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	09/12/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32801 Based on medical record review and interview the facility failed to ensure an admission skin assessment was completed timely and post trauma skin alteration treatments were administered as ordered. This affected one resident (#20) of three records reviewed for skin alterations. Findings include: Medical record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including orthopedic aftercare, diabetes, and multiple fractures. Review of Resident #20's hospital discharge order dated 08/29/24 revealed orders for triad (sterile coating that adheres to wet skin and keeps the wound covered) to coccyx and penis twice daily, mesalt rope (absorbs exudate) and dry dressing to right shin twice daily, hydrofera blue (dressing that kills bacteria and reduces bio-burden) ready with words facing out to the left upper arm wound , right buttocks, left axilla wound, left calf and left elbow to be changed every five days and as needed. Review of Resident #20's orders and treatment administration records dated 08/29/24 to 09/03/24 revealed no evidence the hospital discharge orders were implemented until 09/03/24. Review of Resident #20's paper medical record revealed the paper skin assessment was blank. Review of Resident #20's electronic medical record revealed the admission skin assessment was not completed. Review of Resident #20's wound notes from the Wound Nurse Practitioner (WNP)#500 dated 09/04/24 revealed the resident was being seen for multiple wounds that were present on admission status post a motor vehicle accident. The wounds located right lateral buttocks, right anterior left lower extremity (deep laceration), neck, left lateral proximal leg, left lateral leg, gluteal crease and left upper arm. The resident was on a motorcycle with helmet on and was ejected 40 feet. The resident had extensive number of fractures of ribs, spine, right leg, left arm, right hip non-operable fracture, pelvic fracture, and tibia fracture. Review of Resident #20's wound notes revealed no evidence of a weekly skin assessment for 09/11/24. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #20's plan of care revealed on 09/12/24 the facility initiated a skin impairment plan of care for skin impairments to the left upper arm, right buttock, left axilla, coccyx and penis related to recent trauma (motorcycle accident). Interview on 09/12/24 at 3:15 P.M. with Resident #20 confirmed staff did not perform his wound treatments for four or five days after admission due to it was the weekend then it was a holiday on Monday (09/02/24). Interview on 09/12/24 at 3:18 P.M. with the Director of Nursing (DON) and Wound Nurse (Licensed Practical Nurse) #107 confirmed the resident didn't have a skin assessment completed upon admission until the WNP saw the resident on 09/04/24. The DON and LPN #107 confirmed the hospital discharge wound orders were not entered and treatments were not administered until 09/03/24. LPN #107 reported the WNP was at the facility yesterday (09/11/24) and she had completed rounds with the WNP, however she had not documented the measurements or entered the new orders yet. This deficiency represents non-compliance investigated under Complaint Number OH00157623.

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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 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** 32801 Based on medical record review, observation, interview, and policy review the facility failed to ensure infection control practices were maintained to prevent the spread of COVID-19 and failed to ensure enhanced barrier precaution were maintained during resident care. This had the potential to affect all 54 residents residing in the facility. Findings included: 1. Medical record review Resident #14 was admitted to the facility on [DATE] with diagnoses including respiratory failure, COVID-19, and diabetes. Review of Resident #14's progress note dated 09/08/24 revealed the resident was still complaining of not feeling well; chilled at this time. Resident tested positive for COVID-19. Resident moved to room [ROOM NUMBER]. Review of Resident #14's orders dated 09/08/24 revealed the resident was ordered strict droplet precautions for COVID-19 for ten days. Observation of Resident #14's room and interview on 09/12/24 at 8:10 A.M. with State tested Nurse's Aide (STNA) #126, Director of Nursing (DON), and Assistant Director of Nursing (ADON) #119 and 10:18 A.M., with ADON #119 revealed there was no signage indicating the resident was in isolation, no personal protective equipment (PPE) cart, and no waste receptacle containers for contaminated materials. The staff confirmed Resident #14 had COVID-19 and was supposed to be in droplet isolation. The staff confirmed there should have been signs indicating the resident was in isolation, a PPE cart outside the room, and two cardboard boxes inside the room by the door to place the re-usable gowns and the other for trash (mask, gloves, etc.). 2. Medical record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, dementia, and history of COVID-19. Review of Resident #31's orders dated 09/10/24 revealed Resident #31 was ordered strict droplet precautions for COVID-19 for ten days. Observation and interview on 09/12/24 at 8:20 A.M. of Resident #31's room with Registered Nurse (RN) #103 revealed there was no signage indicating the resident was in isolation, no PPE cart, nor waste receptacle containers for contaminated materials. This was verified with RN #103 at the time of the observation. 3. Medical record review revealed Resident #47 was admitted to the facility on [DATE] with diagnoses including orthopedic aftercare, end stage renal disease, diabetes, and peripheral vascular disease. Review of Resident #47's hospital COVID-19 test dated 09/06/24 revealed the resident tested positive for COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #47's orders dated 09/10/24 revealed the resident was ordered strict droplet precautions for COVID-19 until 09/17/24. Observation and interview on 09/12/24 at 8:27 A.M. of Resident #47's room with RN #103 revealed there was no signage indicating the resident was in isolation, there was a re-usable gown hanging on the outside the door on a hook, the PPE cart only contained face shields and gloves. There was no evidence of mask or gowns. Findings confirmed with RN #103 during observation. 4. Medical record review revealed Resident #29 was admitted to the facility on [DATE] with diagnoses including acute kidney failure, colostomy, and acute pain. Review of Resident #29's orders dated 09/2024 revealed the resident was ordered enhanced barrier precautions (EBP) related to indwelling medical device/wounds/infections/colonization with a MDRO during high contact resident care activities. Observation and interview on 09/12/24 at 9:20 A.M. of Resident #29 with Licensed Practical Nurse (LPN) #107, revealed there was a sign for EBP and a PPE cart outside Resident #29's room. State tested Nurse's Aide (STNA) #141 was in the room with only gloves on providing care and turning the resident. LPN#107 confirmed STNA #141 should have been wearing a gown when providing direct care to Resident #29 because the resident had a colostomy. 5. Interview on 09/12/24 at 8:35 A.M. with STNA #149, DON, and ADON revealed STNA #149 reported there was no N95 masks on the unit, however there were some near the time clock and there were a few on the other unit. The STNA reported she wears the same N95 all day and doesn't change even when she had been in a COVID-19 or isolation room. The STNA also reported the facility was using re-usable gowns in the isolation rooms and they were short on gowns. Interview on 09/12/24 at 8:44 A.M., with the DON and ADON revealed all staff were required to wear N95 at all times when the facility was in COVID outbreak mode. The facility had been in outbreak mode for the last three or four days. Interview on 09/12/24 at 9:16 A.M., with STNA #154 revealed she wears the same N95 mask all day, however, places a surgical mask over her N95 mask when she goes into the room of a resident with COVID-19 and just removes the surgical mask when she exits. Interview on 09/12/24 at 9:20 A.M., with LPN #107 revealed she wears the same N95 mask all day, however, places a surgical mask over her N95 mask when she goes into the room of a resident with COVID-19 room and just removes the surgical mask when she exits. Review of the facility's policy titled Isolation (dated 01/2012) revealed the facility would implement a system (signs) to alert staff and visitors to the type of precautions the resident requires. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy titled COVID-19 (dated 05/15/23) revealed a single case was considered outbreak mode. Positive residents would be maintained strict droplets precautions. Universal source control would be implemented when the facility was considered in outbreak (N95, eyewear). Staff should wear full PPE: N95 mask, gown, gloves, and face shields for care of resident who are known COVID positive for all resident contact. N95's must be changed when exiting a resident room that was COVID positive and a new one donned. PPE should be available before entrance to an isolation room and should be utilized even in the presence of an emergency. Review of the facility's policy titled Personal Protective Equipment (dated 09/2010) revealed to use gown once and then discard into an appropriate receptacle inside the exam/treatment room. Reusable gowns should be laundered after each use. The gowns must be discarded in the appropriate container located in the room. If a disposable gown and mask was used remove and discard into the waste receptacle inside the room. Review of the facility's policy titled EBP (dated 04/01/24) revealed staff should use gown and gloves during high-contact resident care activity (dressing, bathing, transferring, hygiene care, changing linens). This deficiency represents non-compliance investigated under Complaint Number OH00157623.