10/24 at 10:09 A.M. with Family Member #112 revealed she was notified of the allegation right away. The facility assured her the staff member (STNA #101) would not be working on Resident #56's hall ever again. She continued that her daughter has not made allegations like this before, but she does have sensory issues and a light touch may feel like much more to her. Interview on 04/09/24 at 10:30 A.M. with Resident #56 revealed the resident denied any further allegations related to mistreatment by staff members in the facility. No signs of pain or discomfort were noted. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/09/24 at 4:00 P.M. with the Director of Nursing (DON) revealed the facility was unable to substantiate the allegation due to lack of witnesses and evidence. Following the incident, all staff members were educated on the abuse and neglect policy, and the STNA was permitted back to work but kept on another unit. 2. Review of the medical record for Resident #38 revealed an admitted [DATE]. Diagnoses included vascular dementia, hemiplegia and hemiparesis following other nontraumatic intracranial hemorrhage, and type two diabetes mellitus. Review of Resident #38's quarterly MDS assessment dated [DATE] revealed he was cognitively intact. Review of the SRI dated 04/01/2024 and timed 10:18 A.M. revealed Resident #38, alerted a floor staff member that STNA #101 was rough with his care and hit him in his testicles on the night of 03/31/2024. He is incontinent of bowel and bladder, dependent for personal care and has diagnoses of CVA, dementia, and depression. The resident denied reporting to the nurse on duty that night, or other staff members. The resident denied pain during and after the alleged incident. There were no skin areas on 04/01/2024 (during his assessment). The resident reported that he told STNA #101, to be a little more careful. and then If you can't be more gentle, don't come in my room. He does not recall any further encounters that night. His roommate does not recall any incident on 03/31/2024. The resident refused evaluation in the ER. He refused to report to additional authorities. Reported per protocol. The alleged incident was unwitnessed. STNA #101 denied all allegations and knowledge of the incident. She then subsequently resigned her position at her own will. The MD and the resident's son were notified of the alleged incident. Review of the facility's investigation revealed the facility interviewed all parties involved. STNA #101 denied the allegations and resigned from her position. No visible injuries were observed to Resident #38. The interviews conducted revealed no other concerns with care. The authorities were notified, and abuse training was conducted with all staff. Review of Resident #38 care plan dated 04/09/24 revealed the resident had self-care performance deficit. Interventions included a Hoyer lift for all transfers, the resident required extensive assistance by one to two staff for toileting assistance, and extensive assistant of one staff for personal hygiene. Interview on 04/09/24 at 9:42 A.M. with Resident #38 revealed STNA #101 came into his room the other night and beat the crap out of me. He stated she was being rough with care when turning him and he told her to be easier. He then reports STNA #101 stated, I'll show you rough and hit him multiple times in the groin. He reported, it hurt so bad he couldn't stand it He stated he was shocked and something like that had never happened to him before. He reported it to another STNA, and a nurse came and talked to him. He stated that he believed STNA #101 was fired because he had not seen her again. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/09/24 at 4:00 P.M. with the DON reported Resident #38 and Resident #56 do not live in the same hall, both require full assistance with care and transfers. She stated they do not usually attend activities and would not have contact with each other. However, the DON indicated she still felt unable to substantiate the allegations of abuse due to lack of witnesses. Further interview revealed Resident #56's mother felt the situation may have been a false allegation because the resident wanted to go home or the resident interpreted the situation wrong because of the resident's sensory processing disorder (the brain has trouble receiving and responding to information that comes in through the senses) that the STNA handled her rough when she may not. However, there was no indication as to why the residents' (both Resident #38 and #56) allegations/reports of the incidents were not sufficient to determine mistreatment/abuse had occurred. The facility did not provide evidence that either resident had a history of making false allegations. Review of STNA #101's employee file revealed a hire date of 02/29/24. Review of the employee file revealed the STNA had received abuse training upon hire. The STNA resigned her position on 04/01/24. Review of the facility's Abuse, Neglect, Exploitation, and Misappropriation of Resident Property revealed the facility would not tolerate abuse. The policy defines abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. The deficiency was corrected on 04/01/24 after the facility implemented the following corrective actions: STNA #101 was removed suspended pending the outcome of the investigation on 04/01/24 and resigned her position on 04/01/24. All residents with a BIMS of 12 or higher were interviewed by the DON on 04/01/24 to ensure no further abuse concerns were present. All residents with a BIMS lower than 12 received skin assessments completed by the DON on 04/01/24. On 04/01/24 the authorities were made aware of the incident with Resident #38. On 04/01/24 staff members who were working on 03/31/24 were interviewed by the DON to ensure no one witnessed abuse. The DON provided abuse training for all staff members on 04/01/24. This deficiency represents non-compliance investigated under Complaint Number OH 00152682