STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366245	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Glen Health Campus	2150 Montego Drive Springfield, OH 45503

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 medical record review, staff interview, nurse practitioner (NP) interview, and review of facility policy, the facility failed to ensure adequate follow up to a critically low laboratory result. This affected (#74) of four closed records reviewed. The census was 71.Findings Include:Review of Resident #74's closed medical record revealed an admission date of 05/14/25. Diagnoses listed bacterial pneumonia, type two diabetes mellitus, chronic obstructive pulmonary disease, and obesity. Resident #74 was discharged on 05/31/25. Review of an admission Minimum Data Set (MDS) dated [DATE] revealed Resident #74 was cognitively intact.Review of laboratory results dated [DATE] revealed Resident #74 potassium level was critically low at 2.5 milliequivalents per liter (mEq/L) on 05/29/25. The normal range for potassium was 3.5 to 5.3 mEq/L. Review of physician orders revealed Resident #74 was given 40 mEq of Potassium Chloride by mouth at two different times on 05/19/25. A daily dose of Potassium Chloride was changed from 20 mEq to 40 mEq. Review of discharge paperwork dated 05/31/25 revealed no instructions for Resident #74 to have any laboratory test completed.Review of progress notes revealed Resident #74 and family were called on 05/31/25 and told to go the hospital for a critical potassium level of 2.5 mEq/L.Review of hospital records dated 05/31/25 revealed Resident #74's potassium level was at a critical level of 2.9 mEq/L. Resident #74 was admitted for hypokalemia (low potassium) and stayed in the hospital until discharge on [DATE].Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 08/20/25 at 8:00 A.M. revealed Nurse Practitioner (NP) #112 was called on 05/29/25 for the Resident #74's critical potassium level and medications changes were made. The DON stated Resident #74 was called by the former ADON on 05/31/25 when the critical potassium level from 05/29/25 of 2.5 mEq/L was received again from the laboratory. The former ADON did not realize medication changes had been made. The DON confirmed Resident #74's potassium level was not re-checked after 05/29/25 before the resident discharged home on [DATE].Phone interview with NP #112 on 08/20/25 at 11:07 A.M. revealed he made medications changes to attempt correct Resident #74's low potassium level. NP #112 wanted a metabolic panel collected to re-check Resident #74's potassium level. NP #112 was not informed that Resident #74 was discharging on 05/31/25 or he stated he would have had her potassium level re-checked sooner and before Resident #74's discharge. Review of the facility's policy titled Discharge Summary and Plan dated October 2022 revealed when a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. The facility must permit each resident to remain in the facility, and not transfer or discharge.This deficiency represents non-compliance investigated under Complaint Number 1281294.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and review of facility policy, the facility failed to distribute meals in a sanitary manner in the memory care unit. This had the potential to affect all 20 residents that eat in the memory care unit. The census was 71. Findings Include:Observation of lunch being served in memory care unit on 08/19/25 at 11:28 A.M. revealed meals are served from a plastic table set up in the hallway outside the dining area. Utensils used to serve food, plates, cups, and pitchers of drinks were sat directly on the table. The table was not observed to be sanitized before the start of meals service.Food was brought to the hall by a heated carrier at 11:50 A.M. Metal pans of mashed potatoes, salisbury steak, and brussel sprouts were set directly on the table by Activity Assistant (AA) #102. There was not a steam table or any appliance to maintain food temperatures.At 11:52 A.M. the meals were started to be served by AA #102. No food temperatures were taken before meal service. Food was served from the pan on the table using utensils that were sat directly on the plastic table. At 12:10 P.M. Resident #50 requested more food. Certified Nursing Assistant (CNA) #104 brought Resident #50's used lunch plate to AA #102 who scooped more portions of each item onto the plate. Interview with AA #102 and CNA #103 on 08/19/25 at 12:15 P.M. confirmed the table was not sanitized right before meals being served. The table is cleaned by dietary staff when meals are cleaned up, but that would have been right after breakfast. The table is in the hallway and can be touched by staff, residents, or visitors between meals. AA #102 confirmed food temperatures are not taken when food arrives at the hall and before food is served to residents. AA#102 also confirmed she had scooped food onto Resident #50's used lunch plate.Review of the facility's policy titled Food handling dated September 2021 revealed food will be stored, prepared, handled and served so that the risk of foodborne illness minimized. The facility identified Residents (#1, #2, #3, #4, #25, #29, #34, #38, #40, #42, #44, #50, #52, #54, #58, #59, #62, #65, #66, and #67) as eating in the memory care unit.This deficiency represents an incidental finding discovered during the course of the complaint investigation.