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	05/01/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 37100 Based on observations, resident interview, and staff interview, the facility failed to have all required postings readily accessible to all residents in the facility. This had the potential to affect all 70 residents residing in the facility. Findings include: Observations during the annual survey, dated 04/28/25 to 05/01/25, revealed the required postings for resident/resident representatives were located in the hallway outside of the building's interior locked doors. The location of the required postings were in a location that none of the residents had access to. Observations during the same period found that the required postings were not within the three locked hallways of the facility in which the residents were confined to. Interview with Residents #48 and #65 during resident council meeting on 05/01/25 at 10:25 A.M. confirmed they have never seen documents or postings on the walls or anywhere in their living spaces to contact the ombudsman or the state department of health. They confirmed they would like to know this information. Interview with Activities Recreation Director #195 on 05/01/25 at 10:26 A.M. confirmed the required postings were not on the residents' living areas. She confirmed the postings were in the hallway, as people walk to the front doors, but confirmed the residents do not have access to that area on a routine basis (without staff supervision).

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47059 Based on record review, staff interview and facility policy review, the facility failed to ensure accurate advanced directive information was present throughout the medical record for Resident #3. This affected one resident (#3) out of three residents reviewed for advanced directives. The facility census was 70. Findings include: Resident #3 was admitted on [DATE] with diagnoses that included neurocognitive disorder with Lewy bodies, encephalopathy, aphasia, dysphagia, atherosclerosis, gastrostomy, major depressive disorder and psychosis not due to a substance or known physiological condition. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #3 was severely cognitively impaired with a Brief Interview for Mental Status score of zero out of 15. Review of the current active orders for Resident #3 revealed an order for Full Code dated [DATE]. The banner on the electronic medical record indicated Resident #3 was a Full Code. Review of the care plan for Resident #3 revealed the care plan stated Do Not Resuscitate Comfort Care Arrest (DNRCC Arrest) - Resident/Family has chosen a DNRCC-A status; cardio-pulmonary resuscitation (CPR) measures will not be attempted during a cardiac arrest. The plan of care was initiated [DATE] and revised on [DATE]. The plan of care elaborated that the Code Status will be posted in the chart, staff should administer oxygen as needed, contact appropriate individuals if cardiac arrest occurs, control any bleeding that occurs, position for easier respirations, position resident for comfort, and suction airway as needed. A physician signed DNRCC-A identification form that was placed in Resident #3's chart. The plan of care also identified with a physician's order and resident/family request the resident may be hospitalized for routine tests and treatment. Review of the forms in the electronic medical record confirmed there was a Do Not Resuscitate (DNR) form filed in the electronic medical record on [DATE] indicating Resident #3's code status is DNRCC-A. Interview on [DATE] at 10:40 A.M. with Registered Nurse (RN) #179 confirmed the electronic medical record indicated Resident #3 was a Full Code and the banner on the electronic medical record was where the staff would look to verify if the resident was a Full Code or DNR. Interview on [DATE] at 02:45 P.M. with the Director of Nursing (DON) confirmed the electronic medical record banner (and order) stated Full Code and there was a DNR form in the chart for DNRCC-A. Interview on [DATE] at 3:30 P.M. with the DON and Senior Administrator #206 confirmed Resident #3's electronic medical record does display and order for Full Code with care planning and documentation indicating Resident #3's code status was DNRCC-A. The electronic medical record platform changed [DATE] and there have been some issues with the transfer of historical data, so all records will be audited for accuracy. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy Resident Rights Regarding Treatment and Advanced Directives, dated [DATE], revealed during the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advanced directives. Decisions are periodically reviewed and any services that would be otherwise required, but are refused, will be documented in the comprehensive care plan.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52017 Based on medical record review, interview and facility policy review, the facility failed to assess Resident #53 prior to utilizing a physical restraint. This affected one resident (#53) out of one resident reviewed for physical restraints. The facility census was 70. Findings include: Review of Resident #53's medical record revealed that she was admitted on [DATE] with diagnoses that included dementia, pseudobulbar affect (PBA), anxiety, frontotemporal cognitive disorder, psychosis, major depressive disorder and mood disorder. Review of Resident #53's progress note, dated 01/12/25, revealed that Resident #53 started running and screaming in the hallway, and staff redirected her to her room. Review of physician's visit consult, dated 01/15/25, revealed that the physician dictated she has these very quick onset hyper episodes where she will run up and down the hallways, curse, push, shove, tear, pound on anything that comes in her way. These episodes usually last 30 minutes and then fade off. Sometimes just put in her room and hold the door to prevent her to escape for 30 minutes. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment, dated 03/31/25, revealed that Resident #53 had severe cognitive impairment. She had verbally abusive behaviors, physically abusive behaviors, other behaviors directed towards others, and rejection of care one to three days of the seven-day assessment reference period. She wandered four to six days of the seven-day assessment reference period. She required supervision with transfers and ambulation. Review of Resident #53's facility assessments, dated December 2024 to March 2025, revealed no assessments for a physical restraint. Review of Resident #53's current physicians orders, dated April 2025, revealed no orders for a physical restraint or physical restraint monitoring. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #53's care plan initiated 06/21/23 and last revised 04/09/25, revealed the resident had the potential for mood swings and behavior issues related to mood disorder, depression, anxiety, PBA, and agitation. As evidenced by the resident was tearful, had combative behaviors, paced, verbal aggression, would bang on doors, anxious, refused care, including meds, would run down the halls, throw items, tear things off walls, ball up fist and hit staff. Interventions included administering medications as ordered, attempting non-pharmacological interventions such as one-on-one, change in position or scenery, bargaining, offer food and/or fluids, redirect, activity of choice, toileting, and diversional activities, provide a calm environment and approach in a calm manner, encourage socialization and participation in activity events, follow up with psych, if resident is demonstrating socially inappropriate behaviors, attempt to redirect; if unable to redirect, remove from public areas, if resident is resistive to care, leave resident if safety is not a concern and reapproach at a later time, and may administer as needed (PRN) medications as ordered when the resident exhibits increased agitation, anxiety, pacing, hallucinations, mood changes, restlessness, wandering, physically or verbally abusive behaviors, and repetitive verbalizations. There were no interventions related to physical restraints. Interview on 05/01/25 at 10:00 AM with the Medical Director, regarding physician's visits consult note, dated 01/15/25, revealed that Resident #53 did have violent behaviors, and staff put her in her room to prevent her from coming out, because she was a danger to herself and other residents. Interview on 05/01/25 at 11:09 A.M with Director of Nursing (DON) confirmed that there were no incident reports, documentation or restraint assessments for Resident #53. Review of the facility Restraint Free Environment policy, dated 06/01/24, stated that medical symptoms warranting the use of restraints should be documented in the resident's medical record. The resident's record needs to include documentation that less restrictive alternatives were attempted to treat the medical symptom but were ineffective, on-going re-evaluation of the need for restraint, and effectiveness of the restraint in treating the medical symptom. The care plan should be updated accordingly to include the development and implementation of interventions to address any risks related to the use of the restraint.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43064 Based on medical record review, interview and facility policy review, the facility failed to ensure residents had appropriate diagnoses for psychological medications. This affected five residents (#35, #48, #50, #53, and #63) of nine residents reviewed for unnecessary medications or behavioral-emotional health services. The facility census was 70. Findings include: 1. Review of Resident #63's medical record revealed an admitted [DATE] with diagnoses including dementia, unspecified mood disorder, hypertension, unspecified fracture of first, second, third, and fourth lumbar vertebra, restlessness and agitation, and muscle weakness. Review of Resident #63's Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed severely impaired cognition. No behaviors were indicated. Review of Resident #63's physician order dated 03/06/25 revealed an order for escitalopram oxalate 10 milligrams (mg), selective serotonin re-uptake inhibitors (SSRIs) antidepressant, one tablet by mouth in the morning for depression. Review of Resident #63's plan of care revised 04/04/25 revealed the potential for adverse side effects of psychotropic medication, the resident had agitation and mood disorder. Interventions included Abnormal Involuntary Movement Scale (AIMS) per policy, documenting side effects of medication, notifying the physician of any mental status changes, observing and documenting any abnormal behavior or moods, observe, document and report to physician any signs of drug related complications. The care plan did not address any specific behaviors. Review of Resident #63's plan of care revealed it did not address her antidepressant use. Review of Resident #63's physician order dated 04/21/25 revealed an order for Depakote delayed release 125 mg (anti-epileptic medication used as a mood stabilizer) twice a day for behaviors. Interview on 04/30/25 at 2:20 P.M. and 4:30 P.M. with the Director of Nursing (DON) verified behaviors was not a diagnosis and was not an appropriate diagnosis for Depakote. She verified Resident #63 did not have a diagnosis of depression and was receiving escitalopram oxalate anyways. She also verified Resident #63's care plan did not address Resident #63's antidepressant. Review of the Depakote prescribing information at depakotehcp.com/prescribing-information revealed Depakote delayed release was an anti-epileptic drug indicated for the treatment of seizures, prophylaxis of migraine headaches, and treatment of manic episodes associated with bipolar disorder. 2. Review of Resident #35's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's disease, unspecified mood disorder, unspecified psychosis not due to a substance or known physiological condition, anxiety disorder, restlessness and agitation, and cognitive communication deficit. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #35's comprehensive MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. No behaviors were noted. Review of Resident #35's physician note dated 03/20/24 revealed an order for Depakote Sprinkles 125 milligrams (mg) two capsules by mouth two times a day for mood. Review of Resident #35's plan of care dated 04/04/25 revealed the potential for adverse side effects of psychotropic drug use. The resident had agitation and mood disorder. Interventions included AIMS per policy, documenting side effects of medication, notifying the physician of mental status changes, observing and documenting any abnormal behaviors, and observing and reporting to the physician any signs of drug related complications. Interview on 04/30/25 at 2:20 P.M. with the DON verified mood was not a was not an appropriate diagnosis for Depakote. Review of Depakote prescribing information at depakotehcp.com/prescribing-information revealed Depakote sprinkles were an anti-epileptic drug indicated for the treatment of seizures. This was the only indication of use. 3. Review of Resident #48's medical record revealed an admitted [DATE] with diagnoses including dementia with other behavioral disturbance, vascular dementia with agitation, atherosclerotic heart disease, generalized anxiety disorder, major depressive disorder, delirium due to known physiological condition, restlessness and agitation, history of traumatic brain injury, and alcohol abuse. Review of Resident #48's plan of care dated 10/10/23 revealed the resident had the potential for adverse side effects of psychotropic drug use related to delirium. Interventions included AIMS per policy, documenting side effects, notifying physicians of any mental status changes, observing and documenting any abnormal behavior, and observing, documenting, and reporting to the physician drug related complications. Review of Resident #48's physician's order dated 12/20/23 revealed an order for Depakote Delayed Release 250 mg one tablet three times a day for agitation. Review of Resident #48's quarterly MDS 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition. He experienced behaviors of wandering and rejection of care during one to three days of the seven-day assessment reference period. Interview on 04/30/25 at 2:20 P.M. with the DON verified agitation was not an appropriate diagnosis for Depakote. Review of Depakote prescribing information at depakotehcp.com/prescribing-information revealed Depakote delayed release was an anti-epileptic drug indicated for the treatment of seizures, prophylaxis of migraine headaches, and treatment of manic episodes associated with bipolar disorder. 52017 4. Review of Resident #50's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's disease, major depressive disorder, anxiety disorder, and psychotic disorder. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #50's physician's orders dated April 2025 revealed an order for Depakote Sprinkles Oral 125 mg, give two capsules by mouth three times a day with a diagnosis of agitation. Review of Resident #50's physician's neurology consult dated 04/16/25 revealed under recommendations that Depakote should continue due to mood liability, restlessness, impulsivity, disinhibition, demanding and anger. Interview on 04/30/25 at 2:20 P.M. with the DON confirmed that the diagnosis of agitation on the April 2025 physician's orders, for Resident #50 was not an appropriate diagnosis for the use of Depakote Sprinkles. The DON also stated that the physician had been notified to provide an appropriate diagnosis. 5. Review of Resident #53's medical record revealed an admitted [DATE] with diagnoses including dementia, pseudobulbar affect (PBA), anxiety, frontotemporal cognitive disorder, psychosis, major depressive disorder and mood disorder. Review of Resident #53's physician's neurology consult dated 01/15/25 revealed under recommendations to increase Depakote to 375 mg three times a day to help with the agitation, restlessness, and impulsivity. Review of Resident #53's physician's orders, dated April 2025, revealed an order for Depakote Sprinkles Oral, give 375 mg by mouth three times a day for a diagnosis of PBA. Interview on 04/30/25 at 2:25 P.M. with the DON confirmed that the diagnosis of PBA on the April 2025 physician's orders, for Resident #53, was not an appropriate diagnosis for the use of Depakote Sprinkles. The DON also stated the physician had been notified to provide an appropriate diagnosis. Review of Medscape prescribing information at Depakote (divalproex sodium) dosing, indications, interactions, adverse effects, and more for Depakote, revealed that the uses for Depakote, are the treatment of mania related to bipolar disease, epilepsy and migraines. Review of the facility Use of Psychotropic Medication policy, dated 10/01/22, revealed that other medications not classified as antipsychotic, antidepressant antianxiety or hypnotic medications but can affect brain activity should not be used as a substitution for another psychotropic medication unless prescribed with a documented clinical indication consistent with accepted clinical standards of practice. Categories of medications that can affect brain activity (e.g. antihistamines, anti-cholinergic medications and central nervous system agents for use in conditions such as seizures, mood disorders, PBA, and muscle spasms or stiffness) and their documented use appears to be a substitution for another psychotropic medication (rather than for the original or approved indication) are subject to the requirements pertaining to psychotropic medications.

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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** 37100 Based on medical record review, staff interview and facility policy review, the facility failed to properly monitor resident bruises. This affected one (Resident #37) of three residents reviewed for skin conditions. Also, the facility failed to implement wound orders in a timely manner. This affected one (Resident #70) of three residents reviewed for skin conditions. The facility census was 70. Findings include: 1. Resident #37 was admitted to the facility on [DATE]. Her diagnoses were malignant neoplasm of unspecified part of unspecified bronchus or lung, dementia, hemiplegia and hemiparesis, epilepsy, mood disorder, hyperlipidemia, hypothyroidism, aphasia, anxiety disorder, insomnia, major depressive disorder, vitamin D deficiency, lack of coordination, muscle weakness, cerebral infarction, low back pain, dysphagia, hypertension, psychosis, cognitive communication deficit, and urinary incontinence. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #37 had a significant cognitive impairment. Review of the progress notes dated 12/31/24 revealed a bruise was noted to Resident #37 right eye, measuring 3.0 centimeters (cm) by 2.6 cm. It noted the bruise was consistent with the resident accidentally hitting her head on the nurse's right lower arm during treatment. A new order to monitor the area every shift until resolved was initiated. Review of Resident #37 progress notes dated 01/01/25 to 03/24/25 revealed no progress notes and/or other documentation to support how the resident obtained the bruise to her right eye. Review of Resident #37 progress notes dated 03/25/25 revealed the facility was to monitor a bruise to the right eye of Resident #37 every shift for skin integrity until resolved. It also stated that the bruise has healed on this date. Review of Resident #37 treatment administration record (TAR) dated 01/01/25 to 03/25/254 revealed the facility documented it monitored Resident #37's bruise to her right eye each shift, until it was documented as being resolved on 03/25/25. Review of Resident #37 skin assessments/documentation, dated 01/01/25 to 03/25/25, revealed there was no documentation to monitor the size, condition, color, or other descriptive factors of the bruise to her right eye other than the initial skin assessment/progress note written on 12/31/24. Review of Resident #37 care plans revealed a focus are of, The resident has an actual area of skin impairment related to redness and swelling under right eye. This care plan was implemented on 04/16/25. There were no other care plans implemented for a bruise to Resident #37 right eye from 12/31/24 to 03/25/25, and Resident #37 does not currently have any redness/swelling underneath her right eye that is being treated/monitored. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 05/01/25 at 10:39 A.M. confirmed Resident #37's bruise to her right eye healed on 03/25/25. When asked where the bruise came from, she stated it was from a care injury on 12/31/24. When asked if the bruise lasted three months, she couldn't confirm if/when the bruise was healed, but documentation supported that the bruise was from 12/31/24 and it continued to be monitored until 03/25/25. She confirmed there are no other skin assessments currently, for bruising/redness/swelling to her right eye; the care plan that was implemented on 04/16/25 should have been implemented for the bruise that occurred on 12/31/24. She confirmed when monitoring a bruise, there should be descriptors (size, color, etc.) each week that were documented on a skin assessment document. She confirmed she would have to look for those documents to determine if that occurred. The facility management was asked for Resident #37 skin assessment documentation to support her right eye bruise was being monitored/measured from 01/01/25 to 03/25/25 on the following dates and times: 04/30/25 at 1:30 P.M. and 05/01/25 at 10:39 A.M. and 11:50 A.M. The facility was unable to provide the requested documentation. 43064 2. Review of Resident #70's medical record revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis affecting right dominant side, aphasia, type two diabetes mellitus, chronic obstructive pulmonary disease, burn of unspecified region of body, vascular dementia, malignant neoplasm, acquired absence of right breast and nipple, and anxiety. Review of Resident #70's comprehensive MDS 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. Review of Resident #70's physician order dated 04/04/25 to 04/15/25 revealed an order to cleanse the right chest with wound cleanser, pat dry, apply MediHoney and island boarder gauze dressing every day shift. Review of Resident #70's wound physician note dated 04/09/25 revealed the resident had a burn wound to her right chest. The physician's treatment plan included applying calcium alginate with silver with a gauze island with boarder every day. Review of Resident #70's plan of care dated 04/15/25 revealed the resident had an actual skin impairment related to burn injury to the right chest. Interventions included evaluating for pain and providing pain relieving interventions as ordered, initiating wound treatment, nursing to observe wound dressing daily, observing and documenting character of the wound weekly, and observing for clinical changes. Review of Resident #70's physician order dated 04/16/25 to 04/29/25 revealed an order to cleanse wound to the right chest with wound cleanser, pat dry, apply calcium silver alginate, and island boarder gauze dressing every day shift and as needed. Interview on 04/30/25 at 10:21 A.M. with Unit Manager #144 verified the physician order was not timely implemented. She reported their system had changed over and this had caused a delay in the order changing. She reported the nurses were aware of the correct order, but was unable to provide evidence the correct order had been used.

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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** 43064 Based on record review, observation, interview, and review of the facility policy, the facility failed to ensure fall interventions were in place for Resident #13. This affected one resident (#13) of six residents reviewed for falls. The facility census was 70. Findings include: Review of Resident #13's medical record revealed an admitted [DATE] with diagnoses including Alzheimer's disease, peripheral vascular disease, aphasia, bipolar disorder, generalized anxiety, unspecified psychosis, cognitive communication deficit, and dysphagia. Review of Resident #13's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he had severely impaired cognition. He had one fall without injury during the lookback period. Review of Resident #13's plan of care dated 03/08/24 revealed he had the potential risk for falls related to cognitive function, decreased physical function, and medication use. Interventions included attempting to redirect with food and fluids, encourage frequent rest periods, referring to therapy, encouraging to be in a supervised area, monitoring due to recent medication changes, bed against wall, Dycem (non-slip material) to the seat of the wheelchair, call light in reach, bed to be in lowest position, nonskid footwear. Added on 02/10/25 was the intervention resident to sit up by nurse station when in chair and added on 03/25/25 staff education to keep resident in supervised area when up in wheelchair as tolerated. Review of Resident #13's progress note dated 02/10/25 revealed a new intervention was when the resident was in his chair to keep him by the nurse's station or in activities. Review of Resident #13's progress note dated 03/25/25 at 9:35 A.M. revealed the nurse was notified by the kitchen manager that the resident was on the floor. The nurse arrived to the lounge area seeing the resident on the floor close to the table. The resident was unable to explain what happened. He was assessed and found to have a skin tear on his right elbow. The resident was moved closer to the nurse's station for closer supervision. Review of Resident #13's progress note dated 03/26/25 revealed the interdisciplinary team met and reviewed the 03/25/25 fall. The intervention was to educate staff to keep the resident in the common area when up in his wheelchair. Observation on 04/30/25 at 9:10 A.M. and 9:20 A.M. revealed Resident #13 in the dining area without supervision. At 9:20 A.M. an aide walked out of a resident room and checked on another resident in the dining room. Interview on 04/30/25 at 9:20 A.M. with Certified Nursing Assistant (CNA) #114 verified Resident #13 had been in the dining room without supervision. (continued on next page)

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	365980	A. Building B. Wing	05/01/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/30/25 at 4:30 P.M. with the Director of Nursing (DON) verified for the 03/25/25 fall the intervention was not in place and she had to educate staff. She verified that Resident #13 should not be in the dining area by himself. Review of the policy Fall Prevention and Management Policy, dated 01/08/25, revealed individualized interventions were to be implemented based on the assessment and risk factors.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on interview and record review, the facility failed to provide pain medication as ordered for Resident #70 and notify the physician when the medication was unavailable. This affected one resident (#70) of two residents reviewed for pain management. The facility census was 70. Findings include: Review of Resident #70's medical record revealed an admitted [DATE] with diagnoses including hemiplegia and hemiparesis affecting right dominant side, aphasia, type two diabetes mellitus, chronic obstructive pulmonary disease, burn of unspecified region of body, vascular dementia, malignant neoplasm, acquired absence of right breast and nipple, and anxiety. Review of Resident #70's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition. Review of Resident #70's physician order dated 04/04/25 revealed an order for Butrans Transdermal Patch Weekly (Schedule III controlled substance for pain) one patch applied transdermally one time a day every seven days for pain. Review of Resident #70's Medication Administration Record (MAR) for April 2025 revealed the Butrans patch was not applied on 04/04/25 and 04/11/25. The patch was marked as being given on 04/18/25 and 04/24/25. Review of Resident #70's progress note dated 04/04/25 revealed the Butrans patch was not available. Review of Resident #70's physician note dated 04/07/25 revealed the resident had chronic pain syndrome, the physician recommended continuing the Butrans patch. Review of Resident #70's progress notes revealed no indication the physician was notified the Butrans patch was unavailable. Interview on 04/30/25 at 10:18 A.M. and 11:05 A.M. with the Director of Nursing (DON) revealed nobody had notified her or the physician that the Butrans patch was unavailable. She reported the pharmacy received the order on 04/03/25 but they did not get the prescription until 04/25/25 because the physician was unaware. She reported the resident's pain had been controlled by switching her as needed medication to scheduled.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 37100 Based on facility staff schedule review and staff interviews, the facility failed to provide registered nurse (RN) coverage as required. This had the potential to affect all 70 residents residing in the facility. Findings Include: Review of facility staff schedule, dated 07/14/24 to 08/31/24, revealed the following days did not have the proper RN coverage: 07/14/24 (no RN), 07/16/24 (no RN), 07/17/24 (no RN), 07/20/24 (no RN), 07/21/24 (no RN), 07/22/24 (no RN), 07/23/24 (no RN), 07/24/24 (no RN), 07/27/24 (only seven hours of RN coverage), 07/28/24 (no RN), 07/30/24 (no RN), 07/31/24 (no RN), 08/05/24 (only 5.25 hours of RN coverage), 08/07/24 (no RN), 08/10/24 (no RN), 08/14/24 (no RN), 08/19/24 (no RN), 08/20/24 (no RN), 08/21/24 (no RN), 08/24/24 (no RN), 08/25/24 (no RN), 08/27/24 (no RN), and 08/28/24 (no RN). Interview with Director of Nursing (DON) on 05/01/25 at 11:00 A.M. confirmed the dates listed above did not have proper RN coverage.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43064 Based on record review, observation and interview, the facility failed to monitor, thoroughly document, and prevent Resident #48's behaviors. This affected one resident (#48) of four residents reviewed for mood and behavior. The facility census was 70. Findings include: Review of Resident #48's medical record revealed an admitted [DATE] with diagnoses including dementia with other behavioral disturbance, vascular dementia with agitation, atherosclerotic heart disease, generalized anxiety disorder, major depressive disorder, delirium due to known physiological condition, restlessness and agitation, history of traumatic brain injury, and alcohol abuse. Review of Resident #48's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition. He experienced behaviors of wandering and rejection of care during one to three days of the seven-day assessment reference period. Review of Resident #48's physicians order dated 05/10/24 revealed an order to monitor his behavior related to antipsychotic use. These behaviors included paranoid ideations, agitation, and not thinking clearly or logically. Review of Resident #48's physician order dated 05/10/24 revealed an order to monitor his behavior related to antidepressant use. These behaviors included refusing routine care, feeling of hopelessness, and lack of appetite. Review of Resident #48's physician orders revealed nothing related to monitoring sexual behaviors. Review of Resident #48's plan of care dated 11/05/24 revealed the resident demonstrated behaviors where the resident will add in verbal comments to escalate situation, and was verbally inappropriate and would grab at staff. Additionally, the resident rubbed backs and kissed the hands and lips of other residents. Resident #48 was intrusive, and would wear no shirt in the lounge area, he would become agitated, argumentative, and physical with staff. Interventions included a medication change on 10/05/23, medication as ordered, encouraging to pull his shirt down, notifying the physician as needed, offering distraction, stop sign to door, and when behaviors occur de-escalate and document. Review of Resident #48's Certified Nursing Assistant (CNA) documentation for February 2025 revealed sexually inappropriate behaviors occurred on 02/02/25, 02/03/25, 02/04/25, 02/09/25, and 02/10/25. Review of Resident #48's progress notes for February 2025 revealed no indication of what his behaviors were on 02/02/25, 02/03/25, 02/04/25, 02/09/25, and 02/10/25. Review of Resident #48's CNA documentation for March 2025 revealed sexually inappropriate behaviors occurred on 03/24/25, 03/30/25, and 03/31/25 (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #48's progress notes for March 2025 revealed no indication of what his behaviors were on 03/24/25, 03/30/25, and 03/31/25. Review of Resident #48's plan of care dated 03/31/25 revealed the resident had been observed displaying sexually inappropriate behavior including kissing, skin to skin rubbing, and verbal sexual conversations or content. Interventions included limiting any at risk situations, maintaining the resident's dignity, providing alternate activities, providing cues as needed that behavior is unacceptable, and redirecting from entering other resident rooms without permission. Review of Resident #48's CNA documentation for April 2025 revealed sexually inappropriate behaviors occurred on 04/01/25, 04/07/25, and 04/08/25. Review of Resident #48's progress notes revealed no indication of what his behaviors were on 04/01/25, 04/07/25, and 04/08/25. Observation on 04/30/25 at 9:12 A.M. revealed Resident #48 sitting on the couch in the common area next to Resident #35 holding and rubbing her hand. CNA #132 was sitting on a nearby chair and had not said anything. At 9:15 A.M. the surveyor glanced at Resident #48, and he became agitated, stating 'I'm not doing anything wrong'. CNA #132 then looked over to Resident #48 and told him he needed to move away from Resident #35. Resident #48 was agitated, but he complied. Interview on 04/30/25 at 9:17 A.M. with CNA #132 verified Resident #48 should not be holding hands with other residents. Interview on 04/30/25 at 9:23 A.M. with Licensed Practical Nurse (LPN) #196 verified Resident #48 had a behavior of trying to touch other residents inappropriately. She reported the intervention was to keep an eye on him while he was in the common area. Interview on 04/30/25 at 2:20 P.M. with the Director of Nursing (DON) revealed if the CNAs were observing sexual behaviors they should be reporting it to the nurse, and the nurses should be doing a detailed note. She verified the aides indicating sexual behaviors could mean anything for him from lifting up his shirt to kissing other residents. She verified there should be more detailed notes ensuring that any inappropriate behaviors were reported to the relevant responsible parties. She also verified that Resident #48 should not be sitting on a couch next to a female resident due to his behaviors.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43064 Based on observation and interview, the facility failed to maintain the kitchen in a clean and sanitary manner and failed to obtain food temperatures in a sanitary manner. This had the potential to affect all 69 residents who consumed food from the kitchen. Resident #3 consumed nothing by mouth. The facility census was 70. Findings include: 1. Observation on 04/28/25 at 9:30 A.M. and on 04/30/25 at 11:45 A.M. revealed a large grate (about two feet by one foot) in front of the oven; the area under this grate was four to six inches deep. The area had a very thick layer of multiple black and brown substances, and the whole area appeared moist. All walls and surfaces underneath the grate were covered in this. Additionally, observation revealed the floor under equipment and around the edges of the kitchen had a buildup of dirt, food debris, and other items. A plastic cup was observed under the reach-in refrigerator on both occasions. Interview on 04/28/25 at 11:15 A.M. with [NAME] #175 revealed the area under the grate sometimes emitted a smell. Interview on 04/28/25 beginning at 11:45 A.M. with Dietary Manager #138 verified the floor under equipment and in the corners needed to be cleaned. He additionally verified the buildup in the area under the grate. He reported this area drained from the dishwasher. Interview on 05/01/25 at 9:10 A.M. with Maintenance Director #117 indicated that the grate not only received backflow from the dishwasher but was also subject to the kitchen staff's sweeping and mopping and he and the kitchen staff should be responsible for cleaning it. 2. Observation on 04/30/25 beginning at 11:45 A.M. revealed [NAME] #175 taking temperatures of the food on the hot holding unit prior to meal service. She obtained the temperature of the baked beans and then used an alcohol swab and obtained the temperature of the hot dogs, she used the same alcohol swab and moved on to the next food. [NAME] #175 obtained the temperature of the ground hot dog and used a new alcohol swab, she then obtained the temperature of the puree beans and used the same alcohol swab, she then moved on to the next food. [NAME] #175 obtained the temperature of the puree hot dog and used a new alcohol swab and then obtained the temperature of the string beans, she then moved on to the next food. Interview on 04/30/25 at the end of the observation with [NAME] #175 verified the observation.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 43064 Based on observation and interview, the facility failed to maintain the laundry room in a clean and sanitary manner. This had the potential to affect all 70 residents residing in the facility. Findings include: Observation on 05/01/25 at 10:05 A.M. of the laundry room with Maintenance Director #117 revealed the washers were about a foot and a half to two feet from the back wall. All along the back wall were polyvinyl chloride (PVC) pipes and water lines leading from the washer to a drain. Everything from the wall to the pipes were covered in lint. On the floor were multiple wet spots including two puddles that had turned green. The floor around this area was black. In the dirty side of the laundry room, there was a sink with a buildup of dust, lint, and other debris. There were multiple areas of this floor that were cracked and peeling. Along the wall where the flooring was peeling, there was a buildup of dirt and leaves. Interview on 05/01/25 at 10:05 A.M. with Maintenance Director #117 verified the observation, and stated the area needed cleaned. The facility provided policy did not address the concern.