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	04/30/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, interview, and policy review, the facility failed to ensure resident representatives were notified when there was a change in the residents' treatments/ medications as required. This affected three of three residents reviewed for changes in condition. Findings include: 1. Review of Resident #45's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included anoxic brain damage, epilepsy (seizures), major depressive disorder, and anxiety disorder. Review of Resident #45's profile under the electronic medical record (EMR) revealed the resident's emergency contacts were listed. Her sister was identified as the resident's emergency contact #1, with a contact phone number included. Review of Resident #45's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She was able to make herself understood and was able to understand others. She was not known to display any behaviors during the seven day assessment period. Review of Resident #45's nurses' progress notes revealed there were four occasions over the past five months in which there was no documented evidence of the resident's representative (her sister) being notified when there was a change in the resident's condition and/ or new orders for treatment had been received. The four occasions were as follows: On 01/01/25 at 8:18 P.M., Resident #45's physician was called about Vicks (menthol vapor rub) and cough drops. The physician gave approval for Vicks to be applied three times a day as needed (prn) and also approved the resident to keep cough drops in her room. There was no evidence the resident's representative was notified of the new orders. On 02/16/25 at 5:25 P.M., Resident #45 complained of vaginal burning and discomfort. She also complained of mid-thoracic back pain and decreased urination. Her physician was notified and ordered a urinalysis to be done. There was no indication in the progress not that the resident's representative was notified of the new order. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/25 at 4:40 P.M., Resident #45 was seen by the nurse practitioner. The nurse practitioner gave a new order to discontinue her Buspar (anti-anxiety medication) and to increase her Remeron (an anti-depressant). The resident was made aware, but there was no indication of her sister being notified of the change in medication orders. On 04/09/25 at 2:42 P.M., Resident #45 was seen by the nurse practitioner. A new order was given to start Prozac (an anti-depressant) and decrease her Remeron. She also discontinued the resident's Vistaril (an anti-anxiety medication). The resident was made aware and in agreement to the changes. There was no evidence of the resident's sister being notified of the new medication changes. On 04/29/25 at 10:57 A.M., an interview with Resident #45 revealed she had been in the facility for about a year now. She was there for therapy following her traumatic brain injury. She reported she was her own person, but her sister was to be notified of any changes in her condition or in her medications/ treatment plan. On 04/30/25 at 9:15 A.M., an interview with the facility's Director of Nursing (DON) revealed she was not able to find evidence of Resident #45's sister being notified of the previously mentioned new orders that had been received. She confirmed the nurses' progress notes did not show any documented evidence of the resident's sister being notified as was desired by the resident. The facility's Administrator, who was present during the interview, revealed Resident #45 was her own person and they informed her of any changes in her orders, such as with her medications. The Administrator reported she had went back to talk to the resident about that yesterday and was told it was okay for them to notify just the resident about any medication changes. She informed the Administrator she continued to want her sister notified of any changes in her condition. On 04/30/25 at 9:45 A.M., a follow up interview with Resident #45 confirmed she had a conversation with the facility's Administrator the day before regarding who to notify of new orders. She confirmed she had told the Administrator it was okay just to let her know about the medication changes, but then talked to her sister yesterday evening, who still wanted to be notified when new orders were received. The resident was informed it was her right to decide who would be notified of changes in her condition or of medication/ treatment changes. She reported she would like for the facility to also notify her sister of any new orders she was given. She talked to her sister daily, but did not always remember to tell her everything that was going on with her. Review of the facility's policy on Change in a Resident's Condition Status revised December 2016 revealed it was the facility's policy to promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/ mental condition and/ or status. The nurse would notify the resident's attending physician or on-call physician when there had been a need to alter the resident's medical treatment significantly. A significant change of condition was defined as a major decline or improvement in the resident's status that would not normally resolve itself without intervention by staff or implementing standard disease-related clinical interventions and required interdisciplinary review and/ or revision to the care plan. Unless otherwise instructed by the resident, a nurse would notify the resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status. 2. Review of Resident #51's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia, an altered mental status, major depressive disorder, and adult failure to thrive. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #51's profile under the EMR revealed her son was listed as her emergency contact #1. The resident's daughter was listed as her emergency contact #2. Review of Resident #51's annual MDS assessment dated [DATE] revealed the resident had highly impaired hearing without the use of hearing aids and clear speech. She was able to make herself understood and was usually able to understand others. Her cognition was moderately impaired. Review of Resident #51's nurses' progress notes revealed there were two separate times the resident had a change in her condition that warranted new orders from the physician. Both times there was no documented evidence of the resident's representative being notified of her change in condition and/ or new orders received. The nurses' progress notes revealed the following: On 11/27/24 at 4:28 A.M., a large, dark brown blood clot was noted in the resident's brief (incontinent brief). It was not clear where the clot had come from. A message was left for the physician and the resident's daughter (emergency contact #2) was updated. There was no evidence of the resident's son being notified of the change in the resident's condition. On 11/27/24 at 11:13 A.M., the nurse contacted the physician about the resident. New orders were given for a complete blood count (CBC) to be drawn stat (immediately). There was no documented evidence of the son being notified of the new order for the lab draw. On 04/14/25 at 1:26 PM, Resident #51 was visited by the nurse practitioner. She gave a new order for the use of Voltaren gel topically to her bilateral lower legs as needed (PRN) for pain. The resident was made aware of the new order, but there was no documented evidence of the son being informed of the new order. On 04/30/25 at 9:15 A.M., an interview with the facility's DON revealed she was not able to find any evidence of Resident #51's son being notified of the resident's change in condition on 11/27/24 or the new orders that had been given on 11/27/24 and on 04/14/25. The Administrator, who was present during the interview, revealed Resident #51 was her own person. She was informed the resident's most recent annual MDS assessment completed on 02/03/25 identified the resident's cognition as being moderately impaired. She acknowledged the resident's son was identified in her medical record as being her emergency contact #1 and should have been informed of the change in condition and new orders that had been given. 3. Review of Resident #44's medical record revealed the resident was admitted to the facility on [DATE]. His diagnoses included Parkinson's disease, congestive heart failure, major depressive disorder and anxiety disorder. Review of Resident #44's profile included under the EMR revealed his son was listed as his durable power of attorney for healthcare and his emergency contact #1. Review of Resident #44's admission MDS dated [DATE] revealed the resident did not have any communication issues but his cognition was moderately impaired. He was not known to display any behaviors or reject care during the seven day assessment period. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #44's nurses' progress notes revealed there were five separate occasions when the resident had a change in condition and/ or received new orders from the physician or nurse practitioner, without evidence of the resident's DPOA for healthcare/ emergency contact #1 was notified. The nurses' progress notes revealed the following: On 02/26/25 at 1:35 P.M. the nurse practitioner was in to see Resident #44 and gave new orders for the resident to start breathing treatments PRN (as needed) for 14 days. The resident was made aware of the new order, but there was no indication of the son being notified of the new order. On 02/26/25 at 9:39 P.M., Resident #44's lab work was reviewed by the physician and new orders were received for the resident to receive Prostat (a liquid protein) and to have lab work in two weeks. Again, the resident was made aware, but there was no indication his son was notified of the new orders. On 03/12/25 at 11:18 A.M., Resident #44 was seen by the nurse practitioner. He complained of low back pain while urinating. A new order was given to obtain a urinalysis (U/A). The resident was made aware, but there was no documented evidence of the son being informed of the resident's change in condition and new order received for a U/A. On 03/28/25 at 11:32 P.M., Resident #44 was started on Cipro (an antibiotic) that evening. His U/A was still pending. There was no documented evidence that the resident's son was informed of the resident being placed on an antibiotic. On 04/09/25 at 1:06 P.M., Resident #44 was seen by the nurse practitioner and his lab work had been reviewed. She gave a new order to start Vitamin D and repeat the resident's Vitamin D level in eight weeks. The resident was made aware, but there was no documented evidence to show his son had been made aware as well. On 04/29/25 at 3:13 P.M., an interview with the facility's DON revealed it was the facility's practice to notify the resident of any new orders, if the resident was considered their own person. She denied that they would notify a resident's family of any new orders or changes in condition, if the resident was their own person. For those residents with cognitive impairment, they would notify the resident's emergency contact/ power of attorney (POA) of any changes in the resident's condition or new orders. She was asked about Resident #44 to determine if he was considered his own person. She reported Resident #44's son was to be notified of any change in condition or new order, as he was the resident's POA. It was reviewed with the DON, all the documentation in Resident #44's progress notes of changes in his condition and/ or new orders that did not have any documented evidence of the resident's son being notified. She recorded the dates and times of the above and was asked to provide any evidence to the contrary. No additional information was able to be provided to show the son had been made aware of those new orders. This deficiency represents non-compliance investigated under Complaint Number OH00164776.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28923 Based on record review, observation, interview, and policy review, the facility failed to ensure fall prevention interventions were implemented for residents at risk and with a history of falls as per their plan of care. This affected two (Resident #45 and #51) of three residents reviewed for falls. Findings include: 1. Review of Resident #45's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included anoxic brain damage, epilepsy (seizures), major depressive disorder, and anxiety disorder. Review of Resident #45's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident did not have any communication issues and was cognitively intact. She required supervision to touching assistance with with transfers. She was indicated to have had one fall with injury (not major injury) since her prior assessment. Review of Resident #45's care plans revealed she had a care plan in place for being at risk for falls related to deconditioning, gait/ balance problems, hypotension (low blood pressure), incontinence, the use of psychoactive medications, and being unaware of her safety needs. The care plan was initiated on 12/01/23. The goal was for her not to sustain serious injury through the review date. The interventions included the need to ensure her garbage can was within reach. That intervention was initiated on 05/03/24. On 04/30/25 at 9:07 A.M., an observation of Resident #45 noted her to be sitting in bed with her legs crossed. She had the lower half of her body covered with a blanket and she was watching something on her iPad. Her bed was in the back left corner of the room and the right side of the bed was against the side wall and the head of her bed was against the back wall the window was on. Her trash can was noted to be away from her bed and out of her reach against the other side wall opposite from the one her bed was against. It was positioned next to the night stand that was between the bathroom door and the entry door to her room. An interview with the resident at the time of the observation revealed that was the location they always had her trash can at. She confirmed she could not reach it where it was placed when she was in bed. Also confirmed she was not supposed to get up without assistance and the staff did not leave her trash can by her bed, when she was lying in bed. On 04/30/25 at 9:13 A.M., an interview with the facility's Director of Nursing (DON) revealed Resident #45's fall prevention interventions included the need to keep the resident's garbage can in reach. She confirmed the resident's garbage can was not within her reach, when it was placed against the wall opposite of the wall her bed was on. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy on Managing Falls and Fall Risk revised March 2018 revealed based on previous evaluations and current data, the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with input from the attending physician, would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. If interventions have been successful in preventing falling, staff would continue the interventions or reconsider whether those measures were still needed if a problem that required the intervention had resolved. 2. Review of Resident #51's medical record revealed she was admitted to the facility on [DATE]. Her diagnoses included adult failure to thrive, dizziness and giddiness, hypertension, unspecified dementia, and difficulty walking. Review of Resident #51's annual MDS assessment dated [DATE] revealed the resident had highly impaired hearing, without the use of hearing aids. Her vision was adequate with the use of glasses. She was able to make herself understood and was usually able to understand others. Her cognition was moderately impaired. She did not display any behaviors and was not known to reject care. She required supervision or touching assistance with bed mobility and transfers. Review of Resident #51's care plans revealed she had a care plan in place for being at risk for falls related to anemia, weakness, and having complaints of pain at times. The care plan was initiated on 05/03/22. The goal was for her not to have any fall related injuries. Her interventions included the use of a visual reminder in her room to call for assistance. That intervention was added as a fall prevention intervention on 10/02/23. On 04/29/25 at 2:30 PM, an observation of Resident #51 noted her to be sitting up in her bedside chair next to her bed. There were no signs posted in her room for a visual reminder for the resident to call for assistance, as per her plan of care. On 4/29/25 at 2:40 PM, an interview with LPN #100 revealed Resident #51 was at risk for falls. She recalled the resident fell about a month ago. She was questioned about what fall prevention interventions were in place to prevent falls from occurring. She was not aware of the intervention for the resident to have a visual reminder in her room to call for assistance. She reported the resident was in room [ROOM NUMBER], when her fall occurred about a month ago. She verified the resident's current room did not have any visual reminders in the room to call for assistance. Observations of the resident's prior room noted there to be a sign posted in that room on the wall by bed A To call for assistance. LPN #100 verified Resident #51 was in bed A when she was in room [ROOM NUMBER]. She indicated the resident changed rooms about a week or so ago and the visual reminder sign was not moved with the resident. This deficiency represents non-compliance investigated under Master Complaint Number OH00165235 and Complaint Number OH00164776.