

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>395619                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY<br>COMPLETED<br><br>11/18/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Rolling Fields, Inc                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>9108 State Highway 198<br>Conneautville, PA 16406 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                |                                                 |
| F 0812<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on review of a facility policy, observations, and staff interviews, it was determined that the facility failed to ensure that food was stored in accordance with standards for food safety in a resident pantry for two of two refrigerators reviewed (Fig and Elmwood). Findings include: Review of facility policy entitled Cleaning Pantry Refrigerator dated 9/17/25, indicated Check all items for expiration dates and discard any items that are out of date and ensure all items belonging to Elders are labeled with Elders name and date. Observations on 9/22/25, at 2:22 p.m. of a refrigerator in the Fig wing pantry used for residents revealed a grocery bag with a half-eaten sandwich, an apple, a cookie and a bag of chips with no name or date and five containers of yogurt with an expiration date of 7/17/25. Observations of the freezer revealed ice packs used on resident body parts sitting next to an open container of ice cream and lemon swabs used to moisten resident mouths. Interview at the time of observations Nursing Assistant Employee E1 confirmed that the grocery bag with a half-eaten sandwich, apple, cookie and chips lacked a name or date; that the five containers of yogurt were beyond their expiration date; and the ice packs in the freezer used on resident body parts were sitting next to open container of ice cream and lemon swabs. He/she also confirmed that food items in the resident refrigerator should have a resident name and open date and should be discarded before or by their use by date and that the ice packs used on resident body parts should not be stored along with food. Observations on 9/22/25, at 2:35 p.m. of a refrigerator in the Elmwood wing pantry used for residents revealed in the freezer a milkshake with no lid and no name or date; a bowl of sherbert with no lid and no name or date; a frozen meal with no name or date; a breakfast wrap with no name or date and a best buy date of 7/17/25; and ice packs used on residents body parts sitting next to the uncovered milkshake and sherbet. Further observations revealed an employee's lunch box sitting in the refrigerator next to resident food items. During an interview at the time of observations Nursing Assistant Employee E2 confirmed that the milkshake, sherbet, and frozen meal lacked a name and date; the breakfast wrap was beyond its expiration date; ice packs used on resident body parts was sitting next to an open uncovered milkshake and sherbet; and an employee's lunch box was in the resident's refrigerator. He/she also confirmed that food items in the resident refrigerator should have a resident name and open date and should be discarded before or by their use by date and employees should not store their lunch boxes in the resident refrigerator. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management</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<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>395619                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY<br>COMPLETED<br><br>11/18/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Rolling Fields, Inc                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>9108 State Highway 198<br>Conneautville, PA 16406 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |                                                 |
| F 0605<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide a clinical rationale for the continued use of a PRN (as needed) psychotropic (affecting the mind) medication beyond 14-days for one of five residents reviewed (Resident R2). Findings include: Review of facility policy entitled PRN Psychotropic Medication Use dated 9/17/25, indicated All PRN psychotropic orders are limited to 14 days. If continuation is required: The prescriber must document clinical justification. Review of Resident R2's clinical record revealed an admission date of 8/22/25, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), diabetes (a health condition that is caused by the body's inability to produce enough insulin) and generalized anxiety disorder (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Review of Resident R2's medication administration record revealed an order for Vistaril (medication to treat anxiety) 25 milligrams (mg) four times a day as needed with a stop date of 9/5/25, and another order for Vistaril 25 mg four times a day as needed with a start date of 9/9/25. Resident R2's clinical record lacked evidence of a clinical rationale for continued use beyond 14 days. During an interview on 9/24/25, at 12:33 p.m. the Director of Nursing confirmed that Resident R2's Vistaril lacked a clinical rationale for continued use beyond 14 days and also confirmed that to continue Resident R2's Vistaril a clinical rationale was needed. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p> |                                                                                                |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>395619                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY<br>COMPLETED<br><br>11/18/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Rolling Fields, Inc                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>9108 State Highway 198<br>Conneautville, PA 16406 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                |                                                 |
| F 0628<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Provide the required documentation or notification related to the resident's needs, appeal rights, or<br>bed-hold policies.<br><br>Based on review of facility policy and clinical record, and staff interview, it was determined that the<br>facility failed to include required components of recapitulation of stay (summary of resident's stay<br>and course of treatment in the facility) for one of four closed records reviewed (Resident<br>R50).Findings include: Review of facility policy entitled Recapitulation of Resident Stay dated<br>9/17/25, indicated that all residents discharged . have a complete, accurate and timely recapitulation<br>of stay . and The facility shall complete a recapitulation of stay for all residents upon discharge<br>.Review of Resident R50's clinical record revealed an admission date of 8/14/25, with diagnoses that<br>included diabetes (a health condition that is caused by the body's inability to produce enough insulin),<br>osteomyelitis (a bone infection), and hypothyroidism (a condition when the thyroid produces low<br>amounts of thyroid hormones)Review of clinical record revealed that Resident R50 was discharged on<br>8/29/25.Review of Resident R50's clinical record revealed an incomplete recapitulation of Resident<br>R50's stay and lacked the required components.During an interview on 9/25/25, at 10:50 a.m. the<br>Director of Nursing (DON) confirmed that Resident R50's closed record lacked the required<br>components of the recapitulation of his/her stay. The DON also confirmed that a complete<br>recapitulation of Resident R50's stay should have been completed.28 Pa. Code 211.5(f)(i)(iv)(xi)<br>Medical records |                                                                                                |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>395619                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                       | (X3) DATE SURVEY<br>COMPLETED<br><br>11/18/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Rolling Fields, Inc                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>9108 State Highway 198<br>Conneautville, PA 16406 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                |                                                 |
| F 0849<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>Based on review of hospice contract, clinical records, and staff interview, it was determined that the facility failed to make certain that hospice documentation was maintained in the clinical record for one of one residents reviewed for hospice services (Resident R1). Findings include: Review of a facility contract with a local hospice services agency dated 4/2/25, indicated that .Hospice plan of care (referred to as hospice plan), hospice shall furnish a copy of the hospice plan . at the time of the resident's admission into the hospice program. Review of Resident R1's clinical record revealed an admission date of 7/15/25, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), malignant neoplasm of unspecified part of right bronchus or lung (lung cancer), and hyperlipidemia (high cholesterol). Review of Resident R1's physician orders revealed an order for a local hospice agency services dated 7/15/25. Resident R1's clinical record lacked evidence that the hospice agency provided the facility with a current hospice plan of care. During an interview on 9/24/25, at 2:20 p.m. the Director of Nursing confirmed that Resident R1's clinical record lacked evidence of the hospice agency's plan of care and also confirmed that Resident R1's clinical record should have a plan of care from the hospice agency. 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(d)(1)(3) Nursing services</p> |                                                                                                |                                                 |