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	06/10/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, staff interviews, and facility policy review, the facility failed to ensure a dignified dining experience for all residents except those who eat in the dining room. Facility identified 27 Residents (#1, #4, #5, #6, #7, #8, #12, #27, #34, #37, #43, #44, #50, #54, #56, #58, #60, #61, #62, #64, #65, #66, #67, #71, #73, and #74) who eat in the dining room. Facility census was 74. Findings include: Observations on 06/01/26 at approximately 9:00 A.M. revealed residents who did not eat in the dining room were served their meal in the sitting nook on bedside tables that were pulled out from the rooms and/or stored in the corner of the sitting nook. Residents were not provided a stable table to sit at. Resident's food was left on the serving tray and the food covers were not removed for the resident's.Observations on 06/01/26 at approximately 12:45 P.M. revealed residents who did not eat in the dining room were served their meal in the sitting nook on bedside tables. Residents were not provided a stable table to sit at, and were eating their food off bedside tables. Resident food was also served on the serving tray and the food covers were not removed. Observations and interview on 06/03/26 at approximately 1:25 P.M. with Kitchen Manager #137 revealed residents who did not eat in the dining room were served their meal in the sitting nook on bedside tables. She confirmed this was not a dignified home like dining environment and revealed she was not sure why residents were not set up to eat at the tables on the unit or in the dining room. Kitchen Manager #137 also verified resident food was also served and left on the trays without having trays and food covers removed. Kitchen Manager #137 confirmed in the dining room resident have food uncovered and plates are placed on the table along with drinks and silverware. She reported she was unsure why staff did not removed the lids and trays but reported its probably a faster clean up for the staff.Review of facility policy titled Customer Service undated, revealed every resident deserves to be treated with respect and dignity at all times. This deficiency represents non-compliance investigated under Complaint Number 2699816

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure choice was offered for hospice services provider. This affected one resident, (#2) of one residents reviewed for hospice. The facility census was 74.Findings include: Review of the medical record for Resident #2 revealed an admission date of 07/20/18 with diagnoses including dementia with other behavioral disturbance, Diabetes Mellitus due to underlying condition with diabetic autonomic neuropathy, unspecified psychosis not due to a substance or known physiological condition, major depressive disorder, severe with psychotic symptoms and chronic kidney disease stage V. Review of physician orders for Resident #2 revealed an order dated 04/02/26 to admit to Hospice #333 for end stage renal disease. Review of the care plan dated 04/02/26 revealed resident/family has elected hospice care. Admit to Hospice #333 for diagnosis of end stage renal stage. Interventions included all resident/family wishes will be maintained in the clinical record and reviewed on a quarterly and as needed basis to ensure that all wishes are still relevant, encourage activities of choice and coordinate plan of care with resident, family and hospice staff. Review of the Hospice #333 consent form revealed it was signed by Resident #2's Guardian on 03/31/26. An Interview with the Guardian of Resident #2 on 06/01/26 at 4:00 P.M. via telephone revealed they were not offered a choice of hospice providers when hospice services were initiated for Resident #2. The Guardian reported they were simply informed that Resident #2 was being placed on hospice services through a specific hospice agency and were not provided with information regarding alternative hospice providers or given the opportunity to select a hospice agency of their choosing. Subsequent record review for Resident #2 revealed a hospital Discharge summary dated [DATE], which stated the family was initially interested involving hospice but at time of discharge informed hospital they were not ready to transition to hospice at discharge and will consider it at a later time. Interview on 06/03/26 at 4:45 P.M. with the Director of Nursing (DON) verified the facility had no evidence of documentation of any hospice provider choice being offered or conversations regarding which hospice provider the the guardina would like Resident #2 to be referred to. Interview on 06/04/26 at 10:00 A.M. with Director of Social Services #181 revealed she discussed hospice services with Resident #2's family through a care conference. The care conference sign-in sheet provided was dated 04/23/26 after Resident #2 was admitted to hospice. Director of Social Services #181 verified she had no further evidence that a hospice provider of choice was offered for Resident #2. Review of the facility policy titled, Hospice Services Facility Agreement, revised October 2022, revealed it is the policy of this facility to provide and/or arrange for hospice services in order to protect a resident's right to a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the facility. This deficiency represents non-compliance investigated under Complaint Number 2699816

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide spend down notices when resident's personal funds account reached $200 less than the Social Security Insurance resource limit. This affected two residents, (Resident #26 and Resident #47) of five residents reviewed for personal funds. The facility census was 74. Findings include: 1.Resident #26 was admitted [DATE] and had diagnoses that included dementia, psychotic disturbance, and major depressive disorder. Review of the Resident's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #26 was unable to complete an interview to assess mental status. Review of the facility's quarterly statement of resident funds for Resident #26 indicated an ending balance of $4234.16 on 03/31/26. Review of the spend down notice for Resident #26 dated 04/23/26 revealed the Resident Fund balance was within $200 or was exceeding what is allowable under Medical Assistance. Interview with Business Office Manager (BOM) #216 on 06/02/26 at approximately 1:58 P.M. confirmed the spend down limit for Medicaid residents in Ohio was $2000. Interview with BOM # 216 on 06/03/26 at approximately 3:16 P.M. confirmed that last documented spend down notice provided by the facility to Resident #26 was in April 2026. 2.Resident #47 was admitted [DATE] and had diagnoses that included dementia, psychotic disturbance, and chronic kidney disease. Review of Resident #47's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #47 was unable to complete an interview to assess mental status. Review of the facility's quarterly statement of resident funds for Resident #47 indicated an ending balance of $5162.44 on 03/31/26. Review of the spend down notice for Resident #47 dated 04/23/26 revealed the Resident Fund balance was within $200 or was exceeding what is allowable under Medical Assistance. Facility record review documented that both Resident #26 and Resident #47 had Ohio Medicaid as their primary payer of healthcare service. Review of the trial balance of funds handled by the facility for residents revealed Resident # 26 and Resident #47 had balances in excess of $4,500. Interview with Business Office Manager (BOM) #216 on 06/02/26 at approximately 1:58 P.M. confirmed the spend down limit for Medicaid residents in Ohio was $2000. Interview with BOM # 216 on 06/03/26 at approximately 3:16 P.M. confirmed that last documented spend down notice provided by the facility to Resident #47 was in April 2026. This violation represents non-compliance investigated under Complaint 2579178.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy review, the facility failed to ensure the Physician and family were notified of a change in condition. This affected oneresident, (#36) of one reviewed for change in condition. The facility census was 74. Findings include:Review of the medical record for Resident #36 revealed an admission date of 04/22/26. Diagnoses included metabolic encephalopathy, unspecified dementia with behavioral disturbances, Alzheimer's disease, altered mental status, failure to thrive and edema. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 99 indicating resident was rarely if ever understood. The MDS stated Resident was dependent with most activities of daily living and required moderate to maximum assistance for mobility. Review of the plan of care dated 04/04/26 revealed resident had impaired cognitive process for daily decision making and was at risk for further decline in cognitive status. Interventions included to communicate with staff, family, physician and the resident regarding the resident's needs and obtain input from family and friends.Review of physician orders dated 04/24/26 for Amlodipine Besylate (used to treat high blood pressure) oral tablet 10mg to give once daily, Aspirin (analgesic) oral tablet 81 mg delayed release give once daily, Cholecalciferol (vitamin) oral capsule 25 micrograms (mcg) give once daily, Cyanocobalamin (vitamin) oral tablet 500 mcg daily, Memantine (used for dementia) oral tablet 10mg give once daily, Quetiapine (antipsychotic) 25mg give 0.5mg tablet once daily, Divaproex Sodium (anticonvulsant) oral capsule 125 mg delayed release sprinkle give four capsules twice daily all of the prior listed medication were scheduled to be given at 7:00A.M. Resident # 36 also had physician orders dated 04/23/26 for Fluticasone-Salmeterol 250-50mcg aerosol powder give one puff twice daily, Pantoprazole Sodium (proton pump inhibitor) 40 mg oral tablet delayed release give one twice daily, both scheduled at 7:00A.M. and Sucralfate (antiulcer medication) 1 gram (GM) give four times daily an scheduled at 9:00 A.M. and 1:00P.M. Review of physician orders dated 05/29/26 for nicotine transdermal patch 24 hour 14MG/24hr transdermal patch once daily and scheduled for 7:00 A.M.Review of the medical record revealed Resident #36 had not been administered morning medications on 06/04/26. Review of progress notes as of 06/04/26 at 1:29 P.M. revealed no mention of any change in condition, notification to residents family or the physician or Director of Nursing and no indication or documentation that resident was not given any morning medications or had nausea or vomiting. Progress notes did not indicate any mention of care conferences or planning for the care conferences. Interview on 06/04/26 at 12:50 P.M. with Registered Nurse (RN) #162 confirmed Resident #36 had not received any of his morning medications. RN reported he had been ill earlier in the morning and had vomited on the floor. He reported he did not give resident any of his morning medications due to his illness. The RN confirmed he had not informed the family or the Physician of Resident #36's condition and reported he was waiting for the Physician to come onsite to inform them and see what the plan should be. He reported resident had vomited around 8:30 A.M. to 9:00 A.M. and acknowledged it was almost 1:00:P.M. in the afternoon and the resident had afternoon medications coming due. The RN also confirmed he did not complete any assessment (including vital signs) on Resident #36 as he was resting and acknowledged he had not documented anything related to the resident's condition or a reasoning of why Resident #36 missed his morning medication. Interview on 06/04/26 at 1:20 P.M. with the Director of Nursing confirmed her expectation would be with any condition change the Physician or Nurse Practitioner and family to be notified immediately. She confirmed this would include if resident had nausea and vomiting and missed all morning medications. At 2:40 P.M. the DON confirmed after surveyor intervention, she spoke with the medical team and they had been notified and resident had been assessed. Review of facility policy titled Notification of Changes dated 01/01/25 revealed the facility shall promptly inform the physician and residents family for any changes in condition. This deficiency represents non-compliance investigated under Complaint Number 2739488.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and facility policy review, the facility failed to maintain a home like environment by ensuring residents had maintained personal property/personal items This affected one resident (#26) of five reviewed for environment, the facility also failed to ensure the linen provided did not have holes in it this affected one resident (#50) of five reviewed for environment. Facility census was 74. Findings include: 1. Review of the medical record for Resident #26 revealed an admission date of 01/05/24. Diagnoses included dementia without behaviors, psychotic disturbance, vascular dementia, dysphagia and pulmonary disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 99 indicating impaired cognition. Review of the plan of care dated 01/06/25 revealed resident needed encouragement to participate in activities of interest and preferred self-directed activities such as listening to music in his room. The care plan dated 05/01/25 revealed resident had behaviors of hoarding food in drawers. Review of the medical record found no mention of behaviors of removing pictures from his wall or information stating resident was not allowed to have access to his personal items. Observation and interview on 06/01/26 at 11:28 A.M. with Resident #26 revealed he had nothing on his walls but had several pictures on the floors. He stated he was not allowed to hang pictures due to it putting holes in the walls. He had a dresser that had two drawer face boards that were broken off and sitting on top of the dresser. No personal items were observed in the resident's room besides the pictures on the floor. Observation and interview on 06/01/26 at 11:30 A.M. with Certified Nursing Assistant (CNA) #213 confirmed Resident #26 had pictures on the floor as the resident pulled them down. She also reported resident broke the dresser drawer face boards. CNA #213 confirmed it was not easy to open the drawers with the face board broken off and stated maintenance would fix the dresser when able. Interview on 06/01/26 at 2:49 P.M. with Resident #26's representative revealed the resident's room was bare with no personal items put up. He confirmed the resident had a few pictures and also confirmed the resident had a radio but stated it was broken or missing. Interview on 06/03/26 at 8:20 A.M. with the Administrator confirmed the Resident would put his radio in his dresser drawer and he was asked to return the radio to the family. The Administrator showed the radio to the survey team and confirmed it had been in his office for several months. He confirmed the family visits frequently and confirmed he had not returned the radio during any of these visits and had no explanation why he kept the radio in his office and why he had not returned Resident #26's personal belongings to the family. He confirmed staff do not have full access to his office to get the radio if resident had requested it. Review of facility policy titled Resident Rights dated 06/01/24 revealed the facility shall inform the resident of their rights and ensure direct care and indirect care staff were educated on resident (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rights. Review of facility policy titled Safe and Homelike Environment dated 06/01/24 revealed facility shall provide a safe clean and homelike environment allowing resident to use personal belongings to the extent possible. The facility shall create and maintain a homelike environment that deemphasizes the institutional setting including allowing residents to use their personal belongings. 2.Review of medical record for Resident #50 revealed an admission date of 04/24/26 with diagnoses including unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and Type II Diabetes Mellitus. Observation on 06/02/26 at 8:46 A.M. and 3:01 P.M. revealed Resident #50's bed spread with several holes covering her bed. Interview on 06/01/26 at 3:01 P.M. with Certified Nursing Assistant (CNA) #193 verified the several holes in the blanket and it was not appropriate. Interview on 06/04/26 at 2:35 P.M. with Director of Maintenance #152 revealed if the laundry staff have linens with holes in them, they put them in a pile, and he uses them as rags, but the facility had purchased blankets recently. Review of purchasing invoices dated 03/31/26, 04/02/26, and 04/14/26 provided by the facility revealed no blankets had been ordered and verified by the Director of Maintenance #152. Review of facility policy titled Resident Environmental Quality revised 11/29/22, revealed it is the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. This violation represents non-compliance investigated under Complaint 2574479, 2584875, and 2739488.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and medical record review the facility failed to ensure indications for use were appropriate for psychotropic medications for two residents, (#49 and #75) and the facility failed to ensure two residents (#2 and #49) were monitored for psychotropic medication side effects. This affected three out of five residents sampled for unnecessary medications. The facility census was 74.Findings include: 1. Review of Resident # 49's medical record revealed an admission date of 06/21/23 with diagnoses that included but were not limited to dementia, anxiety disorder, mood affect disorder, pseudobulbar affect, psychosis, and frontotemporal neurocognitive disorder. Review of Resident # 49's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severe cognitive impairment and required total assistance from staff with toileting, transfers and hygiene. Further review revealed she received antipsychotics, antianxiety and antidepressant medications with indications for use noted. Review of Resident # 49's active clinical physicians orders for June 2026 revealed the following orders: Order dated 04/24/26 for Seroquel (antipsychotic) Oral Tablet 25 milligrams (mg); give one tablet by mouth every eight hours for agitation.Order dated 05/22/26 for Seroquel Oral Tablet 25 mg; give 25 mg by mouth at bedtime for mood.Order dated 06/05/26 for Depakote (anticonvulsant) Oral Tablet Delayed Release 125 milligram (mg); give three tablets by mouth at bedtime for depression with psychotic features.Order dated 06/05/26 for Depakote Oral Tablet Delayed Release 125 mg; give one tablet by mouth in the afternoon for depression with psychotic features. Review of Resident #49's Medication Administration Records (MARs) dated May 2026, and June 2026 revealed no documentation for monitoring adverse effects of psychotropic medications. Interview on 06/03/26 at 1:50 P.M. with the Director of Nursing (DON) confirmed indications for use for psychotropic medications were not appropriate and there were no orders for monitoring adverse effects or documentation for monitoring adverse effects for Resident # 49's psychotropic medications. 2. Review of the medical record for Resident #2 revealed an admission date of 07/20/18 with diagnoses including dementia with other behavioral disturbance, diabetes mellitus due to underlying condition with diabetic autonomic neuropathy, unspecified psychosis not due to a substance or known physiological condition, major depressive disorder, severe with psychotic symptoms and chronic kidney disease stage V. Review of the most recent significant change Minimum Data Set (MDS) 3.0 assessment for Resident #2 dated 04/08/26 revealed the resident had moderate impaired cognition and indicated Resident #2 had a diagnosis of psychotic disorder, depression and was taking an antipsychotic medication on a routine basis. Review of the physician's order for Resident #2 revealed an order dated 03/28/26 for Quetiapine (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fumarate (an antipsychotic medication) 50 milligrams (mg) by mouth two times a day for agitation and mood disorder; and an order dated 05/09/26 for Quetiapine Fumarate (an antipsychotic medication) 25 mg two times a day for agitation and mood disorder. Review of the medical record for Resident #2 revealed it did not include monitoring of side effects related to the administration of Quetiapine Fumarate. Further review of the medical record for Resident #2 revealed Abnormal Involuntary Movement Scale (AIMS) evaluations were completed on 08/15/25 and 05/13/26. Review of the care plan last revised on 05/12/26, revealed Resident #2 has the potential for adverse side effects of psychotropic drug use related to dementia, depression, psychosis, behaviors, agitation. Interventions included AIMS per policy and as needed and document side effects of medication. Interview on 06/03/26 at 11:44 A.M. with the Director of Nursing (DON) verified AIMS test were not completed per policy and no side effect monitoring was completed for Resident #2. Review of facility policy titled Use of Psychotropic Medication last revised 10/01/22, revealed the indications for use of any psychotropic drug will be documented in the medical record. Residents who receive an antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, quarterly, with a significant change in condition, change in antipsychotic medication, as needed or as per facility policy. The effects of the psychotropic medication on a resident's physical, mental, and psychosocial well-being will be evaluated on an on-going basis. The resident's response to the medication, including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. 3.Review of Resident # 75's medical record revealed an admission date of 10/29/25 with diagnoses that included but were not limited to Alzheimer's disease, dementia with agitation, anxiety and insomnia. Review of Resident # 75's Minimum Data Set 3.0 (MDS) dated [DATE] revealed he had severe cognitive impairment and required assistance from staff with transfers, toileting hygiene and dressing. Further review revealed he received antipsychotic and antidepressant medications with indications for use noted. Review of Resident # 75's clinical physicians orders for June 2026 revealed the following orders: Order dated 05/11/26 for Olanzapine (antipsychotic) Oral Tablet 5 milligrams (mg); give 0.5 tablet by mouth at bedtime for psych. Order dated 05/11/26 for Risperidone (antipsychotic) Tablet 0.25 mg; give one tablet by mouth two times a day related to Dementia with severe agitation. Interview on 06/03/26 at 1:52 P.M. with the DON confirmed indications for use for psychotropic medications were not appropriate for Resident # 75's psychotropic medications. This deficiency represents non-compliance investigated under Complaint Number 2739488.

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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, staff interview and policy review, the facility failed to complete a thorough investigation of injuries of unknown origin. This affected two residents (#20 and #83) of two reviewed for abuse investigations. Facility census was 74. Findings include:1. Review of the medical record for Resident #20 revealed an admission date of 04/10/26. Diagnoses included displaced fracture of lateral left fibula, right femur fracture, wedge compression fracture, dementia without behaviors, kidney disease, muscle weakness, and osteoporosis. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of six indicating impaired cognition and required partial moderate assistance with activities of daily living.Review progress notes dated 04/14/26 revealed during morning rounds resident was observed to be lying in bed holding her right leg and yelling in pain. The resident was unable to state if she had fallen and a stat X-ray was ordered. The X-ray later resulted and identified a fracture of the neck of the right femur and the resident was sent to the hospital for further treatment. Review of the Self-Reported Incident (SRI) investigation number 273302 revealed staff became aware of the incident on 04/14/26 and informed the Administrator on 04/14/26 around 2:00 P.M. The resident had pain in the right leg that was found to be a femur fracture without a known cause. The investigation reviewed the injury of unknown origin and revealed the resident had recently sustained a fracture of the humorous at the previous facility and a fractured finger while at the hospital. The investigation stated facility shall do a look back of staff from the past 72 hours. The schedule revealed within the past 72 hours, Registered Nurses (RN) #127 and #199, Licensed Practical Nurses (LPN) #117, #133, #143, and Certified Nursing Aides (CNA) #106, #138, #142, #154, #169, #173, #213, #217, #223, and #225 had worked on Resident #20's hall. Review of staff interviews revealed LPN #133 and #143 and CNA #138 and #169 were interviewed by management but no statements were provided. LPN #117 and CNA #154 and #225 were contacted with no return calls made and no statements provided. RN #127 and #199, and CNA #106, #142, #173, #213, #217, and #223 were not interviewed or attempted to be interviewed and no statements were provided. The investigation also did not include staff education and did not include review or interviews with like residents. Interview on 06/03/26 at 8:35 A.M. with the Administrator confirmed several staff members were contacted but did not return their call to provide a statement and several staff were not interviewed. He also confirmed the file had no evidence of staff education and no mention of like residents having interviews or skin checks.2. Review of the medical record for Resident #83 revealed an admission date of 08/30/24 and discharge date on 03/30/26. Diagnoses included Alzheimer's disease, vascular dementia, and mood disorder. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 99 indicating impaired cognition Resident #83 required substantial maximum assistance with activities of daily living.Review progress notes dated 03/23/26 revealed staff found a discoloration to the right buttocks with outer edges yellow and center was purple. Resident was guarding his hip. An X-ray was completed and found no fracture or dislocation. Review of the Self-Reported Incident (SRI) investigation number 272461 revealed staff became aware of the incident on 03/23/26 around 2:00 P.M. The resident had a large bruise of unknown source. The investigation revealed the injury of unknown origin investigation did not state which staff reported the incident and what hall the resident resided on. The statements obtained came from staff working various halls according to review of the staff schedules. Interviews and statements were conducted with LPN #171 and CNA #190 and #214. Additional staff working from 03/22/26 to 03/23/26 included RN #116 and #162, LPN #105, #115, #133, #198, and #300, and CNA's #126, #131, #142, #154, #159, #163, #193, #204, #208, #213, #225, #305, #310. The investigation found no evidence of staff training of abuse and no evidence of an assessment being completed for Resident #83.Interview with the Administrator on 06/03/26 at 8:35 A.M. confirmed the injury of unknown origin was reported to him about 24 hours (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after it was found and then he reported it and began the investigation. Review of facility policy titled Abuse, Neglect and Exploitation dated 01/01/24 revealed facility shall investigate suspicion of abuse or neglect including interviewing all persons including the alleged victim, perpetrator any possible witnesses. Facility shall also complete thorough documentation of the investigation. This deficiency represents non-compliance investigated under Complaint Number 2994932 and Complaint Number 2739488.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of hospital records, and staff interview, the facility failed to notify the Office of the State Long-Term Care Ombudsman regarding a hospitalization and transfer for one resident (Resident #35) and failed to assist one resident (Resident #8) with discharge planning services. This affected two residents (#35 and #8) of three residents reviewed for discharge planning. The facility census was 74. Findings Include: 1. Review of Resident #35's medical record revealed an admission date of 08/21/24 with diagnoses including Alzheimer's dementia with behavioral disturbance, chronic obstructive pulmonary disease (COPD), essential hypertension, and right hip fracture. Review of hospital records revealed Resident #35 was transferred to the hospital on [DATE] following a fall on 05/12/26 which resulted in right hip pain. Continued review revealed Resident #35 was diagnosed with a right femur fracture and underwent a right hip hemiarthroplasty on 05/14/26. The resident returned to the facility on [DATE] following hospitalization and surgical repair. Review of the facility documentation dated 05/21/26 revealed Resident #35 returned to the facility with post-operative care needs including pain management, wound care, physical therapy, occupational therapy services, and fall precautions. Documentation further revealed the resident required substantial to maximal assistance with activities of daily living following the hospitalization. Interview with the Director of Nursing (DON) on 06/04/26 revealed the requested documentation related to care conferences and transfer documentation for Resident #35 was not available. The DON verified no documentation was available demonstrating the Office of the State Long-Term Care Ombudsman had been notified regarding Resident #35's hospitalization and transfer. Interview with Social Services Director #181 on 06/05/26 at 10:36 A.M. Social Services Director #181 stated the Ombudsman was not notified of Resident #35's hospitalization because she was unaware such notification was required. Social Services Director #181 further stated the facility had discussed the issue and was creating a tracking log to ensure future Ombudsman notifications were completed. Social Services Director #181 was unable to provide documentation demonstrating the Ombudsman had been notified regarding Resident #35's hospitalization and transfer. No documentation was provided prior to survey exit to support notification occurred. 2. Review of Resident # 08's medical record revealed an admission date of 10/28/21. Diagnoses included Alzheimer's disease, dementia, mood affective disorder and multiple sclerosis. Review of Resident # 08's Minimum Data Set 3.0 (MDS) dated [DATE] revealed the resident had severe cognitive impairment and required total assistance from staff with incontinence care, transfers and mobility. Interview on 06/04/26 with Resident #08's power of attorney (POA) revealed in November 2025 she requested the facility initiate transfer to a different facility. She stated the facility had not followed up with getting needed information or regarding status of the transfer from the requested facility. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/04/26 at 9:25 A.M. with the Social Services Director #181 revealed the process for transferring a resident to another facility is once the request was received from family, the facility sends all the required information, logs it in the transfers log and notifies the Ombudsman's office. She stated the facility follows up with the transfer request for any additional information they may need and the status of the transfer. Interview on 06/04/26 at 9:28 A.M. with the Administrator verified there was a request for transfer in November 2025, and he stated he sent the requested information; however, he had not followed up on the status and had no documentation of sending requested documents or communication with the transfer facility. The Administrator verified the facility was responsible for coordinating the transfer and following up with the transfer request and he had no evidence it was completed for Resident #08. This deficiency represents non-compliance investigated under Complaint Number 2667090.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident representative interviews and policy review, the facility failed to ensure a care plan was created for communication and language services for Resident #36, contractures for Resident #55, and physical therapy services for Resident #84. This affected three (#36, #55 and #84) of 20 residents in the sample reviewed for care planning. The facility census was 74. Findings include 1. Review of the medical record for Resident #36 revealed an admission date of 04/22/26. Diagnoses included metabolic encephalopathy, unspecified dementia with behavioral disturbances, Alzheimer's disease, altered mental status, failure to thrive and edema. Review of the plan of care dated 04/04/26 revealed resident had impaired cognitive process for daily decision making and was at risk for further decline in cognitive status with interventions to communicate with staff, family, physician and the resident regarding the resident's needs and obtain input from family and friends. The care plan dated 05/01/26 revealed no care plan for communication or language and no interventions for a Resident who spoke Somali and did not speak or understand English. A special instruction note was documented in the medical record and stated Resident #36 spoke Somali and to call the interpreter and provided the phone number. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 99 indicating resident was rarely if ever understood. The MDS stated Resident was dependent with most activities of daily living and required moderate to maximum assistance for mobility. Interview on 06/01/2026 5:23 PM with Resident #36's representative who reported he spoke Somali. He revealed he understands Somali and at times can respond. He confirmed Resident #36 did not speak or understand English. He revealed concerns of how staff communicate with him as they have been using family to translate and felt it inappropriate to communicate medical needs without a actual interpreter. and family reported staff do not speak somali and do not use a translator. Observations on 06/01/26 at 1:10 P.M. revealed Resident #36 received his meal tray and staff were assisting resident. The Director of Nursing was also present and was speaking to him in English. Observation on 06/04/26 at 12:45 P.M. revealed Resident #36 got out of bed and wandered into another resident's room across the hall. Registered Nurse (RN) #162 redirected resident and walked him to dining area and handed him off to a Certified Nurse Aide (CNA). CNA #204 was talking with resident and giving instructions to go to the table to eat she was speaking in English with no staff attempting to use translator service. Interview on 06/04/26 at 12:50 P.M. with RN #162 confirmed Resident #36 did not speak English and spoke Somali. He confirmed facility staff should be reaching out to family or using the interpreter phone line to speak with resident. Interview on 06/04/26 at 4:03 P.M. with CNA #204 confirmed Resident #36 spoke Somali but stated (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he understood English and she would just gesture to him to communicate and stated she would expect him to gesture as well. She stated no staff spoke Somali from her knowledge and reported she was unaware of any translation services or communication devices available for use. Interview 06/04/26 at 4:30 PM with the Director of Nursing (DON) confirmed therapy had provided a communication board and they have a translator services staff can use to communicate with Resident #36. The DON confirmed Resident did note have a communication/language care plan. 2. Review of the medical record for Resident #55 revealed an admission date of 10/30/12 with diagnoses including neurocognitive disorder with Lewy Bodies, aphasia, contracture, unspecified joint, adult failure to thrive, muscle wasting and atrophy, unspecified site, and unspecified psychosis not due to a substance or known physiological condition. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS) could not be conducted, the resident was dependent for all care, and Section GG indicated Resident #55 had no impairments to upper or lower extremities. Review of Resident #55's physicians orders dated 09/22/25 revealed an order place two rolled washcloths in bilateral hands at all times while at rest. Review of the Activities of Daily Living (ADL) care plan last revised 10/30/20 revealed Resident #55 has self-care deficits, requires total assistance with ADL's and is non-ambulatory. Interventions included rolled washcloths to both hands as ordered. Further review of Resident #55's care plan revealed there was no care plan addressing the residents contractures. Subsequent record review revealed a podiatry consult progress note dated 12/24/25 revealed Resident #55 has mild contractures to knees bilaterally. Interview on 06/04/26 at 1:48 P.M. with Director of Rehab #175 revealed Resident #55 has not had any physical therapy services within the last year and could not verify if Resident #55 had contractures to lower extremities. Director of Rehab #175 verified Resident #55 had bilateral hand contractures and therapy recommendations dated 09/22/25 revealed to place rolled wash cloths in hands. Interview on 06/04/26 at 2:55 P.M. with the Director of Nursing (DON) verified there was no care plan in place for contractures to upper and lower extremities and no further contracture management was in place to prevent contractures from worsening to lower extremities. 3. Review of the medical record for Resident #84 revealed the resident was admitted on [DATE] and had diagnoses that included Type 2 Diabetes Mellitus, acquired absence of right foot, and acquired absence of other left toes. Review of the Resident's Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicates Resident #84 had severe cognitive impairment and the resident used physical therapy services in the last 7 days. Review of the medical record for Resident #84 revealed orders written on 11/13/25 for physical therapy five times a week for 30 days for gait training, neuromuscular reeducation, therapeutic exercise, therapeutic activity, and group (activity.) Review of the care plan for Resident #84 found no (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record for the provision of physical therapy services or objectives of physical therapy service to meet resident medical needs. Interview with Director of Nursing (DON) #156 was conducted at 9:13 A.M. on 06/08/26. DON #156 confirmed that there was no information about physical therapy contained in Resident #84's care plan. Review of facility policy titled Comprehensive Care Plans (Revised 8/22/22) states that the comprehensive care plan will describe services that are furnished (to a Resident) to attain or maintain the resident's highest practicable physical well-being. This deficiency represents non-compliance investigated under Complaint Number 3013989.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident representative interviews and policy review, facility failed to ensure care conferences were completed as required and completed as scheduled. This affected two (#36 and #35) of two residents reviewed for care conferences. The facility census was 74. Findings include: 1. Review of the medical record for Resident #36 revealed an admission date of 04/22/26. Diagnoses included metabolic encephalopathy, unspecified dementia with behavioral disturbances, Alzheimer's disease, altered mental status, failure to thrive and edema. Review of the plan of care dated 04/04/26 revealed resident had impaired cognitive process for daily decision making and was at risk for further decline in cognitive status with interventions to communicate with staff, family, physician and the resident regarding the resident's needs and obtain input from family and friends. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 99 indicating resident was rarely if ever understood. The MDS stated Resident was dependent with most activities of daily living and required moderate to maximum assistance for mobility. Review of the medical record found no evidence related to care conferences being completed or being scheduled. Interview on 06/01/26 at 5:12 P.M. with Resident #36's representative reported he had a care conference scheduled with facility staff on 06/01/26 and no one contacted him. He reported he called in several times and no one provided him an update. He revealed he had no care conferences since Resident admitted to the facility and confirmed was unsure of residents medical needs as he had not receive updates. Interview on 06/03/26 at 10:30 A.M. with Social Services Designee (SSD) #181 and the Director of Nursing (DON) confirmed Resident #36 had not had a care conference since his admission. They reported resident and several family members speak Somali and they found a family member that speaks English. SSD #181 confirmed they had a care conference scheduled for 06/01/26 and it had to be rescheduled for 06/08/26 due to the Ohio department of health coming for the annual survey. She confirmed after surveyor intervention, Resident's family was informed of the rescheduled care conference on 06/03/26. SSD confirmed the resident had been admitted since 04/22/26. 2. Review of Resident #35's medical record revealed an admission date of 08/21/24 with diagnoses including Alzheimer's dementia with behavioral disturbance, chronic obstructive pulmonary disease (COPD), essential hypertension, and right hip fracture. Review of facility documentation revealed Resident #35 experienced a fall on 05/12/26 and was transferred to the hospital on [DATE] for evaluation of right hip pain. Hospital records revealed Resident #35 was diagnosed with a right femur fracture and underwent a right hip hemiarthroplasty on 05/14/26. The resident returned to the facility on [DATE] with physician orders for pain management, wound care, physical therapy, occupational therapy, and fall precautions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of ADL documentation following the resident's return from the hospital revealed Resident #35 required substantial to maximal assistance with dressing, toileting, personal hygiene, transfers, and bed mobility. Documentation supported the resident experienced significant changes in mobility and functional status following the fracture and surgical repair. Review of facility documentation dated 05/21/26 revealed Resident #35 returned to the facility following hospitalization for a right hip fracture and surgical repair. Documentation indicated the resident was medically stable, working with therapy services, and had post-operative care needs including pain management, aspirin therapy, wound care, and rehabilitation services. Interview with the DON on 06/04/26 revealed surveyor had requested documentation of care conferences completed for Resident #35 since January 2026. The DON confirmed SSD #181 reported that no care conferences had been completed for Resident #35 since January 2026. The DON further confirmed no care conference was conducted following the resident's hospitalization and return to the facility after sustaining a fall resulting in a major injury. The DON acknowledged no documentation was available to support that a care conference had been completed during that time period. Interview with SSD #181 on 06/05/26 at 10:36 A.M. revealed an email review confirmed no care conferences had been scheduled or completed for Resident #35 since January 2026. SSD #181 was unable to provide documentation demonstrating the interdisciplinary team met to review and revise the resident's care plan following the hospitalization, right hip fracture, surgical repair, and return to the facility with new care needs. Review of the facility's Comprehensive Care Plan policy revealed the facility will develop and implement a comprehensive person-centered care plan based upon identified resident needs and interdisciplinary assessment findings. The policy further indicated care plans should address services necessary to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. This deficiency represents non-compliance investigated under Complaint Numbers 2748921 and 2739488 and 2699816.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff and family interviews and policy review, the facility failed to ensure communication and language services were provided to a resident who did not understand or speak English. This affected one (#36) of one residents reviewed for language/communication. The facility census was 74. Findings include:Review of the medical record for Resident #36 revealed an admission date of 04/22/26. Diagnoses included metabolic encephalopathy, unspecified dementia with behavioral disturbances, Alzheimer's disease, altered mental status, failure to thrive and edema. Review of the plan of care dated 04/04/26 revealed resident had impaired cognitive process for daily decision making and was at risk for further decline in cognitive status with interventions to communicate with staff, family, physician and the resident regarding the resident's needs and obtain input from family and friends. The care plan dated 05/01/26 revealed no care plan for communication or language and no interventions for a Resident who spoke Somali and did not speak or understand English. A special instruction note was documented in the medical record and stated Resident #36 spoke Somali and to call the interpreter and provided the phone number. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 99 indicating Resident #36 was rarely if ever understood. The MDS stated Resident was dependent with most activities of daily living and required moderate to maximum assistance for mobility. Interview on 06/01/26 5:23 PM with Resident #36's representative reported Resident #36's speaks Somali. He revealed he understands Somali and at times can respond. He confirmed Resident #36 did not speak or understand English. He revealed concerns of how staff communicate with him as they have been using family to translate and felt it inappropriate to communicate medical needs without a actual interpreter. He stated family reported staff do not speak Somali and do not use a translator. Observations on 06/01/26 at 1:10 P.M. revealed Resident #36 received his meal tray and staff were assisting resident. The Director of Nursing (DON) was also present and was speaking to him in English. Observation on 06/04/26 at 12:45 P.M. revealed Resident #36 got out of bed and wandered into another resident's room across the hall. Registered Nurse (RN) #162 redirected the resident and walked him to dining area and handed him off to a Certified Nurse Aide (CNA). CNA #204 was talking with resident and giving instructions to go to the table to eat she was speaking in English with no staff attempting to use translator service. Interview on 06/04/26 at 12:50 P.M. with RN #162 confirmed Resident #36 did not speak English and spoke Somali. He confirmed facility staff should be reaching out to family or using the interpreter phone line to speak with resident. Interview on 06/04/26 at 4:03 P.M. with CNA #204 confirmed Resident #36 spoke Somali but stated he understood English and she would just gesture to him to communicate and stated she would expect him to gesture as well. She stated no staff spoke Somali from her knowledge and reported she was unaware of any translation services or communication devices available for use. Interview 06/04/26 at 4:30 PM with the DON confirmed therapy had provided a communication board and they have a translator services staff can use to communicate with Resident #36. She confirmed staff should be communicating with resident using appropriate language services. This deficiency represents non-compliance investigated under Complaint Number 2994932.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities designed to meet the interests, preferences, and psychosocial needs of residents. This affected four residents (#5, #28, #35, and #54) of four residents reviewed for activities. The facility census was 74. 1. Review of Resident #35's medical record revealed an admission date of 08/21/24 with diagnoses including Alzheimer's dementia with behavioral disturbance, chronic obstructive pulmonary disease (COPD), essential hypertension, weakness, difficulty walking, unsteadiness on feet, and right hip fracture. Review of the quarterly Care Conference Summary dated 01/22/26 revealed Resident #35 enjoyed socializing within the unit, watching television, and attending movie and popcorn activities. The review further documented the resident generally refused daily group activities but tolerated one-to-one activities. Review of the Activities Quarterly/Annual Participation Review dated 02/25/26 revealed Resident #35 preferred one-to-one visits or in-unit activities with occasional group activities. The assessment documented the resident preferred low-stimulation activities due to decreased energy levels, enjoyed visual entertainment, movie events with popcorn, and select social gatherings when able. Review of activity documentation revealed extremely limited evidence that one-to-one visits, individualized activities, or in-unit programming were provided to Resident #35 consistent with the resident's assessed preferences. Observation of the 100 Hall on 06/01/26 at 9:00 A.M., 10:45 A.M., 12:15 P.M., 1:50 P.M., and 3:35 P.M. revealed residents, including Resident #35, were either seated in the common area or remained in their rooms. During each observation, residents were observed listening to music or sitting quietly. No organized activities, individualized programming, one-to-one visits, or staff-facilitated engagement were observed. Observation of the facility on 06/01/26 from 3:12 P.M. until 3:30 P.M. revealed residents on the 100 Hall were seated in the common area with a television on. No organized activity, staff-facilitated engagement, or individualized activity programming was observed. Residents appeared to be sitting quietly with minimal interaction noted. Review of the facility activity calendar revealed Oldies Music with Karaoke was scheduled during the observation period. At approximately 3:25 P.M., CNA #163 stated, I'm not in activities and I'm the only one on the floor right now. Interview with Activities Director #192 on 06/02/26 at 2:18 P.M. revealed one-to-one activities had not been documented as required. Activities Director #196 stated, To be honest, those 1:1 documents haven't been documented like they should be. We have the residents identified, but the paperwork isn't there. Activities Director #196 further stated activities were not being tracked on weekends and acknowledged resident-specific programs were not being completed consistently. Interview with the Administrator on 06/01/26 at 3:40 P.M. revealed his expectation was for CNAs to assist residents to and from scheduled activities. When informed of surveyor observations of residents sitting in common areas with limited to no staff-facilitated engagement or structured activity programming occurring throughout the survey, the Administrator stated staff should know better. When asked how the facility verified scheduled activities were occurring during evenings and (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weekends, the Administrator acknowledged, That is a good point. We don't have anything. 2. Review of Resident #54's medical record revealed an admission date of 03/15/24 with diagnoses including senile degeneration of the brain, schizoaffective disorder bipolar type, dysphagia, congestive heart failure, chronic kidney disease, Type 2 diabetes mellitus with hyperglycemia, and hypertension. Review of the Activities Quarterly/Annual Participation Review dated 04/27/26 revealed Resident #54 attended activities of choice in the activity room or on the unit. The assessment further documented Resident #54 enjoyed socializing with other residents, live music, and painting. The assessment indicated activity-related goals were being met and interventions were effective. Observation of the 100 Hall on 06/01/26 at 9:00 A.M., 10:45 A.M., 12:15 P.M., 1:50 P.M., and 3:35 P.M. revealed residents were either seated in the common area or remained in their rooms. Residents were observed listening to music or sitting quietly. No organized activities, painting activities, social activities, individualized programming, or staff-facilitated engagement were observed. Observation of the facility on 06/01/26 from 3:12 P.M. until 3:30 P.M. revealed residents on the 100 Hall were seated in the common area with a television on. No organized activity, staff-facilitated engagement, or individualized activity programming was observed. Residents appeared to be sitting quietly with minimal interaction noted. Interview with Activities Director #192 on 06/02/26 at 2:18 P.M. revealed one-to-one activities had not been documented as required and activities were not being tracked on weekends. Activities Director #192 further acknowledged resident-specific activity programs were not consistently occurring. Interview with the Administrator on 06/01/26 at 3:40 P.M. revealed his expectation was for residents to be assisted to activities and for scheduled activities to occur. When informed of surveyor observations showing limited resident engagement and no structured activity programming, the Administrator stated staff should know better. The Administrator further acknowledged the facility did not have a method to verify scheduled activities were occurring during evenings and weekends. 3.Review of Resident #28's medical record revealed an admission date of 04/26/24 with diagnosis including fracture of fourth thoracic vertebra, dementia, adjustment disorder with mixed disturbance of emotions and conduct, insomnia, and Alzheimer's disease. Review of the activities assessment dated [DATE] revealed Resident #28 prefers to do activities on the unit, resident enjoys watching tv on the unit. Review of the activities assessment dated [DATE] revealed Resident #28 enjoys in unit socialization with an occasional group led activity, enjoys watching classic movies with his peers on unit. He also enjoys when we have live music and social events. Resident #28 also enjoys walking outside when weather permitted. Review of most recent Minimal Data Set (MDS) assessment dated [DATE] revealed Resident #28 with severe cognitive impairment. Review of the significant change MDS dated [DATE] revealed Resident #28 likes to be around (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	animals, likes to do favorite activities, enjoys going outside to get fresh air when the weather is good, listens to music, and to do favorite activities. Observations made on 06/01/26 at 11:30 A.M. and 3:00 P.M.; and 06/02/26 at 10:00 A.M. and 2:00 P.M. revealed Resident #28 laying in his bed and no independent preferred or group activities provided. Interview on 06/02/26 at 2:18 P.M. with the Activities Director #192 revealed 1-on-1 activities for residents with high-acuity needs or cognitive impairments she performs 1-on-1 visits but acknowledged these are not documented, noting she was unaware of the requirement to document these interactions until recently. Reviewed activity documentation for Resident #28 from January 2026 through June 2026 revealed 1-on-1 activities ranging from walking on unit, listening to music, folding laundry, coloring, playing ball toss and reading. 1-on1 activities being provided eight times a month. Interview on 06/03/26 at 3:38 P.M. with Certified Nursing Assistant (CNA) #136 revealed she does not do activities with residents. The activity department does the activities. She knows what activities they are having by the calendar on the wall. Interview on 06/03/26 at 3:41 P.M. with CNA # 213 revealed she does assist with the activities in the evenings. The residents watch tv and play music. Interview on 06/03/26 at 3:43 P.M. with Licensed Practical Nurse (LPN) #182 revealed she does a lot of activities with the residents. She plays music and dances with them. Interview on 06/04/26 at 10:03 A.M. with Activities Director #192 stated she provided the documentation she had for activities. No other documentation to indicate Resident #28 was provided activities per preference. 4. Review of Resident #5's medical record revealed an admission date of 08/10/22 with diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance, major depressive disorder, unspecified mood (affective) disorder, pre-excitation syndrome, difficulty in walking ad muscle weakness. Review of activities care plan last revised 11/23/25 revealed Resident #5 needs encouragement to participate in activities of interest, is dependent on staff for activities, cognitive stimulation, social interaction due to cognitive impairment. He enjoys physical activities such as bowling, ball toss, basketball, parties and social events, morning coffee socials and walking on the unit and socializing with his peers. Interventions included arrange for activity aide to visit and encourage resident to observe or designate activity, assist/escort to activities of choice that reflect prior interests and desired activity level, encourage resident to participate in group activities and engage resident in group activities. Review of activities progress notes from March 2026 through June 2026 revealed five documented group activities Resident #5 participated in. Review of one-on-one activity documentation from January 2026 through June 2026 revealed eight one-on-one sessions a month provided by activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the most recent activities quarterly assessment dated [DATE] revealed Resident #5 prefers group activities and social events, physical sports, coffee socials and other party settings. Interview on 06/02/26 at 2:18 P.M. with the Activities Director #192 revealed 1-on-1 activities for residents with high-acuity needs or cognitive impairments she performs 1-on-1 visits but acknowledged these are not documented, noting she was unaware of the requirement to document these interactions until recently. Interview on 06/03/26 at 3:38 P.M. with Certified Nursing Assistant (CNA) #136 revealed she does not do activities with residents. The activity department does the activities. She knows what activities they are having by the calendar on the wall. Interview on 06/03/26 at 3:41 P.M. with CNA # 213 revealed she does assist with the activities in the evenings. The residents watch tv and play music. Interview on 06/03/26 at 3:43 P.M. with Licensed Practical Nurse (LPN) #182 revealed she does a lot of activities with the residents. She plays music and dances with them. Interview on 06/04/26 at 10:03 A.M. with Activities Director #192 stated she provided the documentation she had for activities. No other documentation to indicate Resident #5 was provided activities per preference. Review of the facility policy titled Activities, revised 06/01/24 revealed it is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community. This deficiency represents non-compliance investigated under Complaint Number 2739488.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. Based on personnel file review, facility record review, staff interviews, and facility policy review, the facility failed to ensure the activities program was directed by a qualified activities professional. This had the potential to affect all 74 residents residing in the facility. The facility census was 74. Findings include:Review of the facility Activity Director job description revealed the primary purpose of the position was to plan, organize, develop, direct, and implement the overall operation of the activity department to ensure an ongoing program of activities designed to meet the interests and physical, mental, and psychosocial well-being of each resident. Continued review revealed the Activity Director must be a qualified therapeutic recreation specialist, a licensed activities professional, possess qualifying experience in a patient activities program, be a qualified occupational therapist or occupational therapy assistant, or have completed an approved training course. Review of the personnel file for Activity Director #192 revealed the there was no documentation present to support the staff met the qualifications required to direct the facility's activities program. Review of facility staff roster revealed the facility only had one activity staff, Activity Director #192. Interview with the Administrator on 06/01/26 at 3:40 P.M. revealed his expectation was for Certified Nursing Assistants (CNA's) to assist residents to and from activities and follow the activity calendar. When the Administrator was informed of surveyor observations of residents sitting in common areas with limited engagement, the Administrator stated staff should know better. When asked how the facility verified scheduled activities were occurring during evenings and weekends, the Administrator acknowledged, That is a good point. We don't have anything. Interview with the Activities Director #192 on 06/02/26 at 2:18 P.M. confirmed she was not currently certified to serve as a Activity Director and had not received formal training specific to the Activities Director position. Activities Director #192 also revealed after 3:00 P.M. and on Saturdays/Sundays, the facility CNAs/Aids are responsible for resident engagement; however, confirmed there is no current process to verify or prove these activities are completed. The Activities Director #192 stated activity programming ideas are sourced from the internet and the final activity calendar is reviewed and approved by the Administrator. Activities Director #192 confirmed one-to-one activity visits were not being documented as required, stating To be honest, those 1:1 documents haven't been documented like they should be. We have the residents identified, but the paperwork isn't there. When asked how weekend activities were tracked, Activity Director #192 stated, Activities are not being tracked on the weekend right now. It really just depends on which staff are on the floor and if they have time. It's not consistent. Interview with Human Resources Director (HRD) #210 on 06/02/26 at 2:33 P.M. revealed the facility did not provide formal activity-related training courses or modules for Activity Aides or CNA's responsible for resident engagement. HRD #210 further confirmed the facility had not employed a CNA since 04/07/26 and the position remained vacant. Review of the facility Activities policy dated 06/01/24 revealed the facility was expected to provide an ongoing program of activities based upon each resident's comprehensive assessment, care plan, interests, and preferences. The policy further indicated activities may be provided through group programming, individualized activities, and one-to-one programming designed to meet resident needs and preferences.This deficiency represents non-compliance investigated under Complaint Numbers 2739488, 2730063, 2994932, and 2748921.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on record review and staff interview, the facility failed to ensure timely completion of an ordered diagnostic test following a fall for one resident (Resident #35) reviewed for quality of care. This affected one (#35) of one residents reviewed for quality of care. The facility census was 74. Findings include: Review of Resident #35's medical record revealed an admission date of 08/21/24 with diagnoses including Alzheimer's dementia with behavioral disturbance, chronic obstructive pulmonary disease (COPD), essential hypertension, weakness, difficulty walking, unsteadiness on feet, and right hip fracture. Review of Resident #35's most recent Minimum Data Set (MDS) assessment completed prior to the fall revealed the resident required staff assistance with activities of daily living but remained mobile within the facility. The assessment further revealed Resident #35 was able to transfer with staff assistance and ambulate 10 feet. Review of facility documentation revealed Resident #35 sustained a fall on 05/12/26 while attempting to walk to the bathroom. Documentation and staff interview revealed the Certified Nurse Practitioner (CNP) was notified and an x-ray was ordered following the fall due to the resident's condition and complaints of pain. Review of hospital records revealed Resident #35 presented to the emergency department on 05/13/26 with right hip pain following the fall. Continued review revealed the resident was diagnosed with a right femoral neck fracture and underwent a right hip hemiarthroplasty on 05/14/26. The resident was discharged back to the facility on [DATE] with physician orders for pain management, wound care, therapy services, and fall precautions. Review of facility documentation dated 05/21/26 revealed Resident #35 returned to the facility following hospitalization and surgical repair of the fracture. Documentation indicated the resident required post-operative care, rehabilitation services, pain management, and increased assistance with daily care needs. Interview with the Director of Nursing (DON) on 06/04/26 at 11:15 A.M. revealed Resident #35 sustained a fall on 05/12/26 and the CNP ordered an x-ray shortly thereafter. The DON stated when she arrived at the facility the following day, she discovered the ordered x-ray had not been completed. The DON stated she contacted the CNP regarding the missed diagnostic testing. The DON confirmed the CNP subsequently ordered a STAT x-ray. The DON further confirmed the STAT x-ray identified a femoral neck fracture and the resident was transferred to the hospital for further evaluation and treatment. The DON confirmed the originally ordered x-ray was not completed as directed following the fall. The facility failed to ensure timely completion of the ordered diagnostic testing, resulting in a delay in the diagnosis and treatment of Resident #35's fracture. This deficiency represents non-compliance investigated under Complaint Numbers 3018929, 2674451, and 2614048.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interviews, the facility failed to accurately assess newly identified pressure ulcers. This affected one (#64) out of four residents reviewed for pressure ulcers. The facility census was 74. Findings include: Review of Resident # 64's medical record revealed an admission date of 10/09/23 with diagnoses that included but were not limited to Alzheimer's disease, encephalopathy, anxiety, dementia, mood disorder and intellectual disabilities. Review of Resident # 64's Minimum Data Set 3.0 (MDS) dated [DATE] revealed he had severe cognitive impairment and required assistance from staff with bed mobility, transfers and toileting. Review of Resident # 64's comprehensive care plan dated 01/28/26 revealed a potential for alteration in skin integrity: requiring protective/preventative measures care plan with interventions that included but were not limited to:Place a pillow between legs when in bed to ensure pressure reduction.Encourage to float heels as toleratedPressure reduction cushion to chair to promote comfort and prevent skin breakdown.Pressure reducing mattress on bed to promote comfort and prevent skin breakdown. Review of Resident # 64's active clinical physicians orders dated June 2026 revealed the following orders:Order dated 05/26/26 to cleanse coccyx with normal saline, pat dry, apply triad paste and leave open to air every shift for wound care and after each episode of incontinence.Order dated 05/31/26 to cleanse wound to right inner knee with normal saline, pat dry and apply foam dressing until healed every dayshift for wound care.Order dated 05/31/26 to cleanse left inner knee with normal saline, pat dry and apply foam dressing until healed every dayshift for wound care.Order dated 05/31/26 to place pillow between legs when in bed to ensure pressure reduction every shift for skin integrity. Review of Resident # 64's skin grid for pressure dated 05/31/26 revealed the resident acquired a new pressure area to his left inner knee. The wound was documented as a left knee pressure injury measuring 3.0 centimeters (cm) by (x) 2.0 cm with no depth, no stage, light drainage and no wound description. Further review revealed and additional skin grid dated 05/31/26 that revealed the resident also acquired a new pressure ulcer to his right knee. The wound was documented as a right knee pressure injury measuring 3.0 cm x 1.9 cm with no depth, no staging, light drainage and no wound description. Review of Resident #64's progress notes dated 05/31/26 revealed Registered Nurse (RN) #116 notified the physician, and new treatment orders were received for bilateral inner knee pressure injuries. Interview on 06/01/26 at 2:40 PM with the Director of Nursing (DON) revealed nurses are required to complete skin grids on new wounds including assessing the stage and description of the wounds. DON confirmed skin grids dated 05/31/26 for Resident # 64's left inner knee and right inner knee were blank for stage and there was no other documentation for wound description in the medical record. Interview on 06/02/2026 at 1:50 PM with wound nurse practitioner (WNP) # 229 revealed she assessed new wounds to bilateral inner knees on 06/02/26 and the staging of the wounds were a stage three to the left inner knee measuring 2.0 x 2.0 x 0.2 and an unstageable due to slough to the right inner knee measuring 3.0 x 2.0 x visible depth of 0.2. She stated wounds were likely unavoidable due to Resident # 64's comorbidities, cognition and frailty. She also stated she had no concerns with staff notifying her of wounds or completing treatments. She denies finding residents excessively wet or residents not having interventions in place when she rounds. This deficiency represents non-compliance investigated under Complaint Number 3013989 and 2739488.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews and policy review, facility failed to ensure a resident was assessed timely by qualified staff after a fall, and before being moved by staff. This affected two (#4 and #47) of four residents reviewed for falls. The facility census was 74. Findings include: 1. Review of the medical record for Resident #4 revealed an admission date of 04/23/26. Diagnoses included left femur fracture, Parkinson's, dementia, muscle weakness, unspecified psychosis, psychotic disorder with hallucinations, heart disease and arthritis. Review of the plan of care dated 04/24/26 revealed resident was at risk for falls with interventions including use assistive device for transfers and ambulation and bed to be in low position with floor mat in place. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 99 indicating impaired cognition and required extensive/dependent assistance from staff members for activities of daily living. Review of the fall investigation dated 06/02/26 revealed resident had one knee on the ground with the rest of his body on the bed. Observation on 06/02/26 at 8:27 A.M. found Resident #4 had fallen out of his bed with his knee down on the fall mat bearing weight. Social Services designee (SSD) #181 entered the room and closed the door. About a minute later, SSD #181 exited the room and Resident #4 was back in bed. No other staff were present or entered the room during this time. Interview on 06/02/26 at 8:30 A.M. with Social Service Designee (SSD) #181 confirmed Resident had his knee on the floor mat. SSD #181 stated it was not a fall as staff were instructed it was only a fall if a resident was laying on the floor and had their whole body on the floor. She stated a change of plain was not a fall and confirmed she assisted Resident #4 back to bed without getting a nurse to assess the Resident for possible injuries. Interview on 06/02/26 at 8:33 A.M. with Assistant Director of Nursing (ADON) #212 confirmed she did not assess Resident #4 and was unaware of a fall. She confirmed she would need to check the details before confirming a fall occurred. She stated she was unable to state if a change of plain or if a resident had a body part on the floor would be considered a fall. At 8:53 A.M. ADON returned and confirmed Resident #4 did in fact have a fall. She confirmed SSD #181 should have gotten a nurse to assess Resident #4 for injuries. Interview on 06/02/26 at 9:00 A.M. with the Director of Nursing (DON) confirmed a change of plain was a fall and any part of the resident hitting the floor would be considered a fall. She confirmed SSD had certified Nurse Aide training but confirmed she was not a nurse and was unable to assess the resident for injuries. She confirmed Resident #4 had a previous fall with lower extremity fracture and confirmed the resident had been assessed and found no new injuries. 2. Review of the medical record for Resident #47 revealed an admission date of12/05/23. Diagnoses included Alzheimer's disease, dementia without behaviors, mood affective disorder, heart disease, kidney disease, schizophrenia, and muscle weakness. Review of the MDS assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 99 indicating Resident #47 had impaired cognition and required dependent and substantial assistance for activities of daily living. Review of the plan of care dated 02/05/24 revealed resident was at risk for falls with interventions to offer toileting at dinner, encourage the resident to be in the common areas due to wandering, non-skid footwear and encourage resident to eat breakfast in the dining room. Review of fall investigation dated 12/26/25 revealed resident was observed on her buttock in another residents room. The fall was unwitnessed and the resident was assessed with no injuries identified. Review of the neuro checks dated 12/26/25 revealed staff completed an extra 30 minute check and did not complete the last three neuro checks that were eight hours apart. Review of fall investigation dated 01/23/26 revealed resident was observed on the floor on the hallway on her left side. The fall was unwitnessed and the resident was assessed with injuries including a skin tear to the left forehead and a left knee bruise. Review of the neuro checks dated 01/23/26 revealed staff completed an extra 30-minute check and did not complete any four-hour (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checks as per the instructions and switched to eight hours checks. The neuro check was pre-filled out and was also dated incorrectly with dates of 01/23/26 and 01/24/26 instead of 01/23/26 to 01/25/26. Review of fall investigation dated 04/20/26 revealed resident was observed sitting on a wooden chair with her legs crossed and slid out of the chair onto the floor and hit her left side eye brow. Resident was found to have a bump on her eyebrow. The fall was unwitnessed and the resident was assessed with an injury to her eyebrow identified. The fall investigation also stated the injury type was a burn. Review of the medical record found no evidence of a burn injury. Interview on 06/08/26 at 1:30 P.M. with the DON confirmed Neuro checks from 12/2025 and 01/2026 falls were missing entries and had inaccurate dates on them and confirmed they did not follow the schedule in the instructions. She also confirmed the fall 04/20/26 investigation documented a burn injury and confirmed that was inaccurate and stated Resident #47 had no burn injuries. Review of facility policy titled Fall Prevention and Management Policy dated 01/08/25 revealed each resident shall be assessed for fall risk and all falls shall be reviewed and investigated. In the event of a fall, the resident shall be assessed by the nurse. Review of facility policy titled Head Injury dated 10/01/25 revealed facility shall report head injuries to the physician and implement interventions to prevent further injury. Neuro checks should be completed as indicated and continued monitoring for 72 hours. This deficiency represents non-compliance investigated under Complaint Number 2674451.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews, and facility policy review, the facility failed to properly administer and care for a resident's tube feeding. This affected one (#9) of one residents reviewed for tube feeding care. The facility census was 74.Findings include: Resident #9 was admitted on [DATE] and has diagnoses that include duodenal ulcer, dysphagia following cerebral infarction, and Type 2 Diabetes Mellitus. Review of the Resident's Minimum Data Set (MDS) 3.0 assessment dated [DATE] indicates the Resident was rarely/never understood and the Resident used a feeding tube. Review of the medical record for Resident #9 revealed on order on 05/19/26 for enteral nutrition every 24 hours via pump Glucerna 1.2 at 65 milliliters per hour (mL/hr) for 22 hours (9 A.M. to 7 A.M.) via pump per feeding tube or until 1,430 mL infused. An order written 05/11/26 states every shift for enteral feeding to check feeding tube placement before initiation of formula, medication administration, and flushing tube. An order written 05/11/26 states to wear gloves and gown when providing feeding tube (care.) An order written 05/08/26 states every shift if an enteral feed residual check is over 100 cc (mL) hold one hour and recheck, if still over 100 cc (mL) notify (physician.) An order written 05/11/26 reveals enteral tube flushing six times a day for hydration and feeding tube patency, flush with 150mL every 4 hours. Review of facility care plan for Resident #9 initiated 05/12/26 states to keep head of the bed elevated at all times when tube feed is infusing. Observation of feeding tube change was conducted between 8:13 A.M. and 8:36 A.M. on 06/04/26. Resident #9 was laying in bed in the resident's room. The head of bed did not appear to be elevated above 30 degrees. Registered Nurse (RN) #162 performed the changing of the feeding tube. RN #162 washed hands and put on gloves before beginning care. RN #162 was not wearing a gown. The current tube feeding was infusing at a rate of 55 mL/hr. RN #162 prepared a new tube feeding bottle (Glucerna 1.2) and dated and timed the bottle. RN #162 unhooked the old feeding bottle and discarded it. RN #162 prepared a new flush bag from warm tap water. RN #162 labeled the flush bag with date and time. RN #162 prepared the new tube feeding for infusion on the pump and reused the infusion setting of 55 mL/hr. RN #162 let the pump push some feeding out of the distal end of the tube before connecting it to the patient tube feeding port. During the procedure, there was no check of residual tube feeding volume in the patient stomach, no flush of the feeding tube, no check of tube placement, or no dressing change around the infusion site. Interview was conducted after the procedure with RN #162 about 8:36 A.M. on 06/04/26. RN #162 confirmed there was no tubing flush during the feeding bottle change. RN #162 explained that the pump provided automatic 4 hour flushes and RN #162 generally only does it manually if the resident is getting up, for example going to therapy. RN #162 confirmed that tube placement was not assessed. RN #162 stated he usually performs tube placement check with stethoscope during bolus feeds. RN #162 confirmed that the head of the bed was below 30 degrees. RN #162 stated it was low and mechanically raised the head of the bed. RN #162 confirmed a dressing change was not completed at the tube feeding insertion site. RN #162 that dressing changes at performed later in the day for all residents in the hall. RN #162 confirmed a gown was not being worn during tube feeding care. RN #162 acknowledged a gown should have been worn based on new CDC guideline. Follow up interview was conducted with RN #162 about 9:39 A.M. on 06/04/26. RN #162 confirmed a check of residual tube feeding contents was not performed before initiating a new tube feed bottle. RN #162 also confirmed that during the observation the tube feeding was programmed to infuse at an incorrect rate of 55 mL/hr. RN #162 reported he had changed the infusion rate to 65 mL/hr. Review of facility policy titled Care and Treatment of Feeding Tubes (revised 06/01/24) state feeding tubes will be utilized according to physician's orders. The policy also states the resident's plan of care will address the use of the feeding tube, including strategies to prevent complications. The policy states that the resident's plan of care will direct staff regarding proper positing of the resident consistent with the (continued on next page)

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	365980	A. Building B. Wing	06/10/2026

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's individual needs. The policy states that in accordance with facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location. Tube placement will be verified before beginning a feeding and before administering medications. The enteral retention device will be checked daily to assure it is properly approximated to the abdominal wall and that surrounding skin is intact. This deficiency represents non-compliance investigated under Complaint Number 3018929.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, staff and resident interviews and policy review, the facility failed to ensure food was served at an appetizing temperature. This had the potential to affected 72 out of 72 residents who receive their meals from the kitchen, the facility identified two (#9 and #55) residents who do not eat food from the kitchen. The facility census was 74. Findings include:Observation on 06/03/26 at 12:03 P.M. revealed food temperatures for the regular texture chicken was 191.7 degrees Fahrenheit (F), regular texture vegetable was 196 degrees F, and regular sweet potato was 197 degrees F. Observation on 06/03/26 from 12:19 P.M. to 1:00 P.M. revealed during tray line facility had warming shells (tops and bases) to keep food warm. It was observed staff were using only one piece (either the top or the bottom but not both). The staff also ran out of trays and had to wait for several trays to be collected from the dining room and washed before being used for another resident for lunch service. Observation and interview 06/03/26 at 12:55 P.M. revealed test tray was plated. Temperatures on the steam table included chicken had a temperature of 138 degrees F, the vegetables had a temperature of 160 degrees F and the sweet potato had a temperature of 140 degrees F. Kitchen Manager #137 confirmed the temperatures. Kitchen Manager #137 reported facility did not have enough warming shells for all the residents so they used either the top or the bottom pieces. Observation and interview on 06/03/26 from 1:08 P.M. to 1:50 P.M. revealed the test tray left the kitchen at 1:08 P.M. and arrived to the unit at 1:13 P.M. Staff was observed passing out trays with the last tray passed out at 1:35 P.M. The test tray was tested had temperatures taken at 1:35 P.M. with results for the chicken with a temperature of 120 degrees F, the sweet potato with a temperature of 100 degrees F and the vegetables with a temperature of 80 degrees F. Kitchen Manager #137 confirmed food should be served at the holding temperature of 135 degrees F or higher and should be passed out timely upon reaching the unit. She acknowledged the food on the test tray was cold and acknowledged surveyor assessment it tasted cold. She confirmed she had asked for more warming shells a few times and it had not been approved due to budget constraints and she only had enough to cover food but did not have enough to use a top and bottom shell for all residents. She confirmed the food was also delayed due to running out of trays and having to collect some and do dishes so they could be used again for residents on the last hallway. Kitchen Manager #137 confirmed delays with tray pass and staff having to track down bedside tables as residents were taken to an area with tables. The facility confirmed there are 72 residents who receive their meals from the kitchen and there are two (#9 and #55) residents who do not eat food from the kitchen. Interview on 06/03/26 at 1:45 P.M. with Resident #68 reported his food was cold and gross and tasted like jail food. Review of the facility policy titled Test Tray and Point of Service Food Temperatures, dated 11/29/23 revealed food shall be served at a palatable, attractive and appetizing temperature. Food must be held at 135 degrees F and should be served with an internal temperature of 125 degrees for hot items and below 45 degrees F for cold items. This deficiency represents non-compliance investigated under Complaint Number 2739488.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff and resident interviews and policy review, the facility failed to ensure drinks were provided regularly and upon resident request. This affected one (#26) of one residents reviewed for hydration. The facility census was 74. Findings include:Review of the medical record for Resident #26 revealed an admission date of 01/05/24. Diagnoses included dementia without behaviors, psychotic disturbance, vascular dementia, dysphagia and pulmonary disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) of 99 indicating impaired cognition. Review of the plan of care dated 01/20/26 for alteration in nutrition with interventions to provide favorite foods and fluids. Further review of Resident #26's medical record revealed there was no order for fluid restrictions. Observation and interview on 06/01/26 at 11:28 A.M. with Resident #26 revealed he had no drinks or hydration in his room and he requested a drink from staff, specifically coffee. Resident #26 stated he was thirsty and wanted a coffee. Interview on 06/01/26 at 11:30 A.M. with Certified Nursing Aide (CNA) #213 revealed resident would get coffee when the coffee cart came. CNA #213 was unable to state when this would occur but mentioned it was around lunchtime. CNA #213 stated staff did not pass out drinks or water and residents would get drinks on their trays at meal time and coffee could be given then. CNA #213 confirmed a second time that residents only got drinks with meal trays. Interview on 06/01/26 at 11:37 A.M. with Licensed Practical Nurse (LPN) #105 confirmed after the surveyor interviewed the nurse regarding Resident #26's hydration/drinks the resident was provided water to drink until the coffee cart arrived on the unit. Observation on 06/01/26 revealed the meals arrived on the unit around 12:30 P.M. Review of facility policy titled Hydration fresh water and fluids dated 11/2018 revealed residents with dementia will forget to drink and should be provided encouragement and assistance. This deficiency represents non-compliance investigated under Complaint Number 2739488.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, record review, resident council review, personnel file review, and Quality Assurance and Performance Improvement (QAPI) review, the facility failed to effectively administer the facility by failing to ensure the activities program was directed by qualified personnel and failing to ensure residents received an activity program that addressed their assessed interests, preferences, and psychosocial well-being. In addition, the facility failed to implement effective corrective actions to achieve compliance after the facility's QAPI program identified concerns related to activity programming and staffing. This had the potential to affect all 74 residents residing in the facility. The facility census was 74.Findings Included:Review of the personnel file for Activity Director #192 failed to reveal documentation demonstrating the individual met the qualifications required to direct the facility's activities program. Further review revealed the facility had been without a Certified Activity Assistant since 04/07/26.Observations conducted throughout the survey revealed residents on multiple units were frequently observed sitting in common areas with limited to no staff-facilitated engagement, individualized activities, one-to-one programming, or organized activity programming occurring despite scheduled activities listed on the facility activity calendar. Interview with the Administrator on 06/01/26 at 3:40 P.M. revealed his expectation was for Certified Nursing Assistant (CNA)s to assist residents to and from activities and follow the activity calendar. When informed of surveyor observations of residents sitting in common areas with limited engagement, the Administrator stated staff should know better. When asked how the facility verified scheduled activities were occurring during evenings and weekends, the Administrator acknowledged, That is a good point. We don't have anything. Interview with Activities Director #192 on 06/02/26 at 2:18 P.M. revealed one-to-one activity visits were not being consistently documented, weekend activities were not being tracked, and resident-specific programs were not being completed consistently.A follow-up interview with the Administrator on 06/08/26 at 2:23 P.M. revealed the facility's QAPI committee routinely reviewed activity programming, staffing concerns, resident concerns, employee retention, and resident outcomes. The Administrator identified activity programming as an area currently being monitored through QAPI and stated the facility was aware of concerns involving the activity department. The Administrator further stated the facility was working with certified activity personnel and seeking additional support for the activity department to improve services provided to residents.This deficiency represents non-compliance investigated under Complaint Numbers 2699816 and 2614048.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review, interview, personnel file review, observation, and review of Quality Assurance and Performance Improvement (QAPI) documentation, the facility failed to implement and maintain an effective QAPI program by failing to identify, monitor, and implement effective corrective actions regarding deficiencies in the facility's activity program. The facility identified concerns related to activity programming and staffing through its QAPI process; however, residents continued to experience limited activity programming and the facility failed to ensure the individual directing the activity program met required qualifications. This had the potential to affect all 74 residents residing in the facility.Findings Included:Interview with the Administrator on 06/08/26 at 2:23 P.M. revealed the facility's QAPI committee routinely reviewed quality measures, resident concerns, staffing concerns, activity programming, employee retention, and operational issues affecting resident care. The Administrator stated activity programming and staffing concerns were areas currently being monitored through the facility's QAPI process.The Administrator stated concerns were identified through resident and family complaints, audits, quality measure data, staffing concerns, and trends identified by department managers. The Administrator further stated the facility evaluates the effectiveness of corrective actions through follow-up audits, review of quality measure data, monitoring of trends, resident and family feedback, and subsequent QAPI reviews.When informed of concerns identified during the current survey regarding activity programming and qualifications of activity staff, the Administrator stated the facility was aware of the concerns and reported they were currently working with certified activity personnel and obtaining additional assistance and support for the activity department.Review of personnel records revealed the individual functioning as Activities Director did not possess documentation demonstrating the qualifications required for the position.Observations conducted throughout the survey revealed residents on multiple units were frequently observed sitting in common areas with limited to no staff-facilitated engagement, individualized programming, one-to-one activities, or organized activity programming occurring despite activities scheduled on the facility calendar.Interview with Activities Director #192 revealed one-to-one activity visits were not being consistently documented, weekend activities were not being tracked, and resident-specific activity programming was not being completed consistently.Despite the facility's awareness of concerns involving activity programming and staffing through its QAPI process, observations, interviews, and record review revealed continued deficiencies related to resident activity services and qualifications of activity personnel. The facility failed to implement effective corrective actions to identify, monitor, and resolve the concerns. This deficiency represents non-compliance investigated under Complaint Numbers 2748921, 2739488, 2699816, and 2614048.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and policy review, facility failed to ensure furniture was maintained in a safe manner. This affected 25 Residents (#4, #7, #9, #12, #16, #18, #19, #23, #26, #30, #31, #36, #42, #45, #47, #49, #61, #62, #64, #66, #68, #69, #70, #72, and #75) living in the third hall. Facility census was 74. Findings include: Observation and interview on 06/01/26 at 10:20 A.M. and 11:28 A.M. revealed the third hall nook had a variety of chairs and couches sitting against the wall. A chair had damage on the arm with the wood framing exposed that was rough. A couch was also damaged with torn/peeling fabric. Interview and observation on 06/03/26 at 1:50 P.M. confirmed the chair in the third hall nook was damaged with exposed wood and a couch in the third hall nook had torn fabric. The Registered Nurse (RN) #199 confirmed residents pick at the furniture and caused the ripped material. She confirmed residents were sitting in the damaged chair and couch and could not remember for how long they had been damaged. Review of facility policy titled Resident Environmental Quality dated 11/29/22 revealed facility shall constructed and maintained to provide a safe functional and sanitary environment for residents. All personnel were responsible for reporting broken equipment. 2.Review of the medical record for Resident #55 revealed an admission date of 10/30/12 with diagnoses including neurocognitive disorder with Lewy Bodies, aphasia, contracture, unspecified joint, adult failure to thrive, muscle wasting and atrophy, unspecified site, and unspecified psychosis not due to a substance or known physiological condition. Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS) could not be conducted. Interview on 06/01/26 at 3:01 P.M. with Certified Nursing Assistant (CNA) #193 verified the missing baseboard to wall behind the bed was not intact and hanging hallway off. Review of purchasing invoices dated 03/31/26, 04/02/26, and 04/14/26 provided by the facility revealed no blankets have been ordered and verified by the Director of Maintenance #152. Review of facility policy titled Resident Environmental Quality revised 11/29/22, revealed it is the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. This deficiency represents non-compliance investigated under Complaint Numbers 2748921, 2739488, and 2584875.