STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395614	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Healthcare and Rehabilitation Center	17350 Old Turnpike Road Millmont, PA 17845

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, clinical record review, and staff interview, it was determined that the facility failed to provide a dependent resident assistance with nail hygiene for one of three residents reviewed for activities of daily living concerns (Resident 46). Findings include: Observation of Resident 46 on July 30, 2025, at 11:47 AM revealed his fingernails were long (extending beyond the tips of his fingers) with darkened material under them. Clinical record review for Resident 46 revealed that the facility developed a plan of care to address Resident 46's risk for alteration in skin integrity related to poor self-care and history of picking at skin (initiated October 4, 2024). A plan of care initiated by the facility on October 4, 2024, noted Resident 46's self-care deficit regarding activities of daily living that listed interventions that included staff assist with daily hygiene, grooming, dressing, oral care, and eating as needed. Resident 46 required the extensive assistance with staff for hygiene and grooming. Review of quarterly MDS assessments (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated June 27, 2025, and July 28, 2025, indicated that Resident 46 needed substantial/maximal assistance with personal hygiene. Observation of Resident 46 again on August 1, 2025, at 9:38 AM with Employee 2 (licensed practical nurse) revealed that the fingernails of his bilateral hands continued to extend beyond the tips of his fingers, darkened substances remained underneath several fingernails, and a red substance (presenting as dried blood) was noted under the fingernails of his right hand. A skin injury one and 1.5 inches long was observed with dried, smeared, blood on Resident 46's left forearm. The surveyor reviewed the concern regarding hygienic care of Resident 46's fingernails during an interview with the Nursing Home Administrator, the Director of Nursing, and Employee 1 (registered nurse/director of clinical operations) on August 1, 2025, at 1:50 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to ensure the highest practicable care regarding a pacemaker for one of 18 residents reviewed (Resident 44). Findings include: Clinical record review for Resident 44 revealed that the facility admitted him on April 4, 2023. Diagnoses listed for Resident 44 upon his admission to the facility included the presence of a cardiac pacemaker (surgically inserted medical device with wires attached to the heart for the purpose of administering electrical impulses to regulate the heart rate). Review of Resident 44's clinical record revealed a current care plan for cardiac disease related to coronary artery disease (a condition where the arteries supplying blood to the heart narrow due to plaque buildup restricting blood flow), congestive heart failure (the heart does not pump blood well enough causing fluid to accumulate), hypertension (high blood pressure), and a pacemaker. The listed interventions included instructions to perform pacemaker checks; however, there was no intervention related to a pacemaker machine or method used to perform pacemaker checks. Clinical record review for Resident 44 revealed no evidence of a current physician's order for pacemaker monitoring until July 31, 2025, after the surveyor brought it to the facility's attention during a meeting with the director of nursing, nursing home administrator, and Employee 1, (registered nurse, director of clinical operations) on July 30, 2025, at 2:30 PM. Interview with the Director of Nursing and Nursing Home Administrator on July 31, 2025, at 2:20 PM confirmed that there was no order for Resident 44's pacemaker checks prior to the surveyor bringing it to their attention on July 30, 2025. They also confirmed that they had no evidence that pacemaker checks were being completed for Resident 44. The facility failed to provide the highest practicable care regarding Resident 44's pacemaker. 28 Pa. Code 211.2(d)(3) Medical director28 Pa. Code 211.3(a)(e)(2) Verbal and telephone orders28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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. Based on observation, clinical record review, and staff interview, it was determined that the facility failed to assess a resident's bed system for potential accident hazards for one of 18 residents reviewed (Resident 15). Findings include: The FDA (The United States Food and Drug Administration) Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, is guidance that identifies key parts of the body at risk for entrapment, describes potential entrapment areas or zones, and recommends maximum and minimum dimensional limits of gaps or openings in hospital bed systems. Three key body parts at risk for life-threatening entrapment in the seven zones of a hospital bed system discussed in this guidance are the head, neck, and chest. To reduce the risk of head entrapment, openings in the bed system should not allow the widest part of a small head (head breadth measured across the face from ear to ear) to be trapped. The FDA is using a head breadth dimension of 120 mm (4.75 inches) as the basis for its dimensional limit recommendations. To reduce the risk of neck entrapment, openings in the bed system should not allow a small neck to become trapped. FDA is recommending 60 mm (two and three-eighths inches) as an appropriate dimension for neck diameter. The openings in a bed system should be wide enough not to trap a large chest through the opening between split rails. The FDA concurs with the dimension of 318 mm (12.5 inches) to represent chest depth for the population vulnerable to entrapment and has used this dimension as the basis for its recommended dimensional limits. This guidance describes seven zones in the hospital bed system where there is a potential for patient entrapment. Zone seven is the space between the inside surface of the headboard or foot board and the end of the mattress. This space may present a risk of head entrapment when taking into account the mattress compressibility, any shift of the mattress, and degree of play from loosened head or foot boards. FDA recognizes this area as a potential for entrapment and encourages facilities and manufacturers to report entrapment events at this zone. Observation of Resident 15's room on July 30, 2025, at 10:17 AM revealed he was in his bed. Observation of Resident 15's bed system revealed that there were assist bars bilaterally at the head of his bed, a trapeze device mounted in the center of his bed, and there was a gap of six to eight inches between the top of his mattress and the headboard. Resident 15's bed system did not include a footboard. Clinical record review for Resident 15 revealed a GUAR-In Bed Positioning / Side Rail Evaluation dated July 10, 2025. The facility assessed Resident 15's bed positioning for safety. The document stipulated that the Gaps between head/foot boards and bed rails are within the FDA dimensional limits (<2-1/3 inches) and do not represent a risk for entrapment. (Devices may be used to decrease gaps/spaces); however, the document did not address the potential spatial concerns between the mattress and the headboard. Observation of Resident 15's room on August 1, 2025, at 9:32 AM with Employee 2 (licensed practical nurse) revealed he was in his bed. Employee 2 measured the space between the top of Resident 15's mattress to his headboard for a measurement of 10 inches. There was no footboard on Resident 15's bed and the mattress appeared to have slid distally within the bed system. The surveyor reviewed the above concern regarding the Zone seven gap within Resident 15's bed system during an interview with the Director of Nursing, the Nursing Home Administrator, and Employee 1 (registered nurse/director of clinical operations), on August 1, 2025, at 1:50 PM. The Director of Nursing indicated that Resident 15 may have had a footboard at one time on his bed; however, the facility was unable to provide documentation of when this bed system change occurred. The facility was unable to provide evidence of an assessment of Resident 15's bed system that included a review of the stability of the mattress positioning to ensure that potential sliding of the mattress did not present a gap size that presented a potential risk for entrapment. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the consultant pharmacist reported any irregularities to the attending physician (and the facility's medical director if applicable) and the Director of Nursing on a separate, written report; and that the attending physician documented a review and actions taken to address the identified irregularity in the resident's medical record for one of five residents reviewed for medication regime concerns (Resident 27).Findings include: Interview with the Nursing Home Administrator, Director of Nursing, and Employee 1 (registered nurse/director of clinical operations) on July 30, 2025, at 1:45 PM revealed that the facility's contracted consulting pharmacist reviews each resident's medication regime monthly and, unless listed on the document entitled, Listing of Residents Reviewed with No Recommendations, a resident has a separate report of the identified potential medication irregularity on which the attending physician documents a review and response. The interview indicated that the separate report would be scanned into the resident's electronic medical record under the miscellaneous section. Clinical record review for Resident 27 revealed that her name did not appear on the Listing of Residents Reviewed with No Recommendations, report for November 2024, December 2024, and March 2025. Resident 27's electronic medical record did not include a separate report from the consultant pharmacist for those months. Interview with the Director of Nursing on August 1, 2025, at 12:24 PM confirmed that upon her review of Resident 27's physical chart, there were no separate reports from the consultant pharmacist for November 2024, December 2024, or March 2025. Interview with the Director of Nursing on August 1, 2025, at 12:38 PM indicated that the consultant pharmacist included recommendations for Resident 27 to nursing staff on November 3, 2024, that read, Please update the Seroquel (antipsychotic medication) order to 25 mg (milligrams) daily. Per GDR (gradual dose reduction) in October it was decreased from 50 mg to 25 mg daily, within a list that included other residents' information. Although it is not in the scope of practice for licensed nursing staff to update a physician's order for a medication, the consultant pharmacist did not refer this recommendation to Resident 27's physician. The consultant pharmacist also did not document this information on a separate report for documentation of the monthly review in Resident 27's medical record. Interview with the Director of Nursing on August 1, 2025, at 12:38 PM indicated that the consultant pharmacist included recommendations for Resident 27 to nursing staff on December 8, 2024, that read, The resident is receiving Cholestyramine (medication that lowers fats, like cholesterol, in the blood). Please ensure periodic labs are conducted to monitor. Documentation of results should be accessible for review, within a list that included other residents' information. The list included a second entry that repeated, Please update the Seroquel order to 25 mg daily. Per GDR in October, it was decreased from 50 mg to 25 mg daily. Although it is not in the scope of practice for licensed nursing staff to generate orders for laboratory testing or update medication dosages, the consultant pharmacist did not refer these findings to Resident 27's physician on a separate report for documentation of the monthly review in Resident 27's medical record. A consultant pharmacist report dated February 3, 2025, requested that Resident 27's physician review Resident 27's use of Hydroxyzine (antihistamine that reduces the symptoms of itching, or hives, on the skin; it can also be used as a sedative to treat anxiety and tension) 50 mg at HS (hour of sleep) for a possible GDR or discontinuation. The physician did not document a review and response to this recommendation until more than a month later (dated March 5, 2025), which agreed to decrease the medication to 25 mg at HS. Due to the time lapse between the February 2024 consultant pharmacist review and Resident 27's physician's response in March 2025, the consultant pharmacist repeated the request for the facility to review Resident 27's Hydroxyzine medication for a possible GDR per a Consultant Pharmacist's Medication Regimen Review Recommendations Pending a Final Response, report generated for Outcomes Entered Between March 1, 2025, and March 5, 2025; however, the consultant pharmacist did not document these findings to Resident 27's physician on a separate report for documentation of the March 2025 monthly review in Resident 27's medical record. Interview with the Director of Nursing on August 1, 2025, at 1:20 PM confirmed that the only evidence a consultant pharmacist reviewed Resident 27's medication regime in March 2025, was the above-mentioned report, which listed several other residents' information and did not generate a separate report to a physician although the entry noted, Routed to: MD. A physician's order dated March 5, 2025, instructed staff to decrease Resident 27's Hydroxyzine medication to 25 mg at bedtime (after the consultant pharmacist's March 2025 review). Resident 27's physician did not complete a timely review and response to the consultant pharmacist's February 3, 2025, reported irregularity. 28 Pa. Code 211

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff and resident interview, it was determined that the facility failed to provide professional dental services for two of two residents reviewed for dental concerns (Residents 27 and 46). Findings include: Observation of Resident 27 on July 30, 2025, at 10:32 AM revealed she was edentulous (without natural teeth). Interview with Resident 27 on the date and time of the observation revealed that she once had a full denture for her upper and lower jaws; however, Resident 27 alleged that staff took her lower denture, and she did not know when or where they took them. Review of Resident Evaluation documentation dated June 1, 2024, at 4:00 AM for a quarterly review revealed that she was mentally oriented to person and place; however, was noted to have current and a history of behaviors. Staff assessed Resident 27 as having a full upper denture plate and a full lower denture plate. and Resident 27 preferred her dentures only removed at night. An annual MDS assessment (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) dated August 2, 2024, indicated that the care area related to dental concerns triggered as Resident 27 had full upper and lower dentures during the review of July 27, 2024, to August 2, 2024. The annual MDS dated [DATE], and a quarterly MDS dated [DATE], revealed that Resident 27 was dependent on staff for oral hygiene. Oral hygiene is defined as the ability to use suitable items to clean teeth; dentures (if applicable). The ability to insert and remove dentures into and from the mouth and manage denture soaking and rinsing with use of equipment. An electronic document entitled, Resident Evaluation V6, dated October 31, 2024, indicated that lower dentures were not applicable for Resident 27 (she did not have a lower denture at that time). A plan of care initiated by the facility on December 23, 2022, to address Resident 27's self-care deficit related to activities of daily living stipulated that Resident 27 required staff to Assist with daily hygiene, grooming, dressing, oral care and eating as needed. A plan of care to address Resident 27's edentulous condition (revised April 16, 2025) noted that Resident 27 had a full upper denture but no lower denture. The plan of care intervention for staff to assist with oral hygiene and dentures as needed was initiated December 27, 2022. The surveyor requested any documentation that the facility identified and addressed Resident 27's missing lower denture during interviews with the Nursing Home Administrator, Director of Nursing, and Employee 1 (registered nurse, director of clinical operations) on July 30, 2025, at 1:45 PM and July 31, 2025, at 2:00 PM. Interview with the Nursing Home Administrator on July 31, 2025, at 2:48 PM indicated that the Nursing Home Administrator confirmed that Resident 27 had an upper and lower denture; however, at some point, lost the bottom dentures but the facility did not know when. The Nursing Home Administrator indicated that there was no incident investigation or progress note to evidence when Resident 27 no longer had her lower denture between the dates of August 2, 2024, and October 31, 2024. The Nursing Home Administrator stated that Resident 27 exhibited a behavior of throwing her dentures at staff. Documentation by the facility's consultant professional dental provider dated January 6, 2025, indicated that Resident 27 was not a candidate for a lower ridge denture. Interview with Employee 1 on July 31, 2025, at 3:26 PM confirmed that the first assessment that indicated Resident 27 no longer had a lower denture was on October 31, 2024, and the facility had no evidence of an attempt to obtain professional dental services to replace the denture until January 6, 2025 (more than two months after). The facility was unable to provide a determination of when Resident 27 lost her lower denture within the three-month time between August 2, 2024, and October 31, 2024, despite Resident 27's dependence on staff for her oral hygiene daily. It was determined that the facility did not obtain timely professional dental services for a resident who lost their denture. Clinical record review for Resident 46 revealed that the facility admitted him on October 6, 2024, with Medicaid as a payment source for his admission to the facility. Observation of Resident 46 on July 30, 2025, at 10:58 AM revealed he had his fingers in his mouth pinching a tooth on his lower right jaw while repeating, can you take it out? Observation of Resident 46's mouth revealed he had missing and discolored teeth. Clinical record review for Resident 46 revealed no evidence of professional dental services provided since his admission to the facility (almost eight months). The surveyor requested any evidence of professional dental services for Resident 46 during an interview with the Director of Nursing, the Nursing Home Administrator, and Employee 1 on July 30, 2025, at 1:45 PM. An admission MDS assessment dated [DATE], assessed Resident 46 has having no obvious or likely cavities or broken natural teeth. A plan of care initiated by the facility on March 27, 2025, indicated that Resident 46 had a dental or oral cavity health problem related to broken and missing teeth

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that medical records were readily accessible to individuals performing health oversight activities for one of 18 residents reviewed (Resident 27). Findings include: The state survey agency entered the facility on July 29, 2025, at 9:00 AM and provided the Nursing Home Administrator the federal Entrance Conference Worksheet, which included the form entitled, Electronic Health Record (EHR) Information. Instructions on the form direct the provider to, Provide specific instructions on where and how surveyors can access the following information in the EHR (or in the hard if using split EHR and hard copy system) for the initial pool record review process. Surveyors require the same access staff members have to residents' EHRs in a read-only format. Clinical record review for Resident 27 revealed that the surveyor was unable to view three months of nurse aide documentation of the completion of tasks necessary for Resident 27's care (e.g., bathing, toileting assistance, bowel elimination records, incontinence care, behavior monitoring, oral hygiene, application of medical devices, etc.). Email communication to the Nursing Home Administrator on August 1, 2025, at 9:17 AM requested instructions regarding how the surveyors could independently review a month of nurse aide documentation (as reports run for licensed staff completion of treatments or medications) for a resident. The Nursing Home Administrator email response on August 1, 2025, at 11:05 AM indicated that she would print the nurse aide documentation that the surveyor requested. Interview with Employee 3 (licensed practical nurse) on August 1, 2025, at 12:50 PM revealed that he could view and print a Documentation Survey Report, that provided documentation by nurse aide staff of the care and services provided to Resident 27 for any month requested. Employee 3 printed this report for the surveyor at that time. The state agency surveyor was unable to view the same information independently without the intervention of facility staff. The facility failed to ensure that surveyors were provided the same medical record access staff members had to residents' EHRs in a read-only format. The surveyor reviewed the above concern with the Nursing Home Administrator, the Director of Nursing, and Employee 1 (registered nurse/director of clinical operations) on August 1, 2025, at 1:50 PM. 28 Pa. Code 211.5(b)(1)(2)(f)(i)-(xi)(i) Medical records