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	04/15/2025

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** 50538 Based on record review, interviews and policy review, the facility failed to implement preoperative orders prior to a scheduled surgical procedure resulting in the procedure being rescheduled. This affected one resident (Resident #18) of five reviewed for physician orders. Findings include: Review of Resident #18's medical record revealed an admitted [DATE] with diagnoses including aftercare following surgery on the nervous system, diabetes, major depression, hypertension and hyperlipidemia. Review of Resident #18's care plan revealed a care plan initiated on 07/23/24 for risk of bleeding related to antiplatelet use, indicating to monitor the resident for bleeding and increased bruising. Review of the physician orders revealed an order for aspirin 81 milligrams by mouth daily for a blood thinner started on 11/08/24. Review of Resident #18's progress notes revealed a note written on 01/27/25 at 10:00 A.M. indicating a call was received from the Neuroscience center to schedule a surgical date of 03/13/25 as the date of Resident #18's craniotomy. He was to arrive at the hospital at 7:00 A.M. that day. His preoperative testing and appointment were to be completed at the bone/joint building across the street from the hospital. The facility scheduling was notified to set up transportation. Review of Resident #18's annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. Review of Resident #18's progress notes revealed a note written on 03/05/25 at 3:50 P.M. indicating Resident #18 left the facility around noon with staff to go to an appointment and returned to the facility at 3:25 P.M. There was no other information provided related to the appointment. Review of Resident #18's progress notes revealed a note dated 03/06/25 at 9:56 P.M. from the resident's medical provider indicating Resident #18 had a benign neoplasm of the pituitary gland and was scheduled for a craniotomy on 03/13/25. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #18's physician's orders revealed no preoperative orders were in place prior to the surgery scheduled for 03/13/25 such as medications to be held, if the resident was to stop intake of food and fluids prior to surgery, or if he was allowed to take his medication prior to surgery. There was no evidence in the medical record of when the resident attended the pre-op appointment. Review of Resident #18's progress notes revealed a note written on 03/13/25 at 10:25 A.M. by the Director of Nursing indicating a call was received from the hospital surgical department indicating Resident #18's surgery was being rescheduled due to a miscommunication about medications being held. The note indicated that only basic surgical instructions were present in the facility not the neurological surgery instructions. The neurology department was to contact the facility with a new appointment. Review of Resident #18's March 2025 medication administration record revealed he received 81 milligrams of aspirin, one tablet by mouth once daily as a blood thinner from 03/01/25 until 03/12/25. There were no instructions to not administer the resident's aspirin prior to surgery. In an interview on 04/10/25 at 2:00 P.M. Licensed Practical Nurse (LPN) #175 stated when orders were received that require transportation the receiving nurse enters the orders into the computer, notifying the receptionist or the activity director so that they can arrange transportation and notify the resident and their responsible party. If the resident is having testing, surgery or a procedure that requires preparation before the procedure, those orders should be entered into the electronic medical record when received. Medications that must be held can have a date entered to start holding the medication and a date entered to stop holding the medication. In an interview on 04/14/25 at 2:06 P.M. LPN #145 stated that the nurse who receives preoperative orders should place them in the electronic medical record and make sure they are entered completely including any orders to hold medications. In an interview on 04/14/25 at 2:12 P.M. LPN #101 stated the nurse receiving preoperative orders should enter those orders into the electronic healthcare record. If the resident is on any type of blood thinning medication and the medication is not addressed in the preoperative orders a call should be made to the surgeon for clarification on what to do about these medications. In an interview on 04/14/25 at 2:42 P.M. Activities Director #136 revealed that when a resident goes out for an appointment, they are accompanied by someone from the activities department or the facility receptionist when that position is filled, the accompanying person is also the transportation driver. Activities Director #136 stated they currently have a Certified Nursing Assistant (CNA), who is on light duty, filling the receptionist position and she has only been filling the position for about three weeks. The previous transportation driver is no longer employed at the facility. Activities Director #136 stated the driver obtains the paperwork to take with the resident to the appointment from the nurse caring for the resident and gives it to the medical staff at the appointment. The driver stays with the resident and receives any paperwork returning with the resident to the facility and the driver gives that paperwork to the facility nurse who is caring for the resident upon their return to the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/15/25 at 1:27 P.M. the Director of Nursing (DON) verified there were no preoperative orders in the electronic medical record for Resident #18's surgery scheduled for 03/13/25. The DON confirmed that Resident #18 received 81 milligrams of aspirin, one tablet by mouth once daily as a blood thinner from 03/01/25 until 03/12/25. The DON further stated her expectations were that the nurse receiving the preoperative orders would enter them into the electronic medical record, document them in the progress notes and notify the responsible party and the resident's medical provider at the nursing home. The DON stated the aspirin should have been held prior to the scheduled surgery date and if an order was not received to hold it, with the preoperative orders, a call should have been made to the surgeon for clarification. The DON verified LPN #147 was the nurse working the day Resident #18 received his pre-operative orders but the nurse did not indicate what the resident's specific pre-operative orders were and this resulted in the resident's survey having to be cancelled and rescheduled because he received his aspirin prior to surgery. The DON verified LPN #147 was no longer employed at the facility due to not following facility procedures. In an interview on 04/15/25 at 2:20 P.M. LPN #200 with the hospital neurosurgery department stated Resident #18's craniotomy surgery was cancelled the morning of 03/13/25 after he arrived at the hospital. LPN #200 stated that during a review of Resident #18's medication administration record it was discovered that he had received 81 milligrams of aspirin, one tablet by mouth once daily as a blood thinner on 03/12/25. The hospital called the facility, and the DON verified Resident #18 had received the medication. The surgeon chose to cancel the craniotomy to remove a benign pituitary tumor because the resident was at high risk for bleeding from receiving the aspirin. LPN #200 further stated the aspirin should have been held for at least one week prior to the surgery. Review of a Pharmacologic Profile used by the facility for antiplatelet agents such as aspirin revealed these types of medications should be used cautiously in people who were at risk for bleeding from procedures such as surgery. Review of the policy titled Charting and Documentation revised July 2017 revealed that changes in the plan of care goals and objectives and events and incidents involving the resident should be documented in the resident medical record. Documentation should be complete and accurate. This deficiency represents non-compliance investigated under Complaint Number OH00163835.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50538 Based on observation and staff interviews, the facility failed to maintain a clean and comfortable environment for the residents residing in the facility. This affected one resident (Resident #6) of five residents interviewed on the 100 and 200 units who utilized the community shower. The facility census was 63. Findings include: In an interview on 04/10/25 at 1:13 P.M. Resident #6 stated that she did not use the shower room on her unit but went to the shower on the other side of the building because the shower on her side had a bad odor and stains on the floor creating an unpleasant shower experience. Observation of the shower room shared by the 100 hall and 200 hall on 04/10/25 at 1:43 P.M. revealed a musty, rotten egg-like odor similar to sewage in the shower room and a gray-brown stain that was approximately an inch wide and four inches in length, on the floor along the wall at the edge of the shower stall, below the emergency call cord. In an interview on 04/10/25 at 1:43 P.M. Housekeeper #138 confirmed the odor and the stain on the floor in the shower room . In an interview on 04/10/25 at 2:15 P.M. the Administrator verified the odor and the stain on the floor in the shower room but she thought it had gotten better since there were no recent resident complaints. In an interview on 04/14/25 at 10:10 A.M. Certified Nursing Assistant #174 stated the shower problem had started about a month ago and got better for a short time. She stated that the shower room did not have an odor in the morning but the odor became apparent after two or three showers were given. This deficiency represents non-compliance investigated under Complaint Number OH00163775.