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	11/06/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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 observation, medical record review, staff interviews, review of facility investigations, review of facility Self Reported Incidents (SRI) and review of facility policy, the facility failed to report injuries of unknown sources in a timely manner to the State agency. This affected four of four residents (Residents #7, #11, #14, and #18) reviewed for injuries of unknown sources. The facility census was 72 residents.Findings include: 1. Review of Resident #7's medical record revealed that Resident #7 was admitted to the facility on [DATE] and had diagnoses that included senile degeneration of the brain, schizoaffective disorder, bipolar disorder and dementia. Review of Resident #7's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that she had a Brief Interview for Mental Status (BIMS) score of 00, indicative of severe cognitive impairment. Resident #7 was assessed as being dependent for mobility and for activities of daily living. Review of Resident #7's care plan dated 03/16/24 and revised on 03/29/24 revealed that Resident #7 had an impaired cognitive process for daily decision making, and that she was at risk for impaired communication. Review of Resident #7's outpatient therapy notes dated 08/14/25 revealed no mention of any injuries or markings on or to Resident #7's left lower arm. Review of Resident #7's nursing progress notes dated 08/16/25 revealed that Resident #7 was noted to have bruising to her left lower arm measuring approximately 8 centimeters (cm) by 4 cm. Ice was applied to contain swelling; it was treated, and responsible parties were notified. Review of Resident #7's interdisciplinary team (IDT) progress note authored by the Director of Nursing (DON) on 08/25/25 revealed that Resident #7 was noted to have bruising to her left lower arm measuring approximately 8 cm by 4 cm. The nurse completed a full assessment with no new skin areas noted. Resident #7 denied pain. When asked, Resident #7 stated, Therapy, therapy. Review of the internal investigation of the injury to Resident #7 revealed that a reasonable conclusion was not documented as to what happened to Resident #7 to cause the injury to her lower left arm. The investigation revealed there were no interviews from Resident #7's outpatient therapy staff or Resident #7's daughter who attended therapy with the resident. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the Ohio Department of Health Certification and Licensing website revealed that the injury of unknown source for Resident #7 was not reported to the State agency. An interview with the Director of Nursing (DON) on 11/05/25 at 3:59 P.M. revealed that the DON suspected that Resident #7 ' s injury occurred at outpatient therapy. The interview confirmed that the facility did not interview the outpatient therapy staff and did not interview the daughter of Resident #7 who attended therapy with Resident #7. The DON confirmed that the injury was not reported to the State agency. The DON stated that she would normally document the conclusion of the investigation in the IDT progress notes. The DON confirmed that the conclusion to the investigation was not documented in the IDT progress note. 2. Review of Resident #14's medical chart revealed that Resident #14 was admitted to the facility on [DATE] and had diagnoses that included unspecified dementia, unspecified mood disorder, dementia, and cognitive communication deficit. Review of Resident #14's care plan dated 02/14/23 revealed that she had impaired cognitive process for daily decision making and that she was at risk for impaired communication related to dementia, aphasia and impaired cognition. She was assessed as being dependent for her activities of daily living (ADL) and for mobility. Review of Resident #14's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that she had a Brief Interview for Mental Status (BIMS) of 00, indicative of severe cognitive impairment. Review of Resident #14's nursing progress note dated 08/06/25 revealed that Resident #14 had a bruise to the right side of the forehead, measuring 4 centimeters (cm) by 1.5 cm. Resident #14 was assessed by a nurse, and the physician and family were notified. Review of the interdisciplinary team (IDT) note on 08/06/25 authored by the Director of Nursing (DON) revealed that Resident #14 had a bruise to the right side of the forehead, measuring 4 cm by 1.5 cm. Resident #14 was assessed, and the physician and family were notified. Additionally, it was noted by the DON in the progress note that there was a new treatment to monitor bruising until it was resolved. The IDT note did not reflect the cause of the injury to Resident #14. Review of the investigation of Resident #14's injury of unknown source revealed that Resident #14 was unable to give a description of what caused the injury and that it was unwitnessed. Review of the Ohio Department of Health Certification and Licensing website revealed that the injury of unknown source for Resident #14 was not reported to the State agency. An interview with the Administrator on 11/05/25 at 3:51 P.M. revealed that it was suspected that Resident #14 received the bruise from her broda chair; however, confirmed there were no interventions put into place to prevent future injuries. An interview with the DON on 11/05/25 at 3:59 P.M. confirmed that the injury was not reported to the State agency. The DON revealed on 11/05/25 at 4:07 P.M. that she would normally document the conclusion of the investigation in the IDT progress notes. The DON confirmed that the conclusion to the investigation was not documented in the IDT progress note. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	3. Review of Resident #18's medical chart revealed that she was admitted to the facility on [DATE] and had diagnoses that included Alzheimer's disease, unspecified dementia, and unspecified mood disorder. Review of Resident #18's care plan dated 12/05/23 revealed that she had impaired cognitive processes for daily decision making and that she had impaired communication due to aphasia. Review of Resident #18's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that she had a Brief Interview of Mental Status (BIMS) score of 00, indicative of severe cognitive impairment. Resident #18 was assessed to need touch assistance with mobility. Review of Resident #18's nursing progress notes dated 10/25/25 revealed that Resident #18 was observed with a bruise on the left side of her forehead. The physician and family were notified on 10/25/25. Review of progress notes dated 10/27/25 revealed that Resident #18 went to the hospital for an evaluation of her bruising. Review of Resident #18's hospital notes dated 10/27/25 revealed that a computed tomography (CT) scan to her head and neck were unremarkable with no acute process, and Resident #18 had no neurological changes. Review of the self-reported incident (SRI) #266821 revealed that Resident #18 provided no meaningful information when interviewed about the incident. The SRI revealed that it was not reported to the State agency until 10/27/25, two days after the discovery of the bruise. An interview with the Director of Nursing on 11/05/25 at 3:59 P.M. confirmed that the bruise was discovered on 10/25/25, and the corresponding SRI was not investigated or reported to the State agency until 10/27/25. 4. Review of the medical record for Resident #11 revealed an admission date of 05/24/24 with diagnoses including dementia, psychotic disturbance, mood disturbance, and anxiety. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 03, indicating severe cognitive impairment. Additionally, Resident #11 was assessed as being dependent on staff for personal hygiene care and transfers with limited mobility. Review of the injury report dated 09/20/25 for Resident #11 revealed the resident was noted with a swollen left finger on the left arm and ice was applied while the on-call provider and family were notified. The injury report dated 09/20/25 further stated Resident #11 was not taken to the hospital. There was no indication documented for the cause of the swelling to Resident #11's left hand or wrist. Further review of the witness statements dated 09/18/25 to 09/20/25 revealed no one witnessed or knew how Resident #11's left hand or wrist was injured. Review the progress note dated 09/20/25 revealed Resident #11's left forearm was noted with swelling with purple color. On call Certified Nurse Practitioner (CNP) #233 was notified and an order for an x-ray was completed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the Ohio Department of Health Certification and Licensing website revealed that the injury of unknown source was not reported to the State agency. Review of the progress note dated 09/21/25 for Resident #11 revealed an x-ray result with no acute osseous abnormality, very mild wrist arthritis and the on call CNP #233 was notified and no new orders were given. Review of the provider note dated 09/22/25, written by CNP #233, revealed staff reported a discoloration of the patient's left hand and wrist on 09/22/25. They stated that she did not allow the thumb to be touched and was able to move the left hand, but could not move the left thumb on command. It was an unknown injury. It stated the patient was not appropriately verbal and unable to recall any injury or event. Staff denied any recent falls or injury. Review of the progress note dated 09/22/25, revealed a new order for an x-ray to the left hand with concentration on thumb area. Review of the progress note dated 09/23/25 revealed the x-ray results received with results of acute fracture of the proximal phalanx of the first digit. Resident #11 had a diagnosis of osteopenia. Resident #11 was unable to say how the incident happened due to dementia. Review of the provider note dated 09/24/25, written by CNP #233, revealed a closed fracture of the phalanx of the finger. Observation on 11/05/25 at 8:59 A.M. revealed Resident #11 had a brace on her left wrist and thumb. Interview on 11/05/25 at 4:04 P.M. with the Director of Nursing (DON) revealed she suspected that maybe Resident #11 had placed her left hand near her wheel and it had become caught in the wheel. The DON revealed that she would normally document the conclusion of the investigation in the interdisciplinary (IDT) progress notes. The DON confirmed that the conclusion to the investigation was not documented in the IDT progress note and further confirmed the injury was not reported to the State agency. Review of the facility policy titled Abuse, Neglect, and Exploitation dated 01/01/24 defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of residents, irrespective of any mental or physical condition, cause physical harm, pain, or anguish. Additionally, the facility policy stated under identification of abuse, neglect, and exploitation the possible indicators of abuse, include but are not limited to physical injury of a resident, of unknown source. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The facility policy titled Abuse, Neglect, and Exploitation dated 01/01/24 stated under the reporting/response section that the facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (i.e. law enforcement when applicable) within specified timeframes: immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than twenty-four hours if the events that cause the allegation do not involve abuse and do not involve serious bodily injury. This deficiency represents an example of continued non-compliance investigated under Complaint Number 2656924.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, staff interviews, review of facility investigations and review of facility policy, the facility failed to thoroughly investigate injuries of unknown sources. This affected three (Residents #7, #11, and #14) of four residents reviewed for injuries of unknown sources. The facility census was 72 residents.Findings include: 1. Review of Resident #7's medical record revealed that Resident #7 was admitted to the facility on [DATE] and had diagnoses that included senile degeneration of the brain, schizoaffective disorder, bipolar disorder and dementia. Review of Resident #7's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that she had a Brief Interview for Mental Status (BIMS) score of 00, indicative of severe cognitive impairment. Resident #7 was assessed as being dependent for mobility and for activities of daily living. Review of Resident #7's care plan dated 03/16/24 and revised on 03/29/24 revealed that Resident #7 had an impaired cognitive process for daily decision making, and that she was at risk for impaired communication. Review of Resident #7's outpatient therapy notes dated 08/14/25 revealed no mention of any injuries or markings on or to Resident #7's left lower arm. Review of Resident #7's nursing progress notes dated 08/16/25 revealed that Resident #7 was noted to have bruising to her left lower arm measuring approximately 8 centimeters (cm) by 4 cm. Ice was applied to contain swelling; it was treated, and responsible parties were notified. Review of Resident #7's interdisciplinary team (IDT) progress note authored by the Director of Nursing (DON) on 08/25/25 revealed that Resident #7 was noted to have bruising to her left lower arm measuring approximately 8 cm by 4 cm. The nurse completed a full assessment with no new skin areas noted. Resident #7 denied pain. When asked, Resident #7 stated, Therapy, therapy. Review of the internal investigation of the injury to Resident #7 revealed that a reasonable conclusion was not documented as to what happened to Resident #7 to cause the injury to her lower left arm. The investigation revealed there were no interviews from Resident #7's outpatient therapy staff or Resident #7's daughter who attended therapy with the resident. An interview with the Director of Nursing (DON) on 11/05/25 at 3:59 P.M. revealed that the DON suspected that Resident #7 ' s injury occurred at outpatient therapy. The interview confirmed that the facility did not interview the outpatient therapy staff and did not interview the daughter of Resident #7 who attended therapy with Resident #7. The DON stated that she would normally document the conclusion of the investigation in the IDT progress notes. The DON confirmed that the conclusion to the investigation was not documented in the IDT progress note. 2. Review of Resident #14's medical chart revealed that Resident #14 was admitted to the facility on [DATE] and had diagnoses that included unspecified dementia, unspecified mood disorder, dementia, and cognitive communication deficit. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #14's care plan dated 02/14/23 revealed that she had impaired cognitive process for daily decision making and that she was at risk for impaired communication related to dementia, aphasia and impaired cognition. She was assessed as being dependent for her activities of daily living (ADL) and for mobility. Review of Resident #14's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed that she had a Brief Interview for Mental Status (BIMS) of 00, indicative of severe cognitive impairment. Review of Resident #14's nursing progress note dated 08/06/25 revealed that Resident #14 had a bruise to the right side of the forehead, measuring 4 centimeters (cm) by 1.5 cm. Resident #14 was assessed by a nurse, and the physician and family were notified. Review of the interdisciplinary team (IDT) note on 08/06/25 authored by the Director of Nursing (DON) revealed that Resident #14 had a bruise to the right side of the forehead, measuring 4 cm by 1.5 cm. Resident #14 was assessed, and the physician and family were notified. Additionally, it was noted by the DON in the progress note that there was a new treatment to monitor bruising until it was resolved. The IDT note did not reflect the cause of the injury to Resident #14. Review of the investigation of Resident #14's injury of unknown source revealed that Resident #14 was unable to give a description of what caused the injury and that it was unwitnessed. An interview with the Administrator on 11/05/25 at 3:51 P.M. revealed that it was suspected that Resident #14 received the bruise from her broda chair; however, confirmed there were no interventions put into place to prevent future injuries. An interview with the DON on 11/05/25 at 4:07 P.M. revealed that she would normally document the conclusion of the investigation in the IDT progress notes. The DON confirmed that the conclusion to the investigation was not documented in the IDT progress note. 3. Review of the medical record for Resident #11 revealed an admission date of 05/24/24 with diagnoses including dementia, psychotic disturbance, mood disturbance, and anxiety. Review of the most recent quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 03, indicating severe cognitive impairment. Additionally, Resident #11 was assessed as being dependent on staff for personal hygiene care and transfers with limited mobility. Review of the injury report dated 09/20/25 for Resident #11 revealed the resident was noted with a swollen left finger on the left arm and ice was applied while the on-call provider and family were notified. The injury report dated 09/20/25 further stated Resident #11 was not taken to the hospital. There was no indication documented for the cause of the swelling to Resident #11's left hand or wrist. Further review of the witness statements dated 09/18/25 to 09/20/25 revealed no one witnessed or knew how Resident #11's left hand or wrist was injured. Review the progress note dated 09/20/25 revealed Resident #11's left forearm was noted with swelling with purple color. On call Certified Nurse Practitioner (CNP) #233 was notified and an order for an x-ray was completed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the progress note dated 09/21/25 for Resident #11 revealed an x-ray result with no acute osseous abnormality, very mild wrist arthritis and the on call CNP #233 was notified and no new orders were given. Review of the provider note dated 09/22/25, written by CNP #233, revealed staff reported a discoloration of the patient's left hand and wrist on 09/22/25. They stated that she did not allow the thumb to be touched and was able to move the left hand, but could not move the left thumb on command. It was an unknown injury. It stated the patient was not appropriately verbal and unable to recall any injury or event. Staff denied any recent falls or injury. Review of the progress note dated 09/22/25, revealed a new order for an x-ray to the left hand with concentration on thumb area. Review of the progress note dated 09/23/25 revealed the x-ray results received with results of acute fracture of the proximal phalanx of the first digit. Resident #11 had a diagnosis of osteopenia. Resident #11 was unable to say how the incident happened due to dementia. Review of the provider note dated 09/24/25, written by CNP #233, revealed a closed fracture of the phalanx of the finger. Observation on 11/05/25 at 8:59 A.M. revealed Resident #11 had a brace on her left wrist and thumb. Interview on 11/05/25 at 4:04 P.M. with the Director of Nursing (DON) revealed she suspected that maybe Resident #11 had placed her left hand near her wheel and it had become caught in the wheel. The DON revealed that she would normally document the conclusion of the investigation in the interdisciplinary (IDT) progress notes. The DON confirmed that the conclusion to the investigation was not documented in the IDT progress note. Interview with the Administrator on 11/05/25 at 5:31 P.M. confirmed that he was aware that investigations had not been fully investigated previously and that it was something that would be discussed in future Quality Assurance Performance Improvement (QAPI) meetings. The Administrator revealed that he and the Director of Nursing had been educated on how to thoroughly perform investigations. Review of the facility policy titled Abuse, Neglect, and Exploitation dated 01/01/24 defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of residents, irrespective of any mental or physical condition, cause physical harm, pain, or anguish. Additionally, the facility policy stated under identification of abuse, neglect, and exploitation the possible indicators of abuse, include but are not limited to physical injury of a resident, of unknown source. This deficiency represents an example of continued non-compliance investigated under Complaint Number 2656924.