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 _____	06/05/2025

name of provider or supplier	street address, city, state, zip code
ROLLING HILLS REHAB AND CARE CTR	68222 COMMERCIAL DRIVE BRIDGEPORT OH, 43912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BEPRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000	INITIAL COMMENTS COMPLAINT INVESTIGATION MASTER COMPLAINT NUMBER OH00166074 COMPLAINT NUMBER OH00166043 ADMINISTRATOR: Samantha Carpenter, #7881 CERTIFIED BED CAPACITY: 75 CENSUS IN HOUSE: 55 The following deficiency is based on the complaint investigation completed on 06/05/25.	F 0000		

laboratory director's or provider/supplier representative's signature | title | (x6) date

SAMANTHA.CARPENTER | 06/20/2025

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.

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F 0921	Continued From page 1	F 0921		
F 0921 SS=F	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure office spaces were clean and sanitary. This had the potential to affect all residents residing in the facility. The census was 55. Findings include: Observation and interview on 06/05/25 at 9:50 A.M. with Director of Maintenance (DM) # 100 revealed an approximate 12-inch section of peeling wallpaper was located near the baseboard of the back wall in Social Services Director (SSD) #84's office. DM #100 pulled back the peeling wallpaper and black areas were visible on the dry wall. DM #100 confirmed he was aware of the peeling wallpaper, but was not aware of the mold-like areas beneath the wallpaper. During observations of the SSD office on 06/05/25, residents were observed stopping at the office and speaking with the SSD. The SSD kept her office door open.	F 0921	This plan of correction ("POC") has been prepared at the request of the Ohio Department of Health, and not because this facility agrees with and/or admits to any of the allegations contained within the notice of deficiency issued by the Department. This POC does not constitute an admission that any of the citations are legally and/or factually correct, to include the scope and severity associated thereto. For the avoidance of doubt, this facility asserts that it was in substantial compliance with all data tags cited by the Department before, during, and after the dates referenced in the notice of deficiency and the dates on which the Department conducted the survey. This POC does not establish any standard of care, contract, obligation, and/or position beyond those of a reasonably prudent nursing home, and this facility reserves the right to raise all possible contentions and defenses in any administrative, civil or criminal action or proceeding. Rolling Hills Rehabilitation and Care Center will continue to ensure employees have a clean and comfortable environment. This plan of correction serves as Rolling Hills Rehabilitation and Care Center's allegation of substantial compliance. Staff member #84 stated she had no adverse effects as a result of this deficiency, she currently does not have any signs/symptoms related to potential mold exposure. The areas of suspected mold were contained and undisturbed. Staff member #84 was immediately moved to a clean and comfortable environment on 06/05/2025 with assistance from facility maintenance and other member of the management team using	06/16/2025

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F 0921	Continued From page 2 Interview on 06/05/25 at 10:00 A.M. with Social Services Director (SSD) #84 stated on 05/05/25, she notified the Administrator of the peeling wallpaper in her office and of her concern regarding the air quality in her office. SSD #84 stated she was told by the Administrator that she could move to another office; however, SSD #84 stated she did not move from her office because when she asked the Administrator if the other office's air quality would be tested (to ensure there was no mold in the office), an answer was not provided. SSD #84 stated she also notified Regional Director of Maintenance (DM) #162 of her peeling wallpaper and of her air quality concerns and was told she could move to another office. Interview on 06/08/25 at 2:14 P.M. with the Administrator confirmed SSD #84's peeling office wallpaper needed to be repaired and the office remediated for potential mold. The Administrator confirmed SSD #84 was immediately relocated to another office in the facility and her office was sealed for remediation and repair. Interview on 06/08/25 at 2:20 P.M. with Regional DM #162 confirmed he was notified by SSD #84 of peeling wallpaper in her office and stated that looking back on it, he should have insisted SSD #84 relocate to another office so repairs could have been made. DM #162 stated SSD #84 told him she had too many things to	F 0921	proper PPE and disinfected all items that were possibly exposed using fungicide. An air quality test was performed on 06/05/2025 with no negative findings. On 06/05/2025 the office sealed off, locked, and placed under construction. On 06/06/2025 the areas of concern were treated x2 with mold armor. On 06/12/2025 another air quality test was performed with no negative findings, office to be reopened and used for operation as of 06/16/2025. The facility followed all CDC recommendations for all potential mold remediation. A whole facility baseline audit was completed to ensure a clean and comfortable environment by the facility Administrator on 06/12/2025. There were no negative findings identified through this audit. All residents located on the unit in proximity to the social services office was assessed along with review of their EHR by the Director of Nursing on 06/12/2025 to ensure there was no negative impact, with no negative findings. The Director of Nursing reviewed the infection control log on 06/13/2025 for signs/symptoms of respiratory concerns in the last 30 days related to potential mold exposure with no negative findings. Interviews were initiated on 06/06/2025 and completed on 06/13/2025 with all interview-able residents by the facility Administrator and designee, to ensure no current concerns with potential mold. There were no negative findings identified. An audit of the grievance/concern log was completed x90 days with no concerns from family, visitors, or staff of suspected mold in the facility. We have not received any reports by staff and/or visitors of an adverse effects as a result of this deficient practice. Verbal	

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F 0921	Continued From page 3 move, and she would not be returning to her position following the birth of her child. This deficiency represents non-compliance investigated under Master Complaint Number OH00166074 and Complaint Number OH00166043.	F 0921	education on the facility best practice for reporting environmental concerns was completed on 06/10/2025 for all facility staff by facility Administrator. A facility walkthrough will be completed weekly x4 weeks by facility administrator/designee, starting on or by the week of 06/13/2025 Results will be brought to the Quality assurance committee for further review and recommendations. Facility administrator will be responsible for overall compliance with this plan.	