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	03/11/2026

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** Based on record review, interview and policy review the facility failed to ensure medications were administered per physician orders. This affected one resident (Resident #73) of five residents reviewed for medication administration. The census was 65. Finding Include: Record review revealed Resident #73 admitted to the facility on [DATE] with diagnoses including abscess of the spleen, chronic viral hepatitis C, and peritoneal abscess.Review of Resident #73's physician orders revealed an order for Cubicin Intravenous (IV) solution reconstituted 500 milligrams (mg) (Daptomycin), give 350 mg IV one time a day at 9:30 A.M. for abdominal abscess until 03/24/26. Further review revealed the resident had a peripherally inserted central catheter (PICC)/ midline (left arm) with orders to monitor for leaking and/ or signs and symptoms of infection every shift.Review of Resident #73 care plan revealed no documentation, goals, or interventions for the resident's intravenous medication therapy related to an active infection, and maintenance, use, or observation of the residents Peripherally Inserted Central Catheter (PICC).Review of Resident #73 medication administration record revealed Cubicin 350 mg IV reconstituted 500 mg daptomycin was scheduled on 02/27/26 at 9:30 A.M.Further review of Resident #73's medication administration record revealed the medication was not administered until 02/27/26 at 3:20 P.M. (six hours late) by Licensed Practical Nurse (LPN) #01.Interview on 03/05/26 at 3:35 P.M. with LPN #01 revealed on 02/27/26, she was the only nurse to administer medications to nearly 70 residents and medications were administered late this day, including Resident #73's Cubicin.Interview on 03/10/26 at 1:50 P.M. with Regional Director of Clinical Operations #106 confirmed on 02/27/26 Resident #73's IV antibiotic, Cubicin 350 mg IV reconstituted 500 mg daptomycin was documented as being administered by LPN #01 at 3:20 P.M., six hours late.Review of facility policy titled medication therapy revised April of 2007 revealed each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. Facility shall review medication related issues as part of its quality assurance committee and activities. This deficiency represents non-compliance investigated under Master Complaint Number 2794699.

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

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	03/11/2026

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 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** Based on interview, and record review, the facility failed to ensure residents received appropriate supervision and intervention to prevent leaving the facility unsupervised. This affected one resident (Resident #55) of two residents reviewed for accidents. The census was 65.Findings include: Resident # 55 admitted to the facility on [DATE] with diagnoses including dementia type two diabetes, hypertension, anxiety, major depressive disorder, and neurocognitive disorder with Lewy bodies.Review of Resident #55's Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03 indicating severe cognitive impairment. The resident utilized a wheelchair and required moderate assistance for transfers and mobility. Review of Resident #55 assessment for elopement review completed on 01/07/26 revealed the resident scored a 10 on the assessment indicating they were a high risk for elopement.Review of Resident #55 care plan revealed a plan of care initiated on 02/13/26 for Resident #55 was an elopement risk/wanderer related to disoriented to place, a history of attempts to leave the facility unattended, and impaired safety awareness. Goals include the resident's safety being maintained. Interventions include distracting the resident from wandering by offering pleasant, diversion, structured activities, food, conversation, television, and books. Identify a pattern of wandering: divert as needed and intervene as appropriate. If resident exhibits signs of exit seeking and/or verbalizes wanting to leave, then initiate 1:1 supervision. Monitor for fatigue and weight loss. Provide activity of interest to deter from wandering. Provide supervision for off-unit activities.Review of Resident #55 progress note dated 03/07/26 at 4:30 P.M. revealed a note authored by Licensed Practical Nurse (LPN) #88 which stated a resident put on their call light and an aide responded. The aide came out and told staff the resident saw another resident by himself outside, sitting on the sidewalk in the parking lot of the facility in the rain. The aides and LPN #88 assisted Resident #55 back into the building. The Medical Director (MD) was notified by LPN #49 and gave a new order for a wanderguard (a wearable bracelet-like device used to monitor and prevent residents at risk for wandering from leaving designated areas; it is part of a larger system which includes sensors on doors which alarm and lock doors when a resident approaches a monitored exit) to be placed.Interview on 03/09/26 at 12:32 P.M. with Resident Representative #800 revealed on 03/07/26, Resident #55 walked out of the door, in the rain, by himself. No one saw him leave, and no one knows how he got there. Resident representative #800 stated they did not think Resident #55 could walk, so they're unsure how he got outside. It was another resident who saw Resident #55 sitting in the parking lot on a parking stop, that resident then called or told a staff member there was a resident outside by themselves in the rain.Interview on 03/09/26 at 12:45 P.M. with Resident #09 revealed Resident #09 was watching TV on 03/07/26 and noticed a man sitting on the parking stop in the parking lot. Resident #09 stated it looked like the man was playing in the water as it was raining outside. Then, Resident #09 realized it was a resident sitting outside. Once she realized it was a resident, Resident #09 pressed her call light and told a (unnamed) Certified Nursing Assistant (CNA) there was a resident in the parking lot.Interview on 03/09/26 at 1:58 P.M. with CNA #68 revealed on 03/07/26 they were working, it was raining at that time. CNA #53 answered Resident #09's call light and came back and alerted staff that Resident #55 was outside sitting in the parking lot. Resident #55's wheelchair was still inside the facility. CNA #68 stated they are unsure how Resident #55 had the strength to push open the doors and walk outside. CNA #68 and CNA #53 went outside to assist Resident #55 back into his wheelchair and back into the facility. CNA #68 stated they had seen Resident #55 attempt to stand, but he usually sits back in his wheelchair; CNA #68 had never seen Resident #55 walk that far. CNA #68 stated Resident #55 does have exit seeking and wandering behaviors and the resident is usually sat at the nurse's station and if he wanders, they will bring him (continued on next page)

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	03/11/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back.Interview on 03/09/26 at 2:16 P.M. with CNA #53 revealed on 03/07/26, Resident #09's call light came on, so CNA #53 went to answer it. Resident #09 stated there was someone outside. CNA #53 looked outside and realized it was Resident #55 sitting in the parking lot, outside, in the rain. CNA #53 stated they have never seen Resident #55 walk, but he had tried to in the past but had fallen. CNA #53 and CNA #68 went outside to assist in getting Resident #55 back inside the building.Interview on 03/10/26 at 8:03 A.M. with Administrator #95 confirmed Resident #55 was found by another resident, who alerted staff, of Resident #55 being outside in the facility parking lot by himself. Administrator #95 revealed there were cameras in the facility, but they did not have a recording from 03/07/26 showing Resident #55 exiting the facility.Interview on 03/10/26 at 2:49 P.M. with Regional Director of Clinical Operations (RDCO) #106 confirmed Resident #55 was found on 03/07/26 outside of the facility in the parking lot, and staff was made aware Resident #55 had left the building by Resident #09.Review of facility policy titled wandering, unsafe resident revised 10/13/2020 revealed the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement or other risk due to judgement or cognition. Policy interpretation and implementation include the staff will identify residents who are at risk for harm because of unsafe wandering (including elopement). The staff will assess at risk individuals for potentially correctable risk factors related to unsafe wandering. Residents who are at risk may have a secure care or other such bracelet device placed for additional security prevention. The resident care plan will indicate the resident is at risk for allotment or other safety issues and interventions will try to maintain safety such as detailed monitoring plan, wanderguard, etcetera will be included. And then saying resident is considered a facility wide emergency if a resident is missing, the elopement / missing resident emergency procedure will be initiated.Review of the policy Wandering, Unsafe Resident dated 10/13/20 revealed the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement or other risk due to judgement or cognition. The policy noted staff will identify residents who are at risk for harm because of unsafe wandering and will assess residents for potentially correctable risk factors related to unsafe wandering. The resident's care plan will indicate the resident is a risk for elopement or other safety issues. Interventions will try to maintain safety, such as a detailed monitoring plan, Wanderguard, etc. A missing resident is considered a facility-wide emergency. If a resident is missing, the elopement/missing resident emergency procedure will be initiated. This deficiency represents non-compliance investigated under Master Complaint Number 2794699 and Complaint Numbers 2785803 and 2747771.

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	03/11/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of the Facility Assessment, and review of the facility's admission agreement, the facility failed to provide sufficient nursing staff was available to ensure resident safety and effectively care for residents. This had the potential to affect all residents residing in the facility. The facility census was 65.Findings include: 1.Review of the closed medical record for Resident #73 revealed an admission date of 02/20/26 with medical diagnoses including peritoneal abscess, anemia, and a history of substance abuse. Resident #73 discharged from the facility against medical advice (AMA) on 02/27/26.Review of a progress note dated 02/27/26 at 10:05 P.M. revealed Resident #73 informed the nurse that she wanted to sign out against medical advice. Resident #73 was educated on the risks of leaving AMA and was informed she could not leave the facility with a peripherally inserted central catheter (PICC) line in. The PICC line was removed by the Registered Nurse on duty by utilizing sterile technique. Pressure was applied to the cite and a pressure dressing was applied. The physician was notified of Resident #73 signing out AMA and Resident #73's boyfriend arrived to take the resident out of the facility. Interview on 03/04/26 at 1:49 P.M. with CNA #77 revealed on 02/27/26, two nurses (LPN #01 and RN #20) walked out of the building and there were no nurses in the facility. Following both nurses' leaving, there were no nurses in the facility until LPN #423 showed up to the building around 5:00 P.M. Prior to LPN #423 arriving, residents were asking for help and assistance and requesting medications, but there were no nurses there to assist them.Interview on 03/04/26 at 3:14 P.M. with Certified Nursing Assistant (CNA) #230 revealed on 02/27/26 there was approximately one hour when there were no nurses in the building after Licensed Practical Nurse (LPN) #01 and Registered Nurse (RN) #20 left the facility at approximately 3:30 P.M. Administrator #95 began making phone calls to get another nurse in the building. CNA #230 recalled during the time where no nurses were in the building, Resident #73 requested multiple times for her intravenous tubing to be removed from her arm, but there was not a nurse present to do so. Interview on 03/09/26 at 11:49 A.M. with Medical Records Staff #50 revealed on 02/27/26, RN #20 walked out of the building. LPN #01 then approached Medical Records Staff #50 and asked if she had keys to the medication room, and LPN #01 replied that's where my keys will be. Medical Records Staff #50 reported she walked out of the building with LPN #01 and assumed LPN #01 had relief because, at the time, LPN #01 was the only nurse in the building. Upon her return to the building, Medical Records Staff #50 realized there were no nurses in the building that anyone was aware of. At that time, approximately 3:30 P.M. (on 02/27/26), there were no nurses in the building and only CNAs on the floor. Around 5:00 P.M., LPN #423 arrived. Interview on 03/09/26 at 11:53 A.M. with LPN #423 revealed on 02/27/26, there were no nurses in the building for a period after LPN #01 and RN #20, who were the two nurses working that day, walked out of the facility at approximately 3:30 P.M. LPN #423 reported she received a call to see if she could come to work and arrived approximately 40 minutes later and clocked in on 02/27/26 at 5:03 P.M. LPN #423 reported she did not get report from anyone, no nurses were in the building when she arrived, and about ten minutes after she arrived at the facility, additional nurses arrived and she completed a narcotic count with the arriving nurses.Interview on 03/09/26 at 3:40 P.M. with LPN #01 revealed on 02/27/26, she left the facility directly after RN #20. LPN #01 confirmed she left the keys to the medication cart in the medication room and made Administrator #95 aware she was leaving. LPN #01 reported the DON and ADON had quit the week before, so there were no other nurses in the building and no one to give a handoff report to or complete a narcotic count with. LPN #01 reported on 02/27/26, LPN #01was the only one passing medications as RN #20 did not have proper access to the facility's electronic health record system. Medications scheduled for 8:00 A.M. were administered late. There were nearly 70 residents in the facility and one nurse (LPN #01) trying to pass all medications. LPN #01 reported a (continued on next page)

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	03/11/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	new admission came, and during the day one unit would go up to three hours without a nurse on the unit, but LPN #01 could not be in two places at once. LPN #01 reported it was a nightmare. A telephone interview on 03/10/26 at 2:54 P.M. with Resident #73 revealed she left AMA from the facility as there was never any help in the facility. Resident #73 reported her medications were often late. Resident #73 reported on 02/27/26, she had asked two (unnamed) CNAs to get a nurse to remove her intravenous antibiotic from her PICC line, and no one came. Finally, Resident #73 stated she walked into the hallway with the antibiotic hanging from her arm to find a nurse to remove it. Resident #73 stated she could not find any nurses in the facility at all. Resident #73 recalled feeling like no one cared, which led her to a breaking point and to signing out of the facility AMA later that day.2. The following additional concerns were identified during the onsite complaint investigation:a. Interview on 03/04/26 at 7:26 A.M. with CNA #70 revealed staffing had been rough. Typically, CNA #70 reported they would work with two aides to care for nearly 40 residents. CNA #70 reported residents were not getting quality or timely care completed, including showers. CNA #70 reported the staffing on the night shift (from 11:00 P.M. to 7:00 A.M.) was terrible, with only one aide on the south end of the building and one aide on the north end of the buildings; two aides to care for approximately 70 residents. b. Interview on 03/04/26 at 8:20 A.M. with CNA #105 revealed staffing was not sufficient to meet the needs of the residents. CNA #105 reported staff would not have time to complete showers and would have to hope the next shift was able to complete showers. CNA #105 further explained if care tasks were able to be completed, many times charting was incomplete because staff did not have time to document the care they provided in a timely manner.c. Interview on 03/04/26 at 9:36 A.M. with CNA #42 revealed staffing was very short, especially for CNAs. CNA #42 reported staff would routinely get behind which led to a delay in resident care, such as incontinence care, showers, and medications being provided to residents. The issue affected everyone and residents became frustrated. CNA #42 reported resident call lights could take over 30 minutes for staff to be available to answer the call light, and sometimes residents could wait even longer if two staff members were required for certain care activities. d. Interview on 03/04/26 at 2:57 P.M. with LPN #527 revealed the staffing in the facility was not sufficient. LPN #527 reported when she would enter her shift, residents would be soaked (due to incontinence) because there was only one aide on each side of the building on the overnight shift. LPN #527 stated it was impossible to care for almost 70 residents when their care needs included toileting and incontinence care, dressing, passing medications and treatments, passing and collecting trays, and assisting with feeding. LPN #527 reported everything from resident care to medication administration was late, the staff could not take breaks, and this was negatively affecting the staff and residents and causing staff call offs and burn out.e. Interview on 03/04/26 at 6:21 P.M. with LPN #76 revealed staffing at the facility was horrible. Night shift struggled the most, they were extremely short staffed with a high census and high acuity residents. The facility continued to admit new residents without adequate staff on all shifts to care for them. LPN #76 reported there were currently multiple geriatric psychiatric residents, one of which required 1:1 with a staff member for a history of sexually aggressive behavior towards staff. LPN #76 reported there were other residents with frequent falls, and others who required a lot of attention and oversight for being fall and elopement risks. LPN #76 reported medications and treatments were always late due to lack of staff, and depending on the unit, staff could have up to 50 residents to provide care for. LPN #76 reported the insufficient staffing was causing a lot of staff turnover because staff were burned out, were unable to take breaks, leaving the facility hours after their shift officially ended, and were calling off. LPN #76 reported staff were collectively frustrated because they were unable to provide quality and timely care for residents. Residents were constantly requesting care but were told they had to wait, sometimes for hours, because there were no staff available to assist.f. Interview on 03/05/26 at 7:50 A.M. with LPN #100 revealed the facility was unable to adequately staff the building to meet the needs of the residents. LPN #100 explained that the facility had several geriatric psychiatric admissions with a lot of behaviors, screaming, and some (continued on next page)

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	03/11/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	who have had sexually aggressive behaviors towards staff members. Night shift had the lowest staffing levels, with two nurses and two CNAs in the building on the night shift. LPN #100 reported it was nearly impossible to run with this staffing level due to the needs of the residents. Nurses would try to assist the CNAs, but then medication and treatment administrations would be late. LPN #100 stated several residents required two staff members for assistance with transferring using a mechanical lift. When CNAs take residents into the shower, it would leave one CNA to care for the remaining residents of the facility. LPN #100 reported staff at times had trouble juggling the needs and demands of the residents including answering call lights, providing toileting and/or incontinence assistance, and administering medications and treatments, and sometimes these care tasks were delayed due to insufficient staff. LPN #100 noted if a new admission would arrive during a busy time, the nurse may be unavailable for other residents while they tended to the new admission. LPN #100 reiterated there was no admission nurse (to assist with completing new resident admission tasks) and no Assistant Director of Nursing (ADON) or Director of Nursing (DON) to assist with completing required tasks. g. Interview on 03/05/26 at 8:56 A.M. with Human Resource Staff #51 reported they completed the schedule for the nursing and CNA staff members. Human Resource Staff #51 reported there had been some chaos with staff leaving, and the night shift schedules for both nurses and CNAs had been difficult to fill. Human Resource Staff #51 reported the facility had recently started utilizing agency staff to attempt to fill open holes.h. Interview on 03/05/26 at 9:26 A.M. with Resident #36 revealed there were not enough staff, and the facility was short-handed. There were not enough staff to supervise the residents. Other residents would wander into her room, and she would have to re-direct them. Resident #36 reported Resident #39 would wander into rooms a lot, but the resident was confused and did not know what was going on. Resident #36 reported on another day, an unspecified resident wandered into her room and took her slippers, and she had to ask for them to give them back herself.i. Interview on 03/05/26 at 10:26 A.M. with CNA #73 revealed staffing at the facility was horrible. Some shifts there were only two CNAs in the whole building. Residents had not been able to go down to the dining room because of the lack of staff. Resident rooms were unkempt with garbage left in the rooms. CNA #73 reported residents would be soiled and their care delayed because of lack of staff. CNA #73 reported residents would complain about cold food because staff were not able to pass trays timely to all residents of the facility. Residents had begun to get frustrated and would start yelling at staff for not getting assistance timely. CNA #73 reported they tried not to tell the residents it was due to short staffing, but residents were anxious due to wait and the lack of help.j. Interview on 03/05/26 at 11:01 A.M. with Resident #61 revealed the facility did not have enough staff. There were usually two CNAs working on each (north and south) hall. Resident #61 reported she was more independent and did not need as much help as her roommate, Resident #49. Resident #61 reported staff was visible frustrated and recalled an incident on an unknown date when an unknown staff member was putting Resident #49 to bed and stated, I am tired of this [expletive]!. Resident #61 reported some residents end up staying in bed most or all day because there were not enough staff to get them up.k. Interview on 03/05/26 at 11:10 A.M. with Resident #54 reported medications and help were late, but staff could only do so much with the short staffing. Resident #54 reported the call button takes a long time to be answered by staff, but she understood they were busy. Resident #54 reported staff do not stay (employed at the facility, staff retention was low). Resident #54 reported a few weeks ago, she had reported a bad migraine to the ADON at the time. The ADON stated she would be back but did not come back with any medication. Resident #54 stated she pushed her call light two additional times, but no one came. Resident #54 stated she just had to deal with it (the migraine) and placed a cool washcloth on her head. Resident #54 reported there were days when there was no nurse on her side of the building because they had to go to the other side to assist with something. Resident #54 noted there was only one aide at each end of the building at night, which was not enough.l. Interview on 03/05/26 at 11:26 A.M. with LPN #90 revealed staffing was severely insufficient. There was only one nurse on north and one nurse on south side, and one nurse (continued on next page)

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	03/11/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	could have over 40 residents with one or two CNAs each. Medications were always in the red (indicating medications were past the scheduled time for administration). Residents were not receiving timely or quality care, and the staffing levels were being normalized by the facility. The nurses and CNAs were constantly having to stay hours past the scheduled ends of their shifts to complete an admission or to continue caring for residents due to call offs. m. Interview on 03/06/26 at 1:45 P.M with Resident #09 revealed the facility did not have enough nurses or CNAs. If the call light was pressed (activated), it took about half an hour for the call light to be answered. Resident #09 reported if ice water was requested, one could wait another 20 minutes or more before the staff member returned. Resident #09 reported she was worried about residents who could not speak for themselves and who did not know what was happening. Resident #09 reported night shift had hardly any staff and recalled a night where it took her 45 minutes to get water. Resident #09 reported the staff who were working that night was good, but there were only two aides for the whole building, and they were going back and forth from the north to the south end to help each other. The nurses were short-handed as well, medications are not brought on time or consistently, but she recognized there were other residents in the facility to care for, as well as emergencies and issues that arose.n. Interview on 03/09/26 at 8:50 A.M. with LPN #720 revealed their third day of orientation was supposed to be scheduled on 03/06/26. Upon arrival for her orientation shift at the facility, she found she was working independently on the north end of the facility by herself, with no one to orient her. LPN #720 reported she had not worked on or been trained on that unit before.o. Interview on 03/09/26 at 12:32 P.M. with Resident Representative #800 revealed there were not enough staff working at the facility. Resident Representative #800 stated they were very concerned with the afternoon and night shift staffing as there were not enough staff to assist all the residents.p. Interview on 03/09/26 at 3:54 P.M. with Resident #07 revealed the facility needed more people working. The residents do not get enough help. Resident #07 reported that sometimes there is only one CNA working on each end of the building. Resident #07 reported she had to wait a long time for help and recalled there had been times she had been stuck on the toilet waiting for staff to return. Resident #07 reported she had continued to sit on the toilet to wait for staff even though it hurt her buttocks as she was fearful of falling. Resident #07 reported the wait times were longer on evening and night shifts.Review of the undated facility admission agreement revealed the facility agrees to provide the patient with 24-hour nursing care in a manner and setting appropriate to the patients' needs. Review of the facility admission packet revealed basic services included in the daily rate include twenty-four hour per day nursing care, assistance and/or supervision when required with activities of daily living, including but not limited to, toileting, bathing, feeding and ambulation assistance. Review of the Facility assessment dated [DATE] revealed the purpose of the assessment was to determine what resources were necessary to care for the residents competently during both day-to-day operations and emergencies. The facility must utilize the facility assessment to inform staffing decisions to ensure that there are enough staff with the appropriate competencies and skill sets necessary to care for the residents' needs as identified through resident assessments and plans of care, consider specific staffing needs such as day, evening, and night shifts with adjustments as necessary based on the population, develop and maintain a plant o maximize recruitment and retention of direct care staff, and inform contingency planning for events that do not require activation of the facility's emergency plan but that do have the potential to affect resident care, such as, but not limited to: the availability of direct care nurse staffing or other resources as needed for resident care. The assessment noted that a full time DON, ADON, MDS Nurse, and part-time Wound Care nurse were needed, but the assessment did not identify any information about how many licensed nurses (including RNs and LPNs) were needed to care for the resident population, nor were there provided details about recruitment or contingency plans.This deficiency represents non-compliance investigated under Master Complaint Number 2794699 and Complaint Numbers 2785803 and 2747771.

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	03/11/2026

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation, interview, and record review, the facility failed to ensure the services of a Registered Nurse (RN) were provided for at least eight consecutive hours a day, seven days a week. Additionally, the facility failed to ensure a full time Director of Nursing (DON) was employed and actively working within the facility. This had the potential to affect all residents residing in the facility. The facility census was 65. Findings include: Review of the Facility Assessment completed 01/30/26 revealed the facility must have a full-time DON, a full-time ADON, a full-time wound care nurse, and full-time Minimum Data Set (MDS) nurse.Review of staff clock in times and resident record review in times revealed no documentation of a Registered Nurse being in the building for eight consecutive hours on 02/21/26 or 03/08/26.Interview on 03/04/26 at 8:08 A.M. with Certified Nursing Assistant (CNA) #103 revealed there was no Director of Nursing (DON) or Assistant Director of Nursing (ADON) in the facility. CNA #103 further explained there was no one management nursing-wise to report issues or concerns to and reiterated there was no DON, no ADON, no Minimum Data Set (MDS) nurse, nor a wound care nurse working within the facility.Interview on 03/04/26 at 8:10 A.M. with CNA #801 revealed there was no DON or ADON working within the facility that they were aware of. CNA #801 reported the turnover was bad in the facility and the DON and ADONs come and go. CNA #801 reported there was no communication between floor staff and management and provided an example that new admissions just show up.Interview on 03/05/26 at 8:56 A.M. with Human Resource Staff #51 revealed the previous DON gave a thirty-day notice with an intended final day of work on 03/13/26. On 02/19/26, the former DON stated she was not working out her notice and did not return. On 02/21/26, the previous ADON gave a notice that they were resigning effective immediately. Currently, positions for an MDS nurse, wound care nurse, and ADON are open. Human Resource Staff #51 reported the facility recently hired a DON whose first day of work is planned for 03/16/26.Interview on 03/05/26 at 3:35 P.M. with Licensed Practical Nurse (LPN) #01 revealed the facility is short on Registered Nurse (RN) hours. The facility will schedule an RN, but they call off, don't show up, or quit. Names will appear on the schedule, but bodies are not in the building. LPN #01 reported it had gotten worse with no ADON or DON in the building.Interview on 03/10/26 at 4:22 P.M. with CNA #199 revealed the facility had been without a Director of Nursing for a little while. The previous DON and ADON both quit on the same day. CNA #199 reported no one came to the facility to fill in and stated no corporate nurses were physically in the building to fill in for the DON or ADON. Interview on 03/11/26 at 12:01 P.M. with Anonymous Staff Member #999 confirmed the facility is not meeting the required RN hours. The facility will put RN names on the schedule or the patient per day (PPD) sheets, but no one is physically in the building. The facility has told staff that a new DON had been in on certain days, but no one knows who they are or if they are even in the building. Anonymous Staff Member #999 reported the corporate nurses had not come in to assist the facility staff. This deficiency represents non-compliance investigated under Master Complaint Number 2794699 and Complaint Numbers 2785803 and 2747771.

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	03/11/2026

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and record review, the facility failed to ensure Resident #49 was served food in mechanically altered form to meet her needs. This affected one resident (#49) of three residents reviewed for appropriate diets. The facility identified 13 residents who were identified by the facility to require a mechanically altered diet. The facility census was 65.Findings include:Review of the medical record for Resident #49 revealed an admission date of 09/26/25 with diagnoses including Alzheimer's disease and hypertension. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #49 was identified to be dependent on staff for eating . Resident #49 required a mechanically altered diet. Review of the undated list of residents requiring a mechanically altered diets, provided by the facility, revealed Resident #49 required a mechanical soft diet. Interview on 03/05/26 at 10:26 A.M. with Certified Nursing Assistant (CNA) #73 revealed mechanical soft food should be small, but the kitchen was just cutting the foot up in large pieces. Telephone interview on 03/09/26 at 2:08 P.M. with CNA #777 revealed the kitchen staff provided regular food to residents who required a mechanical soft diet, including Resident #49. Observation on 03/09/26 at 5:00 P.M. of Resident #49's meal tray revealed a meal ticket arrived with Resident #49's supper tray. The ticket noted Resident #49 was on a mechanical soft diet. Continued observation of Resident #49's meal tray revealed on the tray was a hamburger that was cut up in large pieces and placed on a hamburger bun. Interview on 03/09/26 at 5:00 P.M. with CNA #777 at the time of observation confirmed Resident #49 had an order for a mechanical soft diet. CNA #777 confirmed the hamburger cut up into large pieces on a full-size bun was not appropriate on a mechanical soft diet. CNA #777 confirmed the hamburger in large pieces on the resident's tray would not be safe for Resident #49 to consume. This deficiency represents noncompliance investigated under Complaint Number 2785803.

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	03/11/2026

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 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to ensure the Facility Assessment addressed what resources are necessary to care for its residents completely during both day to day operations (including nights and weekends) and emergencies. This had the potential to affect all residents residing in the facility. The facility census was 65.Findings include: Review of the Facility Assessment completed 01/30/26 by Administrator #95 revealed no documentation of the Facility Assessment addressing the resident population, including but not limited to, both the number of residents and the facility's resident capacity, and the care required by the resident population considering behavioral health needs, cognitive disabilities, and overall acuity. Continued review of the Facility Assessment revealed no documentation of the assessment addressing direct care staff including but not limited to Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs). The Facility Assessment revealed no documentation of the overall number of facility staff needed to ensure sufficient number of qualified staff are available to meet each residents needs as identified through resident assessments and care plans.Interview on 03/10/26 at 3:10 P.M. with Regional Director of Clinical Operations #106 and Administrator #95 present confirmed the Facility Assessment was not completed with all required elementsThis deficiency represents an incidental finding identified during the course of the complaint investigation.