STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365980	A. Building B. Wing	11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hills Center	2841 East Dublin-Granville Road Columbus, OH 43231

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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. (continued on next page)

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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview, this facility failed to ensure residents were able to receive care and services from approved physicians only. This effected one (Resident #161) of the four residents reviewed for the right to choose their own care provider. The facility census was 70. Findings include: Review of the medical record for Resident #161 revealed an admission date of 07/11/25 and a discharge date of 09/03/25. Diagnosis included Alzheimer's disease, heart disease, and obstructive sleep apnea. Review of Resident #161's medical profile face sheet revealed under Instructions: For acute changes, resident will need to go to the emergency room. Do not contact facility physicians. Resident does not have an attending physician due to refusal for consent for treatment. Review of Resident #161's Care Conference Summary dated 07/14/25 with a lock date of 07/15/25 revealed the resident's legal guardian was present and indicated that the only ancillary service selected was dental and it indicated that Resident #161 was to go to the Veteran Affairs (VA) hospital for everything. Resident #161's legal guardian also claimed that she was going to take the resident to all outside appointments. Review of the plan of care dated 07/17/25 and revised 08/18/25 revealed Resident #161's family was making decisions for the resident and directing care. It noted the residents daughter was the residents guardian, and the daughter only wanted the resident to be seen by the VA providers. The daughter wanted to handle making all notifications to the VA and scheduling his appointments with them and she did not want facility providers involved in his care. The residents daughter refused to sign the facility's consent to treat. Review of Resident #161's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03 out of 15 indicating severely impaired cognition for daily decision-making abilities. Review of the progress note dated 08/06/25 at 9:42 A.M. created by the Director of Nursing revealed a new order was received from Certified Nurse Practitioner (CNP) for increased agitation. The order was for Depakote (an anticonvulsant) 250 milligrams one time. Review of the progress note date 08/09/25 at 2:48 P.M. created by Licensed Practical Nurse (LPN) #453 revealed the resident's daughter came in around 2:30 P.M. and told this writer that residents legs were swollen. The writer asked when she noted the swelling and the daughter replied now. The writer told the daughter she was going to call and notify the provider. The residents daughter said the resident didn't see the in-house provider, the resident was to see an outside provider, and that she would call the resident's provider herself and take the resident to see the provider.Review of the Interdisciplinary Team (IDT) note dated 08/18/25 at 2:45 P.M. created by the Director of Nursing (DON) revealed an interdisciplinary team review that stated the nurse saw the resident picking at his skin, causing an open area of 1.25 centimeters (cm) by 0.25 cm to the left forearm. When asked what happened to his arm the resident replied, I tore it off. No pain or discomfort was noted or verbalized by the resident. The open area was cleansed with Normal Saline, patted dry, triple antibiotic ointment applied and cover dressing applied. The residents Power of Attorney (POA) was in the building and aware. Medical Director's physician group on-call called and notified. A treatment order was put in place.Interview on 10/16/25 at 2:00 P.M. with the Administrator and DON revealed when Resident #161 admitted to the facility they did not have a signed consent on file for the resident to receive care from the facility's Medical Director or any related providers. The Administrator claimed the facility had been going back and forth with the daughter asking her to sign the consent for medical treatment to be provided by the facility Medical Director and she continued to refuse claiming she wanted only the VA physicians to look at her father. The Administrator and DON acknowledged the examples on 08/06/25, 08/09/25, and 08/18/25 when the facility staff attempted to obtain or did obtain orders to treat Resident #161.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, facility Self-Reported incident review, hospital record review, staff interview, observation, and review of facility policies, the facility failed to ensure residents were free from resident-to-resident altercations resulting in injury as well as ensuring ordered stop signs in doorway openings were in place. This affected two (Resident #159 and #63) of the seven residents reviewed for abuse. The facility census was 70.Findings include: 1. Review of the facility's Self-Reported Incident (SRI) tracking number #263862 dated 08/10/25 revealed there was an allegation of physical abuse between two residents. Per the nurse, two residents were heard screaming, the nurse quickly ran to the scene (in from of Resident #63 doorway) and immediately separated Resident #63 and #159. Enhanced supervision was provided for both residents, including one-on-one care for Resident #63. During Neurological checks and the head-to-toe assessment, the nurse discovered Resident #159 had a cut to her nose and upper lip. There was no evidence of physical or psychosocial distress after the incident. Neither resident could give a reliable account of what transpired due to their cognitive impairment. Resident #159 was sent to the emergency department for further evaluation. Responsible parties and the physicians were made aware. Counseling services were also provided. This SRI was found to be inconclusive by the facility due to the allegation could not be verified or refuted because there was insufficient information to determine whether or not the allegation had occurred. a. Review of the medical record for Resident #63 revealed an admission date of 05/15/24. Diagnosis included Alzheimer's disease, psychosis, and mood disorder. Review of Resident #63's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating a moderately impaired cognition for daily decision-making abilities. Resident #63 was noted to receive antidepressants and opioid medication daily. Review of Resident #63's nursing progress note dated 08/04/25 at 10:44 P.M. created by the Director of Nursing (DON) revealed a new order was received for a stop sign to the door to allow for privacy.Review of the plan of care dated 08/06/24 revealed there was a stop sign to Resident #63's door and staff were to ensure the stop sign was in place. Review of physician orders for Resident #63 revealed an order dated 08/04/25 for staff to check and ensure the stop sign was in the proper place on door. Review of Resident #63's Treatment Administration record for 08/2025, 09/2025, and 10/2025 revealed nursing staff were documenting that the ordered stop sign was in the proper place in resident's doorway. Review of the nursing progress note dated 08/10/25 at 2:48 A.M. revealed an unknown nurse heard a noise and a scream at the hallway so they went to see what was happening, only to see Resident #159 on the floor with Resident #63 close by. The staff asked Resident #63 what happened to Resident #159 and he responded by saying she came to his room and he tried to kick her out and he pushed her out and believed that was what caused her to fall. She was on the floor with blood on her face and on the floor. Resident #159 had a cut to the nose and upper lip. She also lost a tooth. Resident #63 was very agitated, so redirection was provided. Observations on 10/14/25 at 12:00 P.M. and 3:00 P.M., on 10/16/25 at 2:30 P.M. and on 10/17/25 at 11:20 A.M. and at 2:30 P.M. revealed there was not a stop sign in Residents #63's doorway as ordered. Interview on 10/17/25 at 2:30 P.M. with Director of Rehab #368 confirmed Resident #63's doorway did not have a stop sign in place as per order. Director of Rehab #368 claimed Resident #63 and his roommate would remove it often due to going in and out of the room frequently during the day and evening. b. Review of the medical record for Resident #159 revealed an admission date of 07/09/25 and a discharge date of 10/12/25. Diagnosis included Alzheimer's disease, dementia, and heart failure. Review of Resident #159's admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident experienced long and short-term memory impairment and had a severely impaired cognition for daily decision-making abilities. This resident was noted to wander the unit and display disorganized thinking and inattention. Review of the plan of care dated 08/04/25 and revised 10/13/25 revealed Resident #159 was at a high risk for elopement as evidenced by attempting to get out of the unit doors. Resident #159 also noted to wander into other resident's rooms and would collect some of their things and would lay in other resident's bed. Interventions included to redirect her to a safer area if she wandering to a potentially unsafe area or situation.Review of Resident #159's hospital documentation dated 08/10/25 at 4:23 A.M. revealed this resident was an [AGE] year-old Spanish speaking female with severe dementia who presented to the emergency room as a level 2 trauma fall. Apparently, she was at a memory care unit and was assaulted by one of the other dementia patients. The physical assessment revealed there was an

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, review of Emergency Medical System (EMS) run report, review of the Certification and Licensure System (CALS), and facility policy review, the facility failed to timely report injuries of unknown origin to the state agency for Residents #153 and #155 and failed to report a resident to resident incident involving Resident #63. This affected three residents (#63, #153, and #155) of seven residents reviewed for abuse. The facility census was 70.Findings include:1a. Review of the medical record revealed Resident #153 was initially admitted to the facility on [DATE]. His diagnoses included metabolic encephalopathy, cerebral amyloid angiopathy, type II diabetes, unspecified mood disorder, depression, and cognitive communication deficit. Review of the Care Plan entry dated 05/09/24 noted Resident #153 had the potential risk for falls related to cognitive function, decreased physical function, incontinence and medication. A goal was established for Resident #153 to be free from injury. Interventions included to observe for changes in activities of daily living (ADL) ability and to adjust assistance provided accordingly, non-skid footwear, and if the resident was agitated or combative with care, staff should give space and then reapproach. Review of Care Plan for Resident #153 initiated 12/13/24 revealed the resident exhibits behaviors related to aggression toward staff, taking items in his room apart and sitting on the floor. The goal was for the resident to remain safe and not experience complications related to behaviors. Interventions included attempt to establish a routine to reduce confusion for the resident, in the event there was disruptive behavior, redirect the resident and report the behavior, orient the resident to their surroundings, and report any behaviors that could affect the resident's quality of life. Review of handwritten care conference note for Resident #153 dated 05/09/25 revealed behaviors including yelling, pushing over furniture, tearing up the room, aggressiveness during care, and refusing care. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #153 had severe cognitive impairment and was dependent on staff for eating, oral hygiene, toileting, showering/bathing, upper body dressing, lower body dressing, personal hygiene and putting on/taking off footwear. He required substantial/maximal assistance from staff to roll left to right and partial to moderate assistance for sitting to lying and lying to sitting on the side of the bed. He was able to walk ten feet with supervision or touching assistance and walk 150 feet with partial/moderate assistance. Review of the facility nursing progress note for Resident #153 dated 05/30/25 revealed the son of Resident #153 brought to the nurse's attention that the resident's left hand was swollen. The nurse noted the resident flinched when his hand or fingers moved. Review of the x-ray report for Resident #153 dated 05/30/25 revealed an avulsion fracture was seen along the dorsal distal phalanx of one of the digits. Review of progress note for Resident #153 dated 05/31/25 revealed Resident #153 was sent to the emergency room for further evaluation after x-ray results were received. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the emergency room notes dated 05/31/25 for Resident #153 revealed the resident had mild swelling along the ulnar aspect of the left hand over the fourth and fifth metacarpals and mild swelling of the left fifth digit. He had a tiny subungual hematoma at the distal aspect of the left third nail. Because they were initially unable to locate the first x-ray that was taken there was a second x-ray taken at the emergency room with negative findings. Eventually the initial x-ray was located at the physician noted she reviewed both x-rays. The physician noted on the initial x-ray from the facility there was a small indentation along the proximal aspect of the fifth digit only visible on the lateral view that could represent possible fracture. She wrote a finger splint was placed and should remain in place until resident was evaluated. Review of progress note dated 05/31/25 for Resident #153 returned from hospital with finger splint placed on left pinky finger to remain in place until evaluated by primary care physician (PCP) or orthopedics. Review of the orthopedics consultation dated 06/09/25 revealed the physician ordered a splint to wear full time for three weeks, besides hygiene purposes. It noted that the x-ray obtained during this exam noted no conclusive fracture and no obvious joint malalignment. The assessment and diagnoses were noted as left hand swelling with possible occult fracture. Review of the Self Reported Incidents for the facility revealed no incident report was submitted regarding Resident #153's injury of unknown origin on 05/30/25. Review of the record for Resident #153 revealed no documented evidence of an investigation related to Resident #153's injury of unknown origin. Interview with the Director of Nursing (DON) on 10/15/25 at 4:24 P.M. confirmed Resident #153's son had found the hand injury on 05/30/25. She said it was in the early afternoon and she would have expected the aides to notice the injury when they fed the resident at lunch. She said she asked around and wasn't able to find anyone who saw anything so she didn't complete a formal investigation. She said they assumed the injury was from him moving furniture around as it was a common behavior of the rest. She said she did not have documentation of anyone that she spoke with regarding that incident or how they thought it occurred. Interview on 10/16/25 at 10:15 A.M. with the Administrator confirmed that he did file Self-Reported Incidents (SRIs) for Injuries of Unknown Origin, but he relied on the clinical staff to bring to his attention incidents that needed to be reported. 1b. Review of progress notes for Resident #153 dated 06/12/25 revealed a nurse noted swelling on the resident's forehead while walking the hallways. The note indicated Resident #153 had a 4 centimeter (cm) x 3 cm hematoma to mid forehead with no other skin impairment noted at the time. The resident was not able to give a description of how he had the hematoma. The note further stated the resident was walking the hallways attempting move furniture while staff continued to redirect him. Review of the Medication Administration Record for 06/12/25 revealed the behavioral monitoring for Resident #153 was left blank for the 7:00 A.M. to 7:00 P.M. shift. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress note for Resident #153 dated 06/13/25 revealed the resident's son expressed concerns about the bump on the resident's head and blackness around his eyes, and that the son requested the resident to be sent to the emergency room for further evaluation. An order was obtained from the medical director for Resident #153 to be sent to the emergency room for evaluation and treatment. Review of Emergency Medical Services (EMS) Report from 06/13/25 for Resident #153 revealed the EMS author documented that the nurse had said the patient had an unwitnessed fall. Resident #153 was assessed to have multiple hematomas on his forehead and the side of his head. Deep purple bruising was noted in both inner corners of his eyes and swelling was noted around his eyes and nose region. Review of hospital records dated 06/13/25 revealed Resident #153 arrived with multiple contusions (bruises) of the anterior (front) aspect of his head. Hospital notes indicated no acute injuries were identified on his medical imaging (CT) scans. The resident was discharged to a different facility from the hospital. Review of the facility records and SRI document filed with the state on 06/16/25 (four days after the incident) revealed the nurse had said the resident had bumped his head against the furniture, resulting in the bruise on his forehead. There was no documentation noting specific staff members witness statements or an investigation regarding the incident and there was no documentation that a fall or an incident had occurred. There was no documentation of education or training provided to staff on abuse or injuries of unknown origin. Interview with Licensed Practical Nurse (LPN) #114 on 10/15/25 at 4:12 P.M. revealed she did not know why the behavior tracking was blank. She said she did not remember who pointed out the bump to her, she did not see the resident hit his head, and did not know of anyone who saw the injury happen. Interview with the Director of Nursing (DON) on 10/15/25 at 4:24 P.M. revealed she did not have names of any staff members who witnessed the injury to Resident #153's head on 06/12/25. She confirmed she did not keep notes from her investigations. Interview on 10/16/25 11:40 A.M. with Certified Nursing Assistant (CNA) #236 admitted she was working 05/30/25 and 6/12/25 (the days of Resident #153's two injuries) but said she didn't remember anything about either day that Resident #153 was injured and did not see him get injured. Interview on 10/20/25 at 4:12 P.M. with the Administrator, the DON and Regional Clinical Registered Nurse (RN) #444 acknowledged that they did not know for certain the source of the injury and that they had assumed it to be self-inflicted because he moved furniture around often. The SRI was completed after they became aware that the family of Resident #153 had made an allegation of abuse and/or neglect. 2. Review of the medical record revealed Resident #155 was admitted to facility on 03/05/25. Her diagnoses included unspecified dementia, unspecified mood disorder, anxiety disorder, repeated falls, restlessness and agitation. Further review of the residents medical record revealed she was not utilizing or prescribed any anticoagulant medications. Resident #155 passed away on 10/07/25 on hospice care. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of her Minimum Data Set (MDS) dated [DATE] revealed Resident #155 had severe cognitive impairment and was dependent on staff for eating, toileting, showering, dressing, personal hygiene. The MDS revealed she was dependent on staff for rolling left to right, transferring, moving from lying to sitting and walking 10 feet. It was noted she used a manual wheelchair and was dependent on staff for wheeling 150 feet. Review of the care plan entry initiated 03/06/25 revealed Resident #155 had a potential risk for falls related to cognitive function, history of falls, history of fall with fracture, incontinence and recent admission to new environment. Interventions included common area for eating and toileting after lunch, floor mat to floor while resident was in bed, bed in lowest position when occupied and resident to be kept in common area when awake, hipsters to be worn at all times, staff to offer to walk resident when seen trying to get out of wheelchair, proper footwear, offer to toileting prior to dinner, Dycem (pad) to wheelchair, encourage resident to participate in therapies, ensure call light within reach at all times, staff to observe for side effects from psychotropic medication usage, staff to observe for changes in activities of daily living (ADL) ability and adjust assistance provided accordingly. In July 2025, additional fall interventions were added to the care plan including nightstand moved away from head of bed, perimeter mattress, offer snack prior to lunch, and to offer to toilet after breakfast. Review of the progress note for Resident #155 dated 08/22/25 revealed a Certified Nursing Assistant (CNA) alerted the nurse that she noted a bruise while giving a shower to the resident. The nurse assessed the resident to have a right shoulder bruise measuring approximately 13 centimeters (cm) by 7 cm, and a bruise on the right breast and chest area measuring approximately 17 cm x 18 cm. Review of the skin assessment dated [DATE] revealed a right chest area bruise, a bruise to the front right shoulder, a bruise on the rear right shoulder, a right rib area bruise and a right upper arm area bruise. Review of the progress note for Resident #155 dated 08/23/25 revealed a CNA alerted the nurse to a raised area around the neck and pain with palpitations. The nurse called the on call nurse practitioner and an x-ray was ordered. Review of progress note for Resident #155 on 08/24/25 at 11:25 A.M. revealed the x-ray soft tissue result came back as unremarkable. Review of the medical record for Resident #155 revealed no documented evidence of an investigation into the residents bruising from 08/22/25. Review of progress note dated 08/24/25 at 1:49 P.M. revealed a CNA found Resident #155 sitting on the floor next to her wheelchair. The resident was unable to state what had happened. Review of the post fall evaluation progress note for Resident #155 dated 08/24/25 at 3:36 P.M. noted the resident was in a hurry/rush at the time of the fall and that the reason for the fall was not evident. At this time, the resident was assessed to have no new injuries. Review of the progress notes dated 08/25/25 revealed an additional chest and right ribs x-ray was ordered. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of x-ray results dated 08/25/25 revealed Resident #155 had acute fractures of the right fourth and fifth ribs. Review of nursing progress note dated 08/26/25 for Resident #155 revealed certified nurse practitioner (CNP) #422 wrote a new order for Tramadol 50 milligrams (mg) every eight hours for five days for pain. Review of the nurse practitioner progress note for Resident #155 dated 08/27/25 noted Resident #155 had significant agitation and was not as active or mobile due to pain and was noticed to be grimacing at times with movement. The note indicated x-ray results came back and Resident #155 had an acute fracture to the fourth and fifth ribs. Review of the progress notes dated 08/29/25 revealed the nurse notified the nurse practitioner regarding Resident #155's increased weakness and Resident #155 was transferred to the hospital for further evaluation and treatment. Review of the Emergency Medical Service (EMS) Transportation documentation for Resident #155's transfer to hospital dated 08/29/25 revealed the EMS staff were told that the bruises were from a fall on 08/24/25. Review of the hospital after visit summary and hospital documentation dated 08/29/25 revealed the hospital completed chest x-ray's and computerized tomography (CT) scans to the chest, spine and head and they documented the resident was diagnosed with a fall and a closed right clavicle (collar bone) fracture. The documents noted the resident had an age-indeterminate comminuted and displaced fracture of the proximal third of the right collarbone with surrounding thick-walled collection measuring at least 8.8 cm by 4.9 cm that may be related to an evolving hematoma. It also stated that the rib fractures were chronic as were the additional rib deformities, and to follow up with the physician. Interview on 10/16/25 at 10:15 A.M. with the Administrator revealed he was unfamiliar with Resident #155's incident on 08/22/25 and confirmed no SRI had been filed for the incident on 08/22/25 or 08/24/25. Interview on 10/16/25 at 10:28 A.M. with the Director of Nursing (DON) revealed she felt that Resident #155's bruising to the front and back of the shoulder and to the chest on 08/22/25 was due to a fall. She said there weren't any staff members who said they saw this happen though. Interview on 10/16/25 at 5:15 P.M. with Senior Administrator #412 confirmed they had no documentation that any staff interviews were conducted, and that as part of the investigation, they should have documentation of interviews conducted and should retain the documentation. 3. Review of the medical record for Resident #63 revealed an admission date of 05/15/24. Diagnosis included Alzheimer's disease, mood disorder, depression and muscle weakness. Review of Resident #63's care plans revealed no plan related to behaviors of verbal or physical aggression towards other residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 08/06/25 at 8:45 P.M. created by Licensed Practical Nurse (LPN) #168 revealed the nurse heard loud voices coming out of resident's room, another resident was in this resident's room involved in a physical altercation. Both residents were separated with the other resident taken to his room. Resident #63 was noted with a skin tear with scant amount of blood noted to the left forearm, measuring 5 centimeters (cm) by 4 cm. Ice was applied at the area to stop the bleeding. The area was cleaned with Normal Saline, patted dry, steri strips were applied and it was covered with a transparent dressing. Resident #63 denied any pain and declined pain medication at the time. No new skin concerns were noted upon assessment. The residents family and medical director were notified. No new orders were received. Review of Resident #63's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating a moderately impaired cognition for daily decision-making abilities. Resident #63 was noted to display physical and verbal behaviors directed towards others as well as rejection of care. Resident #63 was noted to be free of upper or lower extremity impairments and required a walker for ambulation. He required setup or clean up assistance for eating, oral hygiene, toileting hygiene, and personal hygiene as well as substantial to maximal assistance for bathing and bed mobility. Resident #63 was noted to receive antidepressants and opioids daily. Review of this facility's Self-Reported Incidents (SRI) revealed, an SRI had not been implemented or an investigation completed for the physical altercation incident that occurred between Resident #63 and another unknown resident. Interview on 10/15/2024 at 2:45 P.M. with Senior Administrator #412 confirmed when there was an incident between two residents resulting in an injury, the facility was to implement an SRI and conduct an investigation into that incident. Senior Administrator #412 confirmed the facility did not open an SRI or complete an investigation for an incident that occurred between two residents on 08/06/25. Review of facility policy titled, Abuse, Neglect and Exploitation, dated 01/01/24 revealed that possible indicators of abuse are physical injury of resident, of unknown source. The policy further states that the written procedures for investigations include identifying and interviewing all involved persons including potential witnesses and providing complete and thorough documentation of the investigation. The policy further states that all alleged violations are to be reported to the Administrator and state agency no later than 24 hours after. This deficiency represents non-compliance investigated under Master Complaint Number 2599554 and Complaint Number 1392707.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365980	A. Building B. Wing	11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hills Center	2841 East Dublin-Granville Road Columbus, OH 43231

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility investigation report review, staff interview, and policy review, the facility failed to ensure a thorough investigation was completed for injuries of unknown origin for residents #153 and #155, and failed to complete an investigation into a resident to resident altercation involving Resident #63. This affected three residents (#63, #153 and #155) of seven residents reviewed for abuse. The facility census was 70.Findings include:1a. Review of the medical record revealed Resident #153 was initially admitted to the facility on [DATE]. His diagnoses included metabolic encephalopathy, cerebral amyloid angiopathy, type II diabetes, unspecified mood disorder, depression, and cognitive communication deficit. Review of the Care Plan entry dated 05/09/24 noted Resident #153 had the potential risk for falls related to cognitive function, decreased physical function, incontinence and medication. A goal was established for Resident #153 to be free from injury. Interventions included to observe for changes in activities of daily living (ADL) ability and to adjust assistance provided accordingly, non-skid footwear, and if the resident was agitated or combative with care, staff should give space and then reapproach. Review of Care Plan for Resident #153 initiated 12/13/24 revealed the resident exhibits behaviors related to aggression toward staff, taking items in his room apart and sitting on the floor. The goal was for the resident to remain safe and not experience complications related to behaviors. Interventions included attempt to establish a routine to reduce confusion for the resident, in the event there was disruptive behavior, redirect the resident and report the behavior, orient the resident to their surroundings, and report any behaviors that could affect the resident's quality of life. Review of handwritten care conference note for Resident #153 dated 05/09/25 revealed behaviors including yelling, pushing over furniture, tearing up the room, aggressiveness during care, and refusing care. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #153 had severe cognitive impairment and was dependent on staff for eating, oral hygiene, toileting, showering/bathing, upper body dressing, lower body dressing, personal hygiene and putting on/taking off footwear. He required substantial/maximal assistance from staff to roll left to right and partial to moderate assistance for sitting to lying and lying to sitting on the side of the bed. He was able to walk ten feet with supervision or touching assistance and walk 150 feet with partial/moderate assistance. Review of the facility nursing progress note for Resident #153 dated 05/30/25 revealed the son of Resident #153 brought to the nurse's attention that the resident's left hand was swollen. The nurse noted the resident flinched when his hand or fingers moved. Review of the x-ray report for Resident #153 dated 05/30/25 revealed an avulsion fracture was seen along the dorsal distal phalanx of one of the digits. Review of progress note for Resident #153 dated 05/31/25 revealed Resident #153 was sent to the emergency room for further evaluation after x-ray results were received. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the emergency room notes dated 05/31/25 for Resident #153 revealed the resident had mild swelling along the ulnar aspect of the left hand over the fourth and fifth metacarpals and mild swelling of the left fifth digit. He had a tiny subungual hematoma at the distal aspect of the left third nail. Because they were initially unable to locate the first x-ray that was taken there was a second x-ray taken at the emergency room with negative findings. Eventually the initial x-ray was located at the physician noted she reviewed both x-rays. The physician noted on the initial x-ray from the facility there was a small indentation along the proximal aspect of the fifth digit only visible on the lateral view that could represent possible fracture. She wrote a finger splint was placed and should remain in place until resident was evaluated. Review of progress note dated 05/31/25 for Resident #153 returned from hospital with finger splint placed on left pinky finger to remain in place until evaluated by primary care physician (PCP) or orthopedics. Review of the orthopedics consultation dated 06/09/25 revealed the physician ordered a splint to wear full time for three weeks, besides hygiene purposes. It noted that the x-ray obtained during this exam noted no conclusive fracture and no obvious joint malalignment. The assessment and diagnoses were noted as left hand swelling with possible occult fracture. Review of the Self Reported Incidents for the facility revealed no incident report was submitted regarding Resident #153's injury of unknown origin on 05/30/25. Review of the record for Resident #153 revealed no documented evidence of an investigation related to Resident #153's injury of unknown origin. Interview with the Director of Nursing (DON) on 10/15/25 at 4:24 P.M. confirmed Resident #153's son had found the hand injury on 05/30/25. She said it was in the early afternoon and she would have expected the aides to notice the injury when they fed the resident at lunch. She said she asked around and wasn't able to find anyone who saw anything so she didn't complete a formal investigation. She said they assumed the injury was from him moving furniture around as it was a common behavior of the rest. She said she did not have documentation of anyone that she spoke with regarding that incident or how they thought it occurred. Interview on 10/16/25 at 10:15 A.M. with the Administrator confirmed that he did file Self-Reported Incidents (SRIs) for Injuries of Unknown Origin, but he relied on the clinical staff to bring to his attention incidents that needed to be reported. 1b. Review of progress notes for Resident #153 dated 06/12/25 revealed a nurse noted swelling on the resident's forehead while walking the hallways. The note indicated Resident #153 had a 4 centimeter (cm) x 3 cm hematoma to mid forehead with no other skin impairment noted at the time. The resident was not able to give a description of how he had the hematoma. The note further stated the resident was walking the hallways attempting move furniture while staff continued to redirect him. Review of the Medication Administration Record for 06/12/25 revealed the behavioral monitoring for Resident #153 was left blank for the 7:00 A.M. to 7:00 P.M. shift. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress note for Resident #153 dated 06/13/25 revealed the resident's son expressed concerns about the bump on the resident's head and blackness around his eyes, and that the son requested the resident to be sent to the emergency room for further evaluation. An order was obtained from the medical director for Resident #153 to be sent to the emergency room for evaluation and treatment. Review of Emergency Medical Services (EMS) Report from 06/13/25 for Resident #153 revealed the EMS author documented that the nurse had said the patient had an unwitnessed fall. Resident #153 was assessed to have multiple hematomas on his forehead and the side of his head. Deep purple bruising was noted in both inner corners of his eyes and swelling was noted around his eyes and nose region. Review of hospital records dated 06/13/25 revealed Resident #153 arrived with multiple contusions (bruises) of the anterior (front) aspect of his head. Hospital notes indicated no acute injuries were identified on his medical imaging (CT) scans. The resident was discharged to a different facility from the hospital. Review of the facility records and SRI document filed with the state on 06/16/25 revealed the nurse had said the resident had bumped his head against the furniture, resulting in the bruise on his forehead. There was no documentation noting specific staff members witness statements or an investigation regarding the incident and there was no documentation that a fall or an incident had occurred. There was no documentation of education or training provided to staff on abuse or injuries of unknown origin. Interview with Licensed Practical Nurse (LPN) #114 on 10/15/25 at 4:12 P.M. revealed she did not know why the behavior tracking was blank. She said she did not remember who pointed out the bump to her, she did not see the resident hit his head, and did not know of anyone who saw the injury happen. Interview with the Director of Nursing (DON) on 10/15/25 at 4:24 P.M. revealed she did not have names of any staff members who witnessed the injury to Resident #153's head on 06/12/25. She confirmed she did not keep notes from her investigations. Interview on 10/16/25 11:40 A.M. with Certified Nursing Assistant (CNA) #236 admitted she was working 05/30/25 and 6/12/25 (the days of Resident #153's two injuries) but said she didn't remember anything about either day that Resident #153 was injured and did not see him get injured. Interview on 10/20/25 at 4:12 P.M. with the Administrator, the DON and Regional Clinical Registered Nurse (RN) #444 acknowledged that they did not know for certain the source of the injury and that they had assumed it to be self-inflicted because he moved furniture around often. The SRI was completed after they became aware that the family of Resident #153 had made an allegation of abuse and/or neglect. 2. Review of the medical record revealed Resident #155 was admitted to facility on 03/05/25. Her diagnoses included unspecified dementia, unspecified mood disorder, anxiety disorder, repeated falls, restlessness and agitation. Further review of the residents medical record revealed she was not utilizing or prescribed any anticoagulant medications. Resident #155 passed away on 10/07/25 on hospice care. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of her Minimum Data Set (MDS) dated [DATE] revealed Resident #155 had severe cognitive impairment and was dependent on staff for eating, toileting, showering, dressing, personal hygiene. The MDS revealed she was dependent on staff for rolling left to right, transferring, moving from lying to sitting and walking 10 feet. It was noted she used a manual wheelchair and was dependent on staff for wheeling 150 feet. Review of the care plan entry initiated 03/06/25 revealed Resident #155 had a potential risk for falls related to cognitive function, history of falls, history of fall with fracture, incontinence and recent admission to new environment. Interventions included common area for eating and toileting after lunch, floor mat to floor while resident was in bed, bed in lowest position when occupied and resident to be kept in common area when awake, hipsters to be worn at all times, staff to offer to walk resident when seen trying to get out of wheelchair, proper footwear, offer to toileting prior to dinner, Dycem (pad) to wheelchair, encourage resident to participate in therapies, ensure call light within reach at all times, staff to observe for side effects from psychotropic medication usage, staff to observe for changes in activities of daily living (ADL) ability and adjust assistance provided accordingly. In July 2025, additional fall interventions were added to the care plan including nightstand moved away from head of bed, perimeter mattress, offer snack prior to lunch, and to offer to toilet after breakfast. Review of the progress note for Resident #155 dated 08/22/25 revealed a Certified Nursing Assistant (CNA) alerted the nurse that she noted a bruise while giving a shower to the resident. The nurse assessed the resident to have a right shoulder bruise measuring approximately 13 centimeters (cm) by 7 cm, and a bruise on the right breast and chest area measuring approximately 17 cm x 18 cm. Review of the skin assessment dated [DATE] revealed a right chest area bruise, a bruise to the front right shoulder, a bruise on the rear right shoulder, a right rib area bruise and a right upper arm area bruise. Review of the progress note for Resident #155 dated 08/23/25 revealed a CNA alerted the nurse to a raised area around the neck and pain with palpitations. The nurse called the on call nurse practitioner and an x-ray was ordered. Review of progress note for Resident #155 on 08/24/25 at 11:25 A.M. revealed the x-ray soft tissue result came back as unremarkable. Review of the medical record for Resident #155 revealed no documented evidence of an investigation into the residents bruising from 08/22/25. Review of progress note dated 08/24/25 at 1:49 P.M. revealed a CNA found Resident #155 sitting on the floor next to her wheelchair. The resident was unable to state what had happened. Review of the post fall evaluation progress note for Resident #155 dated 08/24/25 at 3:36 P.M. noted the resident was in a hurry/rush at the time of the fall and that the reason for the fall was not evident. At this time, the resident was assessed to have no new injuries. Review of the progress notes dated 08/25/25 revealed an additional chest and right ribs x-ray was ordered. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of x-ray results dated 08/25/25 revealed Resident #155 had acute fractures of the right fourth and fifth ribs. Review of nursing progress note dated 08/26/25 for Resident #155 revealed certified nurse practitioner (CNP) #422 wrote a new order for Tramadol 50 milligrams (mg) every eight hours for five days for pain. Review of the nurse practitioner progress note for Resident #155 dated 08/27/25 noted Resident #155 had significant agitation and was not as active or mobile due to pain and was noticed to be grimacing at times with movement. The note indicated x-ray results came back and Resident #155 had an acute fracture to the fourth and fifth ribs. Review of the progress notes dated 08/29/25 revealed the nurse notified the nurse practitioner regarding Resident #155's increased weakness and Resident #155 was transferred to the hospital for further evaluation and treatment. Review of the Emergency Medical Service (EMS) Transportation documentation for Resident #155's transfer to hospital dated 08/29/25 revealed the EMS staff were told that the bruises were from a fall on 08/24/25. Review of the hospital after visit summary and hospital documentation dated 08/29/25 revealed the hospital completed chest x-ray's and computerized tomography (CT) scans to the chest, spine and head and they documented the resident was diagnosed with a fall and a closed right clavicle (collar bone) fracture. The documents noted the resident had an age-indeterminate comminuted and displaced fracture of the proximal third of the right collarbone with surrounding thick-walled collection measuring at least 8.8 cm by 4.9 cm that may be related to an evolving hematoma. It also stated that the rib fractures were chronic as were the additional rib deformities, and to follow up with the physician. Interview on 10/16/25 at 10:15 A.M. with the Administrator revealed he was unfamiliar with Resident #155's incident on 08/22/25 and confirmed no SRI had been filed for the incident on 08/22/25 or 08/24/25. Interview on 10/16/25 at 10:28 A.M. with the Director of Nursing (DON) revealed she felt that Resident #155's bruising to the front and back of the shoulder and to the chest on 08/22/25 was due to a fall. She said there weren't any staff members who said they saw this happen though. Interview on 10/16/25 at 5:15 P.M. with Senior Administrator #412 confirmed they had no documentation that any staff interviews were conducted, and that as part of the investigation, they should have documentation of interviews conducted and should retain the documentation. 3. Review of the medical record for Resident #63 revealed an admission date of 05/15/24. Diagnosis included Alzheimer's disease, mood disorder, depression and muscle weakness. Review of Resident #63's care plans revealed no plan related to behaviors of verbal or physical aggression towards other residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 08/06/25 at 8:45 P.M. created by Licensed Practical Nurse (LPN) #168 revealed the nurse heard loud voices coming out of resident's room, another resident was in this resident's room involved in a physical altercation. Both residents were separated with the other resident taken to his room. Resident #63 was noted with a skin tear with scant amount of blood noted to the left forearm, measuring 5 centimeters (cm) by 4 cm. Ice was applied at the area to stop the bleeding. The area was cleaned with Normal Saline, patted dry, steri strips were applied and it was covered with a transparent dressing. Resident #63 denied any pain and declined pain medication at the time. No new skin concerns were noted upon assessment. The residents family and medical director were notified. No new orders were received. Review of Resident #63's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating a moderately impaired cognition for daily decision-making abilities. Resident #63 was noted to display physical and verbal behaviors directed towards others as well as rejection of care. Resident #63 was noted to be free of upper or lower extremity impairments and required a walker for ambulation. He required setup or clean up assistance for eating, oral hygiene, toileting hygiene, and personal hygiene as well as substantial to maximal assistance for bathing and bed mobility. Resident #63 was noted to receive antidepressants and opioids daily. Review of this facility's Self-Reported Incidents (SRI) revealed, an SRI had not been implemented or an investigation completed for the physical altercation incident that occurred between Resident #63 and another unknown resident. Interview on 10/15/2024 at 2:45 P.M. with Senior Administrator #412 confirmed when there was an incident between two residents resulting in an injury, the facility was to implement an SRI and conduct an investigation into that incident. Senior Administrator #412 confirmed the facility did not open an SRI or complete an investigation for an incident that occurred between two residents on 08/06/25. Review of facility policy titled, Abuse, Neglect and Exploitation, dated 01/01/24 revealed that possible indicators of abuse are physical injury of resident, of unknown source. The policy further states that the written procedures for investigations include identifying and interviewing all involved persons including potential witnesses and providing complete and thorough documentation of the investigation. Review of the facility policy titled, Fall Prevention and Management Policy, dated 01/08/25 revealed all falls would be reviewed and investigated. This deficiency represents non-compliance investigated under Master Complaint Number 2599554 and Complaint Number 1392707.