

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER Rolling Hills Rehab and Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and resident agreement review the facility failed to ensure residents were transported to medical appointments. This affected one resident (Resident #17) of four residents reviewed. Findings include: Record review revealed Resident #17 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes, vascular dementia, anemia, hypertension (HTN) and nicotine dependence. Review of the Minimum data set (MDS) revealed Resident #17 had a brief interview for mental status (BIMS) score of 13, out of a possible 15, indicating intact cognition. Medical record review revealed the facility was aware transportation was unavailable for Resident #17 as of 07/18/25 and there was no documentation to support attempts for alternate transportation were made so Resident #17 could attend the appointment. Interview on 07/31/25 at 10:55 A.M. with Resident #17 revealed on 07/21/25 he got up and got ready for an appointment regarding a cyst above his eye. Resident #17 stated he had been waiting for this appointment and went to the front of the building and waited but never saw the van for transport. He stated he eventually asked staff about what was happening and he was told his appointment was cancelled because the van was broken. The resident said he was confused and shocked because he had not cancelled the appointment and he was upset because no one had told him about the transportation cancellation. The resident stated he felt out of the loop on his appointments and other things, and it seemed like others knew about what was going on but he did not. The resident shared he had asked to be kept informed and even said the facility could call his room to update him. An interview on 07/31/25 with Receptionist #602 with the dermatology office confirmed Resident #17 had an appointment scheduled with them on 07/21/25 at 1:30 P.M. but the appointment was cancelled that day. Review of Rolling Hills undated resident admission agreement page three revealed physician ordered services are available through duly licensed, registered, and/or certified practitioners or entities including transportation services. This deficiency demonstrated non-compliance investigated under Master Complaint Number 2576098.</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, hospital record review, review of data found at www.kidneyfoundation.org, policy review and interviews, the facility failed to prevent an incident of neglect when Resident #51 did not receive hemodialysis treatments as ordered due to a lack of facility provided transportation. This resulted in Immediate Jeopardy and actual harm with risk of death beginning on 07/21/25 when Resident #51, who was dependent on hemodialysis due to end stage renal disease, was not transported to a scheduled dialysis treatment. The resident subsequently missed hemodialysis on 07/23/25 again due to a lack of facility provided/arranged transportation. As a result, Resident #51 developed symptoms of fluid volume overload, shortness of breath, fatigue and weakness. The facility failed to timely identify the resident's condition change and did not transfer the resident to the emergency room (ER) until the evening of 07/23/25 at which time she was diagnosed with hyperkalemia (elevated potassium level of 7.7 (critical)) due to missed hemodialysis treatments and required admission to the intensive care unit (ICU) to receive continuous renal replacement therapy (CRRT) to restore the resident's blood potassium level and prevent imminent deterioration of the resident's condition. This affected one resident (Resident #51) of one resident identified by the facility to receive hemodialysis treatments. The facility census was 52. On 08/04/25 at 4:47 P.M. the Director of Nursing #7, Assistant Director of Nursing #6, Administrator #128, Regional Director of Operations (RDO) #614, and Regional Director of Clinical Services 615 were notified Immediate Jeopardy began on 07/21/25 when the facility failed to secure transportation for Resident #51 to receive life sustaining hemodialysis treatments required due to the resident's end stage renal disease. Due to the missed appointments, the resident was hospitalized in the intensive care unit requiring continuous renal replacement. The resident was assessed to have hyperkalemia, was hyponatremic and her electrocardiogram revealed cardiac changes, including heart block, due to the changes in condition associated with the missed hemodialysis treatments. The Immediate Jeopardy was removed on 08/04/2025 when the facility implemented the following corrective actions: On 08/04/2025 from 5:07 P.M. until 5:17 P.M. Regional Director of Operations (RDO) #614 Regional Director of Clinical Services #615, Administrator #128, Director of Nursing (DON) #7 and Assistant Director of Nursing (ADON) #6 were educated via Teams call by VP of Clinical Operations #613 and VPO #612 regarding: Abuse and Neglect Policy, Resident examination and assessment, Change in Resident's Condition or Status with Notification, Transportation and interventions, and Charting and Documentation. On 08/04/2025 at 5:20 P.M. all department heads were educated via in-person meeting by RDO #614 and Regional Director of Clinical Services #615 on Abuse and Neglect Policy, Resident examination and assessment, Change in Resident's Condition or Status with Notification, Transportation and interventions, and Charting and Documentation. Department heads educated included Administrator #128, DON #7, Business Office Manager (BOM) #129, ADON #6, admission Coordinator/Marketing #218, Dietary Manager #65, Social Services #106, Minimal Data Set (MDS) Registered Nurse (RN) #2, Regional Director of Clinical Services #615, RDO #614, and Central Supply/Medical Records #5. On 08/04/2025 from 5:30 P.M. until 6:00 P.M. an audit of the facility appointment calendar was completed for all 52 residents for missed appointments due to transportation concerns the week of 07/21/2025 to 07/28/2025 when the facility was without a wheelchair accessible van. Two additional residents were identified as having missed appointments and were clinically assessed for a decline in condition. The audit completed by ADON #6 identified Resident #15 had a chemotherapy appointment scheduled for 07/21/2025 but arranged transportation did not arrive to transport the resident on 7/21/2025. Resident #15's appointment was rescheduled for 07/31/2025 and transportation was provided by the facility. Resident #17 had a non-life sustaining dermatology appointment scheduled for 07/21/2025. Transportation was canceled by Valley Logistics transportation company; the Activity Director was notified on 7/18/2025 when the Activity Director called to confirm transportation arrangements. This appointment and transportation were rescheduled to 08/18/2025, with the facility to transport. On 08/04/2025 from 6:04 P.M. until 6:40 P.M. resident interviews were conducted to identify possible situations of neglect. Thirty-one (31) residents with a Brief Interview for Mental Status (BIMS) score of 13 or higher were interviewed by the BOM. Residents interviewed included Resident #4, # 5, #10, #11, #12, #13, #14, #15, #17, #18, #19, #20, #21, # 22, #23, #26, #28, #29, # 32, #34, #35, #37, #38, #42, #43, #47, # 48, #50, #51, #53, and #55. Questions included Has staff a resident or anyone else here neglected you? and Have you seen any resident here</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility policy review, facility investigation review and interviews the facility failed to thoroughly investigate and report allegations of sexual abuse to the state survey agency. This affected two residents (Resident #7 and #54) of three residents reviewed for abuse. The facility census was 52. Findings Include: 1. Record review revealed Resident #7 admitted to the facility on [DATE] with diagnoses of vascular dementia, alcohol use, flaccid bladder, hydronephrosis, major depressive disorder, hypertension, metabolic encephalopathy, and anxiety. Record review of Resident #7 quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #7 had severe cognitive impairment, exhibited behaviors and could independently walk at least 150 feet. Record review of Resident #7's assessment for behaviors completed 06/13/25 revealed Resident #7 wandered freely without interruption. Additional factors affecting the resident's behaviors included the resident would become frustrated due to problems communicating discomfort or unmet needs. Record review of Resident #7 assessment for elopement revealed Resident #7 is a high elopement risk due to intermittent confusion, poor safety and environment awareness, and wears a wander guard on their left ankle. Review of Resident #7 record revealed a progress note dated 07/09/25 stating resident was ambulating up and down hall two multiple times throughout the day. No behaviors noted at this time. Patient is laying in his bed in his room, eyes closed, arouses easily, call light in reach. Review of Resident #7 record revealed a progress note dated 07/09/25 authored by Assistant Director of Nursing #6 revealed the resident was noted from staff of having increased sexual behaviors. One on one performed and patient redirectable. Psych nurse practitioner (NP) (not identified) in to see patient awaiting recommendations at this time. Review of Resident #7 record revealed a progress note dated 07/09/25 authored by facility Administrator stating administrator and Director of nursing (DON) notified POA of increased sexual behaviors. Review of Resident #7 care plan completed on 07/09/25 revealed the resident has behaviors including increase sexual behaviors. Interventions include, if reasonable, discussing the resident's behavior. Explain/ reinforce why behavior is inappropriate and/pr unacceptable to the resident and praise any indication of the resident's progress/ improvement in behavior. Record review of Resident #7 paper and electronic medical record revealed no documentation of alleged increased sexual behaviors in relation to the medication order, psych consult, and revised care plan due to sexual behaviors. Record review revealed no documentation of Resident #7 POA being notified of increased sexual behaviors or witnessed observations of being sexually inappropriate with Resident #54. Record review revealed Resident #7 order for cimetidine give 400 milligrams (mg) by mouth (PO) three times a day (TID) for decreased sexual behaviors ordered on 07/16/25. Review of Resident #7's visit and progress note from Psychiatric Mental Health Nurse Practitioner (PMHNP) #626 dated 07/22/25 at 11:55 A.M. stating DON #7 reported the previous week that Resident #7 had pulled a female resident into a room and attempted to pull down her pants. He was caught and re-directed. Resident #7 is a poor historian and has speech issues. The DON reported he roams around the facility most of the day. Resident #7 focused on female residents, one particular who is bedbound and has end stage dementia-they have found him several times in her room with his hand under the blanket. He is found in another resident's room sitting close to her bed. Resident #7 is not allowed alone in female (resident) rooms. Resident #7 is continually re-directed. 2. Record review revealed Resident #54 admitted to the facility on [DATE] with diagnoses including femur fracture, anxiety, hyperlipidemia, dementia, depression, anxiety, constipation, and emphysema. Review of Resident #54 Minimum Data Set (MDS) revealed the resident had severe cognitive impairment and was dependent on staff for activities of daily living (ADL) care. Review of the care plan revealed Resident #54 had impaired cognitive function/dementia or impaired thought process related to dementia. Interventions included supervising and reorient as needed. Review of Resident #54's progress notes revealed a progress note authored by Administrator #1 on 07/09/25 stating the administrator spoke with resident's power of attorney (POA) regarding a room move to the north end of the facility. POA okay with the move. Review of Resident #54's progress notes revealed a progress note authored by social worker 07/09/25 stating the resident was notified about receiving a new room, resident expressed understanding. Administration notified the POA and is okay with move, no concerns at this time. (Please note, there was no documentation regarding any incidents or concerns regarding the need for the resident's room change). Further review of the medical record revealed no evidence of any inappropriate behaviors between Resident #54 and Resident #7 Interview on 07/30/25 at 12:44 P M with Psychiatric Mental Health</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review the facility failed to maintain accurate care plans. This affected one (Resident #51) of nine residents reviewed. The census was 52. Findings include: Record review revealed Resident #51 admitted to the facility on [DATE] with diagnoses including respiratory failure, type two diabetes, (COPD), gastro-esophageal reflux disease (GERD) osteoarthritis, anemia, atherosclerotic heart disease, insomnia, schizophrenia hypercholesterolemia, overactive bladder, borderline personality disorder, hypothyroidism, pyoderma, hypertension, anxiety major depressive disorder, chronic kidney disease, kidney failure, and , renal dialysis dependent. Review of Resident #51 orders revealed an order for hemodialysis every Monday, Wednesday, and Friday for renal failure. Review of Resident #51 minimum data set (MDS) revealed a brief interview for mental status (BIMS) score of 15, indicating Resident #51 was cognitively intact. Review of Resident #51 care plan completed 04/11/25 revealed the resident needed hemodialysis related to renal failure. Goals included the resident will have immediate intervention should any signs or symptoms of complications from dialysis. Interventions include encouraging the resident to go for the scheduled dialysis appointments. The resident receives dialysis at (dialysis center) in St Clairsville on Monday, Wednesday, Friday at 10:30 A.M. Monitor vital signs and notify medical doctor (MD) of significant abnormalities. Monitor, document, report as needed (PRN) for signs and symptoms of renal insufficiency such as changes in level of consciousness, changes in skin turgor, oral mucosa, and changes in heart and lung sounds. Check AV fistula site thrill/bruit; palpate/feel to assess for thrill and auscultate for bruit as ordered. Interview on 07/30/25 at 7:30 A.M. with (name of dialysis center) of St. Clairsville revealed Resident #51 no longer came to their facility for dialysis. (Name of dialysis center) of St. Clairsville revealed Resident #51 used to receive dialysis on their campus but [NAME] for quite some time. Interview on 07/30/25 at 10:34 A.M. with (name of dialysis center) Administrative Assistant of Bridgeport confirmed Resident #51 received dialysis at their location. Interview on 07/30/25 at 4:54 P.M. with Resident #51 confirmed she did not attend dialysis in St. Clairsville, but attended dialysis at (dialysis center) of Bridgeport. Review of Rolling Hills undated policy titled Care Planning- Interdisciplinary Team revealed the facility's care planning [NAME] is responsible for the development of an individualized comprehensive care plan for each resident. The care plan is based on the resident's comprehensive assessment and is developed by Care Planning/ Interdisciplinary Team which includes but is not limited to the following personnel: the resident, attending physician, the registered nurse who has responsibility for the resident, the social service worker, the director of nursing, and others as appropriate or necessary to meet the needs of the resident. This deficiency is an incidental finding discovered during the complaint investigation.</p>		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure operations were conducted in a manner that supported and encouraged the highest level of resident care, as staff were prohibited from speaking freely with state agency personnel, which hindered their ability to advocate for residents without fear of retaliation. The facility administration also failed to ensure contracted staff were not asked to alter legal documents contained within resident medical records. This affected one resident (#7) and had the potential to affect all 52 residents residing in the facility. Findings include: During the onsite investigation the following concerns were identified related to administrative oversight in the facility and the ability for staff to openly communicate with state agency survey staff: a. Interview on 07/30/25 at 3:33 P.M. with Anonymous Staff Member (ASM) #707 revealed staff were targeted after surveys if they speak with the state survey agency. The interview revealed there was a fear of retaliation and staff losing their jobs or being treated differently as a result of speaking with state surveyors. Interview on 07/30/25 at 5:45 P.M. with ASM #406 revealed there was a fear of retaliation from management for advocating for residents and speaking with surveyors during survey. ASM #406 revealed staff were told by DON #1 that staff were required to tell management what was discussed with surveyors. Management watched staff speaking with surveyors and following conversations, management would pull staff away from whatever they were doing to interrogate you. Staff were also coached that as soon as the state survey agency walked into the building, they were told what information they could talk about and information they could not give to the surveyors. ASM #406 stated staff fear retaliation from management if they were caught talking to the state survey agency/surveyors. Interview on 07/30/25 at 6:00 P.M. with ASM #407 revealed management does not want staff to speak with the state survey agency when they come in and staff were encouraged not to speak with the surveyor. Staff were told essentially to cover for the facility if there were any issues or concerns. Staff members were coached on topics to steer away from and told if they have to lie, they can. Management sit and watch the cameras and would watch who, and when someone talked with a surveyor. Management staff would then question whoever they see speaking to them questioning what was asked and what information they provided to the state survey agency. ASM #407 revealed management only seemed to watch the cameras when state staff were in the building. This made staff fear retaliation. ASM #407 revealed this was being done by Director of Nursing (DON) #7 and Administrator #1. Interview on 07/30/25 at 6:15 P.M. with ASM #401 revealed there was a fear amongst staff for talking to surveyors initiated by management. ASM #401 stated management had interfered with surveys by coaching staff on what to talk about with surveyors and topics to steer away from, Administrator #1 has told staff to lie about certain topics. ASM #401 stated staff would avoid being seen conversing with surveyors because if they were caught, staff get pulled into the office. ASM #401 stated there was a fear of retaliation, a lot of favoritism was shown by management and staff were targeted after surveys if they were suspected of coming forward with information. Interview on 07/31/25 at 6:00 A.M. with ASM #405 revealed staff were coached by administration during surveys with the state survey agency. Management would pull staff into offices or rooms and staff were told not to volunteer information and if staff didn't want to answer something to come and get management, but don't bring up anything to the surveyors. If staff get caught speaking to a surveyor they were hounded on what was talked about and what information was given. This has been done by DON #7, Administrator #1 and a corporate staff member (unable to recall name) on different occasions. Interview on 07/31/25 at 11:27 A.M. with ASM #501 revealed there was a fear of retaliation from management if staff talked to surveyors and educated/protected the residents. ASM #501 stated staff were coached to steer away from certain topics, and management somewhat told staff what to say in situations. ASM #501 revealed no staff wanted to talk to state surveyors because if staff were caught talking by management they would get pulled into the office or a private room and asked what was talked about, what was asked, what was said, what the state surveyor said etc Certain employees would be followed around to try to prevent them from speaking to state staff or to overhear their conversations. Further interview revealed this had lead to a decline in resident care because staff were fearful of retaliation negatively affecting the residents. Interview on 07/31/25 at 11:34 A.M. with ASM #502 revealed staff fear retaliation from management. Staff jobs were threatened if management heard staff speaking with state surveyors. ASM stated the staff felt like they became a target. When state staff entered the facility things weren't handled appropriately. ASM #502 revealed if staff brought up a concern especially resident</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>(continued on next page)</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and observation, the facility failed to maintain a clean, safe, comfortable and sanitary environment. This had the potential to affect all 52 residents residing in the facility. Findings include: During the onsite complaint survey, the following information was obtained:a. Interview with Certified Nursing Assistant (CNA) #104 on 07/30/25 at 8:51 A.M. revealed there was mold across the whole building. They have recently had several water leaks, on the north side. The water leaks included the washer. CNA #104 stated they were unsure if it was due to a leak, or an overflowing of water but regardless a large amount of water came out onto the floor of the laundry room, and the entire vending machine room carpet was soaked. CNA #104 confirmed the water mark on the carpet of the vending machine room and a strong musty smell. CNA #104 stated there was a musty foul odor throughout the building, however it is the strongest in the vending machine room. CNA #104 stated the AC units of the resident rooms also have a wet/musty smell.b. Interview with CNA #377 on 07/30/25 at 3:32 P.M. revealed there was a strong musty smell in the facility. CNA #377 stated you are also able to smell this odor when in resident rooms. CNA #377 stated they were concerned about the smell, along with things they've seen that could be mold that is affecting the residents and staff.c. Interview on 07/30/25 at 3:10 P.M. with Licensed Practical Nurse #60 revealed there was a foul odor to the building, not a normal odor but almost like a musty wet odor. Nurse #60 stated nothing was being done about this. The Nurse stated there was a concern for residents especially those with chronic respiratory issues.d. Interview on 07/30/25 at 4:24 P.M. with LPN # 61 revealed there is a mold issue in the building, and the facility was aware, but not addressing the issue appropriately. LPN #61 stated they took a water hose and sprayed the AC unit grills after the last inspection. Resident #17 on the south side of the building had mold in it, and a musty odor. LPN #61 stated on the north end of the building a hot water tank leaked into the carpeted crash cart room, behind the nurses station, and that room smells musty and there was a concern mold or something may be growing under the carpet because after the water flooded into the room, it was never cleaned, to their knowledge.e. Observation with Maintenance #600 on 07/30/35 between 4:46 P.M. and 4:50 P.M. confirmed there was an unknown black speckled substance on the air-conditioning unit of room [ROOM NUMBER], the soiled linen room on the north side of the building, in the back right bottom corner there was a moderate amount of a black, unknown substance along the wall and the crash cart room had a strong foul musty odor. Maintenance #600 stated the hot water tank in the room sharing a wall to the crash cart room had leaked. He confirmed the carpet was not pulled up to assess for the cause of the odor or any damage from the water leak.f. Interview on 07/30/25 at 5:45 P.M. with CNA #300 revealed there was a concern with mold in the building. CNA #300 stated it was probably the worst in the vending machine room and if you lifted up weak spots in the carpet of the vending machine room, it is disgusting underneath, CNA #300 stated they were not sure what was under the carpet but it isn't good and along the wall there was a black substance that wasn't always been there. CNA #300 confirmed the vending machine room had a strong musty odor. CNA #300 stated nothing was being done about the root cause of the odors and black substances across the building, but every once in a while management would put out air fresheners or spray air freshener.g. Observation on 07/31/25 at 6:46 A.M. revealed one resident was sitting in the vending machine room. There was a small stand-up portable white air conditioner in the room. There is a strong musty/damp odor to the room.h. Interview on 07/31/25 at 7:00 A.M. with anonymous staff member #459 stated they had a concern about mold within the facility. They stated a lot of people feel sick when they come to work, especially when working a long stretch of days, then when you have a few days off you feel better and the cycle repeats. Anonymous staff member #459 stated if staff were feeling like this, it wasn't good for the residents who are in the facility 24/7. They stated on the north side of the building there was a leak in the laundry room, which shared a wall with the vending machine room, now there are several flies and gnats that swarm in the vending machine room and it had a strong very musty odor. They confirmed this is a common area for residents, visitors, and family to sit in and socialize.i. Interview on 07/31/25 at 7:55 A.M. with CNA #64 revealed the whole building smelled moldy/mildewy. CNA #64 stated that specifically on the north side, in the vending machine area, was the worst. There was a water leak in the laundry room and the water went to the vending machine room, as they share a wall, and the carpet was soaked. Ever since this incident they have had flies and gnats that seem to be getting worse. The crash cart room behind the nurses station on the north side of the building had a smell to it the same throughout the building a wet musty smell: this had</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/11/2025
NAME OF PROVIDER OR SUPPLIER Rolling Hills Rehab and Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, and interviews the facility failed to provide an effective pest management program. This had the potential to affect all 52 residents residing in the facility. Findings include: a. Interview on 07/30/25 at 9:00 A.M. with Certified Nursing Assistant (CNA) #104 confirmed the flies were horrible around the building. There was also an issue with the gnats however the flies were more prevalent. CNA #104 believed the flies and gnats were possibly due to the musty odor and the dampness of the carpeting and air conditioning units. CNA #104 stated the gnats and flies could also be from the lack of having a housekeeper daily. CNA #104 confirmed flies were often found in resident rooms. b. Interview on 07/30/25 with Licensed Practical Nurse (LPN) #61 at 4:40 P.M. revealed the flies in the building were horrible. There was a resident who had them in his room and he required cream on his legs. The flies will swarm around his legs, and you have to ensure the flies do not stick to them. Families have brought in bug spray because it's gotten so bad. LPN #61 stated staff are being told someone is going to come in and spray the building, but nothing is done about it and the amount of flies is becoming worse. c. Interview on 07/31/25 at 7:00 A.M. with anonymous staff member #459 stated on the north side of the building in the vending machine room there are several flies and gnats that swarm in the vending machine room and it has a strong, musty odor. They confirmed this is a common area for residents, visitors and families to sit and socialize. d. Interview on 07/31/25 at 7:35 A.M. with Anonymous staff member #489 revealed there was an issue with gnats and flies in the building and in resident rooms. Anonymous staff member #489 stated there were no screens on the residents' windows. Anonymous staff member #489 stated this may be where the flies and gnats are coming from however, they were unsure of an exact cause. e. Interview on 07/31/25 at 7:55 A.M. with CNA #64 revealed the facility currently had fly and gnat issues that seem to be getting worse and some families have been bringing in bug spray (no families identified). f. Observation during interview on 07/31/25 at 8:23 A.M. with CNA #34 two gnats flew by, confirmed with CNA #34. g. Interview on 07/31/25 at 8:58 A.M. with CNA #21 revealed there were gnats and flies throughout the building, more flies than gnats. CNA #21 stated staff and residents were getting bit so bug spray was brought in by a few people for residents and staff use. h. Observation on 07/31/25 at 9:59 A.M. of the north side nurses station revealed a black container with four unopened mighty shakes and two unopened magic cups were noted at the desk. Three flies were observed swarming around the shakes and cups. This observation was confirmed with CNA #370. Upon observation of the crash cart room at the north side nurses' station, a gnat was flying around this writer's face. i. Observation and interview on 07/31/25 at 2:10 P.M. of Resident #37 revealed she has a pink fly swatter sitting on her bedside table. Resident #37 stated she requested her family bring it in because there are flies everywhere, they swarm around you, land on you and your stuff so she keeps that beside her. j. Interview on 07/31/25 at 2:15 P.M. with Power of Attorney (POA) #620 confirmed there was an issue with flies in the building, and stated its gross. At one time there was four flies flying around her family member's room at one time when they walked in. She is unsure what is causing the problem but its an issue that wasn't getting resolved. k. Interview on 07/31/25 at 2:28 P.M. with POA #625 stated the gnats and flies were all over the place, you were constantly swatting them away from you or your family. They stated they have brought in a fly swatter before. l. Interview on 07/31/25 at 2:45 P.M. with Anonymous staff member #70 confirmed there was a fly issue in the building and it seemed to get worse this past summer. m. Interview on 08/06/25 at 12:06 P.M. with anonymous staff member #102 revealed there was a significant fly problem in the building. Anonymous staff member #102 stated Resident #19 always has so many flies in their room as well as Resident #22 and Resident #36. This deficiency demonstrates non-compliance investigated under Master Complaint Number 2576098.</p>		