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	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Glen Rehabilitation and Healthcare Center	2150 Montego Drive Springfield, OH 45503

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review, observations, resident and staff interviews and policy review, the facility failed to ensure residents were treated with dignity when they failed to ensure residents did not have long unwanted facial hair. This affected one (#01) out of one residents reviewed for dignity. The facility census was 74. Findings include: Review of the medical record for Resident #01 revealed an admission date of 04/02/24 with diagnoses of Parkinson's disease without dyskinesia, osteoarthritis, contracture, left hand, muscle wasting and atrophy right thigh, and muscle wasting and atrophy, left thigh. Review of the quarterly Minimum Data Set (MSD) dated 11/27/25 revealed resident with moderate cognitive impairment, she has functional limitation in range of motion impairment on both sides of upper and lower extremities. Resident #01 required set-up assistance with eating. Resident #01 required supervision assistance with ambulation. Resident #01required partial assistance with oral hygiene and transfers. Resident #01 required substantial assistance with bathing, personal hygiene, and bed mobility. Resident #01 was dependent on staff assistance with toileting hygiene, dressing, and wheelchair mobility. Review of the Care Plan dated 12/04/25 revealed resident had an activities of daily living (ADL) self-care performance deficit related to fluctuating ADLs, impaired vision, Parkinson's disease, poor balance, and poor coordination with interventions of allow time for resident to express feelings of frustration regarding the need for assistance in ADL tasks, encourage participation in daily care and provide positive reinforcement for activities attempted and/or partially achieved. Review of the nurses' note dated 01/28/26 at 3:15 P.M. revealed a bed bath was given by the Certified Resident Care Assistant (CRCA) without difficulty. Observation on 01/27/26 at 8:53 A.M. revealed Resident #01 was resting in bed with multiple hairs present on her chin, some approximately a half (1/2) inch long. During the observation Resident #01 expressed concern that staff do not assist with her care needs. Observation on 01/29/26 at 11:34 A.M. Resident #01 lying in bed with multiple, inch long chin hair coming from her chin. Interview on 01/29/26 at 11:35 A.M. with Resident #01 confirmed she has multiple, inch long, hair coming from her chin. Interview with Resident #01 confirmed that no one gave her the razer to shave them, no one told her about her chin hair, being there even though she had a bed bath yesterday. Interview on 01/29/26 at 11:43 A.M. with Certified Nursing Assistant (CNA) #209 confirmed she did not shave Resident #01. Interview with CNA #209 also confirmed that Resident #01 has multiple inch long chin hairs present on her chin. Interview with CNA #209 also confirmed that Resident #01 is unable to shave herself and needs assistance from staff. CNA #209 confirmed there is not a reminder to perform personal hygiene on Resident #01. CNA #209 also confirmed that Resident #01 did not refuse to be shaved. CNA #209 confirmed she did not know Resident #01 had an electric razer available in the bathroom. Interview on 01/29/26 at 11:47 A.M. with Registered Nurse (RN) #237 confirmed she did not know Resident #01 had multiple long chin hairs present on her chin. RN #237 confirmed Resident #01 should be offered to shave with each bath. Review of the Activities of Daily Living (ADLs) policy dated October 2025 revealed residents will be provided care, treatment, and services as appropriate. Residents who are unable to perform their own care will receive the services to maintain good grooming and personal hygiene.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of facility self-reported incidents (SRI), staff interview, and policy review, the facility failed to ensure an allegation of abuse was reported to the state agency in a timely manner as required. This affected one (#48) of three residents reviewed for abuse. The facility census was 74. Findings include: Review of medical record for Resident #48 revealed an admission date of 10/10/23 with diagnoses of major depressive disorder and dementia moderate with behavioral disturbance. Review of minimum data set (MDS) dated [DATE] revealed a brief interview of mental status (BIMS) score of three which indicated severe cognitive impairment. Review of communication-with family/next of kin/power of attorney note dated 01/10/26 at 7:54 P.M. revealed this nurse contacted family regarding staff finding the resident in bed naked with another resident who was also naked. Staff immediately removed the resident from the room and took her back to her room. 15-minute safety checks were initiated. Review of the facility's SRI Form Initial Report Resident #48 abuse was reported to the state agency on 01/11/26 at 7:11 A.M., 10 hours and 17 minutes after becoming aware of Resident #48 being found naked in another resident's bed. Date of discovery per SRI was 01/10/26 at 7:50 P.M. Further review of medical record for Resident #48 revealed a nurse's note dated 01/11/26 at 6:45 P.M. late entry revealed the aide reported to the nurse that while doing 15-minute checks on the resident they found the resident in her room with a male resident standing at the bedside as they were kissing. The residents were immediately separated and checks continued. Review of the facility's SRI form initial report Resident #48 abuse was reported to the state agency on 01/11/26 at 8:46 P.M., two hours and two minutes after becoming aware of Resident #48 being found kissing a male resident. Date of discovery per SRI was 01/11/26 at 6:44 P.M. Further review of medical record for Resident #48 revealed a nurses note dated 01/13/26 at 1:30 A.M. revealed observation of the resident in her room laying in bed with another resident on top of her both naked fondling one another. The residents were separated and skin assessments completed with no new areas noted. The resident continues 15-minute checks currently. Review of the facility's SRI form initial report for Resident #48 abuse was reported to the state agency on 01/13/26 at 6:58 A.M., eight hours and eight minutes after becoming aware of Resident #48 being found naked in bed with another resident. Date of discovery per the SRI was 01/12/26 at 10:50 P.M. Interview on 02/10/26 at 1:46 P.M. with the Administrator revealed that she did not file the report the SRI within two hours as she was confused as to the timing of the reporting. Administrator stated she thought she had 24 hours since there was no bodily injury to Resident #48 for any incident. Administrator verified the reports were not submitted within two hours for abuse per the policy. Review of policy titled Abuse Investigation and Reporting dated October 2025 revealed an alleged violation of abuse, neglect, exploitation or mistreatment including injury of unknown source and misappropriation of resident property will be reported immediately, but not later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury.This deficiency represents non-compliance investigated under Complaint Number 2739464.

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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 interview, and policy review, the facility failed to ensure the comprehensive care plan was developed to address a resident's aggressive behaviors. This affected one (#55) of two residents reviewed for behaviors. The facility census was 74.Findings include: Review of medical record for Resident #55 revealed an admission date of 11/25/25 with diagnoses including but not limited to dementia with agitation and major depressive disorder. Review of Resident #55's care plan dated 11/26/25 revealed there was no care plan to address aggressive behaviors. Review of minimum data set (MDS) dated [DATE] revealed a brief interview of mental status (BIMS) score of six which indicated severe cognitive impairment. Disorganized thinking was present but fluctuated. Review of nurses note dated 01/15/26 at 6:52 P.M. revealed the resident was requiring frequent redirection as she is attempting to initiate physical contact with a male resident and becomes agitated with staff stating that is her husband. Review of nurses note dated 01/20/26 at 5:07 A.M. revealed while attempting to give the resident morning medication, the resident spit in the nurse's face. The nurse attempted to redirect the resident when she became increasingly agitated and combative with staff. Review of nurses note dated 01/20/26 at 1:15 P.M. revealed the resident becomes very agitated and argumentative with the nurse when redirected away from another male resident due to her reaching for his hand. The nurse redirects the resident away from the male resident each time. Interview on 01/29/26 at 8:52 A.M. with MDS #198 revealed there was no behavioral care plan for aggressive behaviors for Resident #55. MDS #198 confirmed Resident #55 has exhibited aggressive behaviors. Interview on 01/29/26 at approximately 11:30 A.M. with MDS #198 verified that Resident #55's care plan for behaviors was initiated after it was brought to her attention that there was not one currently by the surveyor. Review of policy titled Care Plans, Comprehensive Person-Centered dated 11/25 revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan will incorporate identified problem areas.

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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 interview, and policy review, the facility failed to timely revise a resident's care plan regarding a change in fluid restrictions. This affected one (#10) of 23 residents reviewed for care plan revisions. The facility census was 74. Findings include: Review of medical record for Resident #10 revealed an admission date of 10/29/25 with diagnoses including but not limited to type two diabetes, sepsis, atrial fibrillation, congestive heart failure, and compression of brain. Review of care plan dated 10/29/25 revealed the resident is at risk for fluid volume deficit related to congestive heart failure, diuretic use, and fluid restriction. Resident is non-compliant with fluid restriction. Physician is aware. Interventions included 1800 ml fluid restriction: 480 ml for breakfast, 480 ml for lunch, and 360 ml for dinner. 480 ml from nursing and snacks, labs as ordered and monitor weight per physician order. Review of minimum data set (MDS) dated [DATE] revealed the resident was cognitively intact. Review of current physician orders revealed fluid restriction starting on 11/20/25 of 2000 milliliters (ml) in 24 hours: dietary 1080 ml (breakfast 480 ml, lunch 360 ml, dinner 240 ml) nursing 920 ml (day shift 500 ml, evening shift 300 ml, night shift 120 ml). Interview on 02/09/26 at 12:26 P.M. with MDS #198 stated resident care plans are updated if an acute process occurs, the MDS update is due, and that anyone can update or revise the care plans. MDS #198 verified that the care plan was not updated to reflect the new fluid restriction of 2000 ml in 24-hour period. MDS #198 verified the care plan still had 1800 ml fluid restriction. Review of policy titled Care Plans, Comprehensive Person-Centered dated 11/25 revealed assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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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, review of facility self-reported incidents (SRI's) observations, staff interviews, and policy review, the facility failed to provide adequate supervision regarding residents sexual behaviors on the memory care unit. This affected two (#48 and #73) of two residents reviewed for supervision. Additionally, the facility failed to ensure residents were transferred in a proper manner. This affected one (#28) of one reviewed for transfers. The facility census was 74. Findings include: 1.Review of medical record for Resident #48 revealed an admission date of 10/10/23 with diagnoses of major depressive disorder and dementia moderate with behavioral disturbance. Review of minimum data set (MDS) dated [DATE] revealed a brief interview of mental status (BIMS) score of three which indicated severe cognitive impairment. Review of communication-with family/next of kin/power of attorney note dated 01/10/26 at 7:54 P.M. revealed this nurse contacted family regarding staff finding the resident in bed naked with another resident who was also naked. Staff immediately removed the resident from the room and took her back to her room. 15-minute safety checks were initiated. Review of nurse's note dated 01/11/26 at 6:45 P.M. late entry revealed the aide reported to the nurse that while doing 15-minute checks on the resident they found the resident in her room with a male resident standing at the bedside as they were kissing. The residents were immediately separated and checks continued. Review of revealed a nurses note dated 01/13/26 at 1:30 A.M. revealed observation of the resident in her room lying in bed with another resident on top of her both naked fondling one another. The residents were separated and skin assessments completed with no new areas noted. The resident continues 15-minute checks currently. 2. Review of medical record for Resident #73 revealed an admission date of 04/26/25 with diagnoses including but not limited to dementia, major depressive disorder, and generalized anxiety disorder. Review of MDS dated [DATE] revealed a BIMS score of three indicating severe cognitive impairment. Review of communication- with family/next of kin/power of attorney note dated 01/10/26 at 7:59 P.M. revealed this nurse called and notified family about staff finding the resident naked in his bed with another resident also naked in his bed. Staff immediately removed the other resident from the room. One staff member stayed with Resident #73 and made sure he got clothes back on and that he was okay. 15-minute safety checks initiated. Review of nurses note dated 01/11/26 at 6:45 P.M. late entry revealed the aide reported to nurse that upon 15-minute check she found this resident in Resident #48's room leaning over the resident in bed kissing her. Residents were separated immediately and administrator notified. Review of nurses note dated 01/13/26 at 2:05 A.M. revealed observations of resident lying in bed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with another resident with clothes off fondling one another. The residents were separated and assisted back to their room. Skin assessments performed with no new areas noted. The resident continues 15-mnute checks. On-call assistant director of nursing and family made aware. Review of facility SRI dated 01/13/26 at 6:56 A.M. with a date of discovery of 01/12/26 at 10:50 P.M. revealed the following details: On 01/10/26 at 7:50 P.M. aides were rounding. On 01/10/26 at 7:54 P.M. Residents #73 was found naked in bed in room with Resident #48. The residents were immediately separated and family, physician, and administrator were notified. 15-minute checks were initiated. On 01/11/26 at 6:44 P.M. Resident #73 was found in Resident #48's room. The residents were immediately separated and family, physician, and administrator was notified. One on One supervision was implemented. On 01/12/26 at 10:50 P.M. staff were rounding and Resident #73 was found in Resident #48's room in bed with her. The residents were immediately separated. On 01/12/26 at 10:52 P.M. families, physician, and administrator notified. One on One supervision was implemented. Interview on 02/10/26 at 1:46 P.M. with the Administrator revealed that 15-minute checks were initiated after the first incident on 01/10/26 where Resident #73 and #48 were found naked in bed. The Administrator stated on 01/11/26 after the residents were found kissing that one-on-one supervision was initiated. The Administrator stated that on 01/12/26 Resident #73's roommate had passed away and the staff were in that room getting the resident cleaned up for transport. Administrator stated the staff member who was supposed to be with Resident #73 also went to help the staff leaving Resident #73 unattended. Administrator stated that during that time Resident #73 went into Resident #48's room and both were found lying in bed naked fondling each other. Administrator verified if one-on-one was completed on 01/11/26 then the residents would not have been able to get into bed together on 01/12/26. Observation on 02/10/26 at 2:15 P.M. of the memory care unit revealed that Resident #48 and Resident #73's rooms were beside each other. 3. Review of the medical record for Resident #28 revealed an admission date of 11/07/22 with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease, hypertensive chronic kidney disease , and chronic systolic (congestive) heart failure. Review of the Quarterly MDS dated [DATE] revealed Resident #28 had moderate cognitive impairment and requires substantial assistance with transfers and Resident #28 was dependent on staff assistance with wheelchair mobility. Review of the care plan, dated 07/14/25 revealed Resident #28 had ADL self-care functional performance deficit related to anxiety, congestive heart failure, chronic fatigue, generalized weakness, impaired mobility, and seizures. Interventions include assist with activities of daily living (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as needed, place call light within reach and transfer with one person assistance. Further review of the care plan revealed a revision on 01/31/26 of the fall care plan revealed Resident #28 was at risk for falls related to cerebral vascular accident affecting the left side and abnormal gait. Interventions included non-skid socks / peroper footwear during transfers, gait belt use, therapy referral and staff education. Review of the nurses note dated 01/25/26 at 6:15 P.M. revealed Resident #28 complained of pain to her right lateral chest and stated she was being transferred from her wheelchair to the recliner by staff and the staff member did not lift her all the way causing her to hit her side on the wheelchair. Bruising was present on her right lateral chest. Physician notified and new orders for a chest X-ray of lateral right side and an X-ray of Resident #28's right hip was ordered. Review of the Interdisciplinary Team (IDT) Meeting Note dated 01/26/26 at 10:25 A.M. revealed Resident #28 informed nurse of pain in her right lateral chest. Upon assessment nurse observed dark purple bruising to her right side. Bruising extends from mid lateral right chest to her right hip, bruising observed in the right side of her groin. Resident #28 stated she was being transferred from her wheelchair to her recliner by staff and the staff member did not lift her all the way causing her to hit her side on the wheelchair. Resident #28 is on 5mg Eliquis twice daily. Nursing Recommendations: Clinical staff education on proper transfer techniques Review of the fall investigation dated 01/25/26 at 6:15 P.M. revealed Resident #28 reported she was being transferred from the wheelchair to the recliner by staff and they did not lift Resident #28 all the way causing Resident #28 to hit side on the wheelchair. Dark purple bruising was observed from Resident #28's right lateral chest to the right hip. Physician was notified and orders were received for a chest X-ray of lateral right side and an X-ray of Resident #28's right hip. Review of the Statement of Witness Form dated 01/25/26 revealed CNA #331 was transferring Resident #28 when the resident was not able to completely stand causing Resident #28 to hit her right side on the wheelchair. Review of the root cause analysis dated 01/30/26 revealed Resident #28 was improperly transferred from the wheelchair to the recliner. CNA #331 was educated on proper transfers on 01/30/26. Interview on 02/09/26 at 10:47 A.M. with CNA #331 confirmed on 01/25/26 at 6:15 P.M. she was transferring Resident #28 when the resident did not stand up fully. Interview confirmed CNA #331, continued the transfer Resident #28 causing Resident #28 to hit her right side on the wheelchair. Interview also confirmed Resident #28 was a one person transfer at the time. Interview also confirmed CNA #331 did not ask for assistance when she noticed the resident did not stand up fully. Review of the Activities of Daily Living (ADL) policy, dated October 2025 revealed resident will be provided care and services as appropriate to maintain their abilities to care out their ADLs including appropriate assistance with mobility and transfers. This deficiency represents non-compliance investigated under Complaint Number 2739464.