STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366389	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hills Healthcare Center.	8700 Moran Road Cincinnati, OH 45244

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 35770 THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NONCOMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observations, medical record review, review of the incident log, review of facility in-service records, review of a personnel file, review of the safety inspection bus checklist, review of witness statements and the facility's internal investigation, review of policies, review of the emergency medical services (EMS) report, review of emergency room (ER) notes, interview with the Medical Director, and resident and staff interviews, the facility failed to ensure a resident dependent on staff, was safely secured in the wheelchair with an appropriate seat belt during transportation in a facility van to a physician's visit. This resulted in Immediate Jeopardy when one resident (#15) was placed at potential risk for serious life-threatening harm and/or injuries, when Former Transport Driver (FTD) #34 abruptly stopped the facility van, causing Resident #15 to come out of her wheelchair and landing on the floor, towards the front of the van sustaining a hematoma (a solid swelling area of clotted blood within the tissues), causing increased pain, and lacerations that required sutures. This affected one (#15) of three residents reviewed for use of assistive devices during transportation. The facility identified a total of 23 residents who utilized a wheelchair, the transport van, and would be required to have their seat belt engaged. The facility census was 100. On 04/30/24 at 3:23 P.M., the Administrator, and Director of Nursing (DON) were informed that Immediate Jeopardy began on 03/15/24 at approximately 12:30 P.M., when Resident #15 was being transported to a physician's appointment via the facility's transportation bus, when FTD #34 failed to properly and safely secure Resident #15 in her wheelchair prior to leaving the facility. During the trip to the physician's office, the driver abruptly stopped for a traffic signal, causing Resident #15 to come out of her wheelchair by sliding under the seat belt and landing on the floor towards the front of the van. FTD #34 stopped to check on Resident #15, and when the resident stated she was hurt and wanted to go the hospital, FTD #34 drove back to the facility with Resident #15 lying on the floor of the van unsecured and rolling around on the floor. Once FTD #34 returned to the facility, he alerted the receptionist to get the Administrator and a nurse and Emergency nine-one-one (911) was called and Resident #15 was then taken to the emergency room for evaluation and treatment. Resident #15 was treated for a hematoma (a solid swelling area of clotted blood within the tissues), pain, and laceration to her lower right leg that required sutures. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER: Forest Hills Healthcare Center.		STREET ADDRESS, CITY, STATE, ZIP CODE: 8700 Moran Road Cincinnati, OH 45244	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy was removed on 03/20/24; however, the deficiency remained at Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) until it was corrected on 04/26/24 when the facility implemented the following corrective actions: On 03/15/24 between 12:30 P.M. and 12:40 P.M., Resident #15 slid from her wheelchair in a facility owned and operated van while being transported by a facility staff member (FTD #34) to a routine scheduled physician appointment. Resident #15 is an [AGE] year-old female admitted to facility on 8/29/23 to reside long term. Resident notes to have diagnoses to include morbid obesity, fibromyalgia, disc degeneration, cerebral infarction, muscle weakness, gait abnormalities, chronic respiratory issues, polyarthritis, and hypertension. Resident #15 requires transportation via wheelchair. Resident #15 noted to have Brief Interview Mental Status (BIMS) of 15 which indicated the resident was cognitively intact. The incident occurred 1.1 miles from the facility at a traffic light. The determination of the Root Cause Analysis (RCA) is inconclusive. FTD #34 stated Resident #15 took her arms out of the seatbelts to look at her papers. Resident #15 denied removing her arms from the seatbelts and stated she just slid out. The investigation revealed FTD #34 did not follow the facility policy that he had previously been educated on by returning the resident to the facility verses calling 911 immediately. On 03/15/24 at 12:45 P.M., Resident#15 arrived back at the facility and was immediately assessed by Licensed Practical Nurse (LPN)/Unit Manager #37 and former DON #38. The resident was discovered on the floor of the van in front of her wheelchair. Resident #15 was lying on her left side with her head up and looking at the staff. Resident#15 had a laceration to her right knee with no other injuries noted at that time. Resident #15 stated she slid from her wheelchair and her right leg was hurting. On 03/15/24 at 12:46 P.M., Nurse Practitioner (NP) #62 was notified and ordered Resident #15 to be sent to the ER. On 03/15/24 at 12:46 P.M., 911 was called by LPN #39. On 03/15/24 at 12:50 P.M., former DON #38 notified Resident #15's family. On 03/15/24 at 1:00 P.M., EMS arrived at the facility and transported Resident #15 to the ER for further evaluation and treatment. On 03/15/24 at 1:15 P.M., former DON #38 and LPN #39 updated Resident #15's care plan to include: Send Resident #15 to the ER, wheelchair safety education for the resident, provide an escort for all transport/appointments and skin/laceration care. On 03/15/24 at 1:35 P.M., the Administrator ceased all transportation for in-house facility transports. On 03/15/24 at 1:45 P.M., the Administrator and former DON #38 interviewed FTD #34 and an investigation started regarding the entire incident and actions that transpired during the incident. On 3/15/24 at 2:00 P.M., a van inspection was completed by Maintenance Director #41 and no mechanical issues or malfunctions were discovered. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/15/24 at 2:00 P.M., FTD #34 was interviewed, and a written statement was obtained. FTD #34 received a final level Corrective Action Form conducted for failure to follow transportation protocol. FTD #34 was suspended as of 03/15/24 pending an investigation of the incident to allow for investigation, education, and ensure no other incidents had occurred. FTD #34 did not return to work and made no other transportation after this incident for the facility. On 03/15/24 at 2:00 P.M., the transportation policy was reviewed with the three staff members authorized to complete resident transports. Maintenance Director #41, Transportation Driver (TD) #30, and FTD #34. On 03/15/24 at 2:30 P.M., the designated facility TD will perform inspections for the transportation vehicle/equipment to ensure safe and functional operation every day prior to any transportation needs. These inspections are to be verified by Maintenance Director #41 after each inspection is completed for the next 30 days then the facility will transition to three times weekly for three months and then monthly ongoing. Should Maintenance Director #41 not be available to complete this verification, it will be performed by Regional Director of Maintenance #40/Designee. On 03/15/24 at 3:30 P.M., Central Supply Coordinator/Transportation Scheduler #31 conducted an audit of a 30-day lookback of all resident's transportation provided by facility to ensure no other incidents had occurred. No concerns were identified from this audit. On 03/15/24 at 4:00 P.M., Resident #15 was immediately switched to another transportation service. The Administrator secured an outside transportation company for all facility transports until further notice. All appointments were transferred to the outside provider. Beginning 03/15/24, to monitor for ongoing compliance, Maintenance #41/Designee will audit the facility van three times weekly for three months and then will perform inspections monthly ongoing to ensure the transportation vehicle/equipment is safe and functioning. Beginning 03/15/24, to monitor for ongoing compliance, Maintenance Director #41/Designee will audit via observations and return demonstrations of the facility transportation drivers weekly for one month and then monthly for three months to ensure residents are secured appropriately and safely. Beginning 03/15/24, to monitor for ongoing compliance, Maintenance Director #41/Designee will supervise one transportation run monthly for one year to ensure appropriate transportation methods are in place per the facility's policy. This was implemented on 3/15/24 and started on 03/26/24 when in-house transports were resumed. All results of the audits will be included in each QAPI with any findings. On 03/16/24 at 8:30 P.M., Resident #15 was transported back to the facility. Resident #15 sustained a laceration on her right knee and seven sutures were placed. All other imaging and diagnostics tests were negative. On 03/17/24 at 10:00 A.M., former DON #38 interviewed Resident #15 and received her verbal statement. Resident #15 stated she was riding in the transport van and when the driver (FTD #34) stopped, she slid out of her wheelchair. Resident #15 indicated she stayed on the floor of the van until the driver got back to the building and then she went to the hospital. Resident #15 was educated on safety during transports. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/19/24 at 10:00 A.M., Regional Director of Maintenance #40 conducted one-on-one (1:1) training, conducted competencies and check offs with a return demonstration with all three authorized transportation drivers (Maintenance Director #41, FTD #34 and TD #30) to ensure previous education was understood and to remain compliant with safety precautions. FTD #34 was not reinstated afterwards due to FTD #34 providing the facility with his resignation. Education included: Vehicle safety, Safety and Health Programs, Mandatory Transport Driver Training, Drivers Training Classroom Curriculum, Company Vehicle Driver Program (Fleet Safety Program), Safer Transportation of Wheelchair Passengers, Passenger Safety During Transport, New Driver Request Forms, Transport Staff Performance Agreement, Emergency Supplies Check list, Monthly Preventative Maintenance, and Quarterly Vehicle Inspection Reports and initiated immediately. The policy was reviewed again on 03/19/2024 by Regional Director of Maintenance #40 with the Administrator, Maintenance Director #41, FTD #34 and TD #30. Regional Director of Maintenance #40 conducted competencies and check offs with a return demonstration to ensure previous education was understood and to remain compliant with safety precautions. On 03/19/24 at 11:00 A.M., the transportation policy was reviewed by the Administrator. All facility transportation remained stopped and no new changes were implemented to the policy. All facility transports were being conducted by an outside provider. On 03/19/24 at 4:00 P.M., a Post Traumatic Stress Disorder (PTSD) screen was completed on Resident #15 and added to the care plan by Director of Social Services #66. The following new interventions were added: To assist and identify what triggers PTSD episodes, encourage slow/deep breathing exercises, reassuring conversation with pleasant topics, observe for increased agitation, anxiety, and offer quiet areas and comfort items, observe resident in group situations and prevent resident from becoming over stimulated, sudden unexpected noises, and new/tv programming may also trigger resident incident, offer quiet area, speak in calm quiet voices and offer reassurance. On 03/20/24 at 11:00 A.M., an Ad Hoc Quality Assurance Performance Improvement (QAPI) meeting was held with attendees including: The Administrator, Former DON #38, Medical Director (MD) #64, LPN/Clinical Manager #70, Maintenance Director #41, LPN/Unit Manager #37, Central Supply Coordinator #31, LPN #39, [NAME] President of Risk Management #72, Regional Director of Clinical Operations (RDCO) #78, and Regional Director of Operations (RDO) #80 regarding this incident and discussion was held regarding transportation protocols and safety, falls, and steps the facility is taking moving forward to prevent further reoccurrence of the incident. On 04/02/24 at 11:00 A.M., the vehicle insurance company obtained a report of the incident and once the insurance started their investigation their findings were handled through the insurance. No results/findings have been returned to the facility. On 04/08/24, Resident #15 had an outside appointment at a physician's office and did not have any identified concerns during the transport via the outside provider. On 05/07/24 between 1:00 P.M. and 2:00 P.M., interviews with TDs #30 and #58 and Maintenance Director #41, each stated they were in-serviced and educated on properly transporting residents and are utilizing the complete Q'Straint system. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/08/24, review of four (#27, #50, #38 and #21) additional resident's medical records who required assistive devices for transportation revealed no concerns. On 05/08/24, review of the facility's Transportation Safety Audits including Inspections and Ride Along's revealed the audits were performed as scheduled from 03/15/24 through 04/26/24 with no issues identified. Findings Include: Review of medical record for Resident #15 revealed the resident was admitted on [DATE] with diagnoses including, but not limited to, morbid obesity, fibromyalgia, disc degeneration, cerebral infarction (stroke), muscle weakness, severe spondylosis, gait abnormalities, chronic respiratory, polyarthritis, and wheelchair dependent for propelling. Review of the plan of care for Resident #15 dated 08/29/23 and revised on 03/20/24, revealed the resident had a self-care performance deficit related to weakness. Resident #15 required substantial/maximal assist with Activities of daily living (ADLs). Review of the personnel file for FTD #34 revealed he was hired on 01/02/24 and was provided with training on safe resident transports. On 03/15/24, FTD #34 failed to follow proper transportation protocols, was suspended, and received a final written warning due to safety/carelessness. FTD #34 resigned his position on 03/19/24. Review of a facility document tiled Driver Essential Competencies assessment dated [DATE], revealed FTD #34 completed a competency assessment and met all requirements to complete the task of transportation and skills were observed by Regional Maintenance Director #40. Review of a facility document titled Appointment /Transportation Request Form dated 03/12/24 for Resident #15, revealed the resident had a follow-up physician appointment on 03/15/24 at 1:45 P.M. Resident #15 was going by a standard wheelchair in the facility's van. Review of the facility's timeline of events revealed on 03/15/24 at approximately 12:30 P.M., Resident #15 was placed in the facility's van by FTD #34 for a routine physician's appointment. FTD #34 reported that Resident #15 fell from the wheelchair during transport. At 12:45 P.M., the van arrived back at the facility and Resident #15 had remained on the floor and was immediately assessed. Resident #15 had complaints of generalized pain, with more specific complaints of pain to the right hip, neck, shoulders, and sustained a laceration to the right knee. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a written statement by FTD #34 dated 03/15/24, revealed at 12:40 P.M., he placed Resident #15 in the facility van. All four tie downs were securely placed on the wheelchair. FTD #34 checked the wheelchair, and it would not move, and then placed the seatbelt across Resident #15's waist and made sure she was properly secured. FTD #34 departed the facility at 12:45 P.M., heading to the resident's doctor appointment. He turned left out of the driveway heading towards State Route 32. Resident #15 requested to see her paperwork in the envelope due to her questioning the time of her appointment. FTD #34 was at a complete stop at a stop sign right outside the facility and handed Resident #15 her paperwork. FTD #34 assured the resident that he had the correct time. FTD #34 was watching the road, the light went from yellow to red, he applied the brakes and stopped at the red light in the right lane. FTD #34 glanced in the rearview mirror and observed Resident #15 sliding under the seat belt and making contact with the floor. FTD #34 immediately pulled over to the side of the road and asked Resident #15 if she was hurt and immediately turned around and went back to the facility. Once he returned to the facility, FTD #34 had the receptionist contact the nurse and the Administrator to come to the van. Review of a progress note dated 03/15/24 at 12:45 P.M. and recorded as a late entry by former DON #38, revealed Resident #15 had a fall from her wheelchair inside the transport van. Resident #15 complained of pain and was sent to the ER. Review of a facility document titled Fall Occurrence revealed on 03/15/24 at 12:45 P.M., resident had an observed fall off the premises while being transported. Resident #15 was found on her back/right side near the wheelchair in the transport van. Review of a progress note dated 03/15/24 at 12:56 P.M. and recorded as a late entry by former DON #38, revealed FTD #34 reported Resident #15 fell from her wheelchair while being transported to an appointment. The resident had head and skin injuries from a witnessed fall. Resident #15 complained of generalized pain, specific to right hip, neck, and shoulder, and had a laceration to her right knee. The Nurse Practitioner (NP) was notified and ordered to send the resident to the ER. EMS arrived and transported the resident to ER. Review of a Post Fall Evaluation dated 03/15/24 at 12:56 P.M. for Resident #15 and authored by former DON #38, revealed the resident had a witnessed fall on 03/15/24 at 12:45 P.M. while being transported in the facility's van by FTD #34. The resident was assessed to be at a high risk for falls. The resident was found inside the van lying on her right side, arms down to the side, right leg turned outward, and left leg was straight and one foot away from the wheelchair. The assessment revealed the resident had contusion and a gash to the back of the head and skin injuries. Resident #15 complained of pain at a six out of 10 (pain scale where zero is none and 10 is severe) in the back of her head, neck, right hip, and right knee which had bruising. The resident was sent to the ER. The root cause of the fall was determined to be resident positioning in wheelchair and diminished safety awareness and required assistance with ambulation/wheelchair. Interventions to prevent future falls included educating the resident and FTD #34 on wheelchair safety during transports. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the EMS run report dated 03/15/24 revealed upon EMS arrival at 1:00 P.M., Resident #15 was found in the transport van in front of the building in a semi-reclined position, alert and oriented, with complaints of right hip pain, head pain, and right knee pain. Resident #15 stated she fell out of her wheelchair during transport and the driver turned around and drove back to the nursing home after she became unsecured from the wheelchair. Resident #15 was assessed to have right knee pain with skin tear and a skin tear on right wrist and small hematoma on back of the right side of her head. Review of the hospital records dated 03/15/24 at 1:36 P.M. for Resident #15, revealed the resident was evaluated for complaints of a fall and neck pain secondary to being flung out of her wheelchair at a stoplight while in her Skilled Nursing Facility (SNF) transport vehicle which stopped suddenly at a traffic light. Resident #15 presented to the ER with neck pain, back pain, pain in her left mastoid area, right knee pain, headache, right arm pain, right dorsal forearm laceration and a laceration on her right knee. Resident #15 reported she hit the left side of the back of her head as well as her neck. The clinical impressions included laceration to resident's right knee which required seven sutures, a fall and cervicalgia (pain in or around your cervical spine). Resident #15 was discharged back to the facility on [DATE] at 7:24 P.M. with orders to follow-up with her physicians. Review of the Transportation Van/Bus Safety Inspection dated 03/15/24 and completed by Maintenance Director #41 after the incident involving Resident #15's fall, revealed the vehicle and all restraints were in proper working order with no malfunctions. Review of the Incident Log revealed on 03/15/24, Resident #15 had a fall. Review of a progress note dated 03/16/24 at 9:05 P.M. for Resident #15, revealed the resident returned from the hospital. Resident #15 received seven sutures to her right knee. The resident reported pain of seven (zero to ten pain scale where zero is no pain and 10 is severe pain). Review of a NP progress note dated 03/17/24 at 3:53 P.M. for Resident #15, authored by NP #62, revealed the resident complained of body pain and spasms. Resident #15 stated she had muscle spasms and increased pain since falling in the transport van and being treated at the ER. Resident #15 received sutures in her scalp and right knee. Resident #15 was diagnosed with acute pain due to trauma and received new orders for Tylenol every four hours and Robaxin (muscle relaxer) 750 milligrams (mgs) three times daily as needed. Review of a progress note dated 03/17/24 at 4:32 P.M. for Resident #15, revealed the on-call provider was notified due to the resident complaining of uncontrolled pain all over and decreased range of motion to both arms resulting in resident needing assistance with feeding. Orders were to continue Tylenol and Robaxin. Review of a NP progress note/post hospital note dated 03/18/24 at 2:29 P.M. for Resident #15, authored by NP #62, revealed the resident fell out of her wheelchair in the van. The resident was assessed with continuing pain, has seven sutures in right knee, and bruising on hands and face. Orders were to continue Tylenol and Robaxin. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 was cognitively intact and required extensive assistance with all activities of daily living (ADLs). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Transport Driver (TD) #30 on 04/30/24 at 9:35 A.M., revealed the staff would normally secure a resident's wheelchair to the van using the Q'Straint system (a system of four-point securement device with retractors or manual belts along with occupant securements [passenger lap and shoulder belts] and four separate anchor points on the floor of the vehicle) but they used the van's manufacturer's installed shoulder/lap belt to secure residents to their wheelchairs. TD #30 reported the facility implemented the Q'Straint system shoulder and lap restraints after the incident on 03/15/24 involving Resident #15 which provided more safety and security with securing residents to their wheelchairs. Interview with Resident #15 on 04/30/24 at 10:31 A.M., revealed when FTD #34 came to her room to get her, he was rushing her telling her to hurry up and they had to go. Resident #15 stated she told him there was plenty of time and his response was I got things to do. Resident #15 stated he put her in the van and as they took off, she asked for her folder with her medical information and FTD #34 handed it to her. Resident #15 stated FTD #34 was driving really fast, and as she was looking at her appointment paperwork, FTD #34 stopped so hard that the force of the stop, brought her to an almost standing position and on her way back down into the wheelchair, she slipped beneath the seat belt which did not lock when the van was stopping. Resident #15 stated that she was lying on her right side and her head was on the floor, and when FTD #34 asked if she was ok, she said no and wanted to go to the hospital. Resident #15 stated FTD #34 drove back to the facility while she was lying on the floor and her head was hitting the floor. Resident #15 stated she asked FTD #34 to stop but he did not and continued to drive back to the facility. Resident #15 stated the paramedics arrived at the facility and took her to the hospital. Telephone interview with FTD #34 on 04/30/24 at 2:16 P.M., revealed on 03/15/24 at approximately 12:30 P. M. he took Resident #15 out the front door and as he was putting the resident in the van, she was fixated on her appointment time. FTD #34 stated he used the four-point system that secured the resident's wheelchair in place to the van and the vehicles lap/shoulder belt to secure resident in the wheelchair. FTD #34 stated he was approximately one mile from the facility, when he stopped for a traffic light and when he looked back, Resident #15 had slid out of her wheelchair and onto the floor. FTD #34 stated he immediately pulled over to ask the resident if she was ok and Resident #15 stated her leg hurt. FTD #34 stated he did not move the resident from the floor for fear she may have other injuries, so he got back in the van and drove back to the facility, ran into the facility, and had the receptionist call the Administrator and the nurse. FTD #34 stated that staff came out to the van and started providing care to Resident #34. Interview with the Administrator on 04/30/24 at 2:30 P.M. revealed on 03/15/24 at approximately 12:30 P.M., FTD #34 left the facility with Resident #15 for a medical appointment. FTD #34 then returned to the facility at approximately 12:45 P.M., came into the facility and stated he needed a nurse and stated Resident #15 had fallen. The Administrator had the receptionist call 911, Licensed Practical Nurse (LPN) #37 grabbed the treatment cart and ran outside to the van with State tested Nursing Assistant (STNA) #36 to assist Resident #15. The Administrator stated when he got to the van, Resident #15 was observed laying on the floor of the van with laceration to her right knee. Resident #15 stated she wanted help getting up. The Administrator stated LPN #37 walked out with him and assessed the laceration and LPN #39 also came to help while he went to get the treatment cart. The Administrator reported that FTD #34 stated the resident took her arms out from under the seatbelt and the next thing he knew, the resident was on the floor. The Administrator stated FTD #34 failed to properly apply the seatbelt system for Resident #15. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with MD #64 on 04/30/24 at approximately 3:00 P.M. revealed he was informed about the incident involving Resident #15 and was okay with the facility calling 911. Observation of the van restraint system and demonstration on how Resident #15 was secured in the van on 05/07/24 at 12:08 P.M. with TDs #30 and #58, revealed Resident #15 was pushed in the van through the rear of the van and the wheelchair was secured using the Q'Straint system. The shoulder/lap belt that was installed by the van's manufacturer was then placed through the opening of the wheelchair's armrest and across the resident's waist and then fastened to an extended strap with a buckle pushed through the opening of the back of the wheelchair which was attached to the floor Q'Straint device. Observation revealed the van's shoulder portion of the seat belt would be across the resident's middle part of her upper left arm and the lap belt was very loose across the resident's lap. TD #30 stated at the time of the incident, the facility was only utilizing the Q-Straint system for securing the wheelchair and not for securing the residents in their wheelchairs. Review of the Q'Straint manufacturer instructions for use, revealed to secure a passenger, attach lap belts using the integrated stiffeners to feed the belts though openings between the seat back and bottoms and/or armrests to ensure proper belt fit around the occupant. The most common way of securing a wheelchair passenger is a four-point securement, which consists of four tie-downs (retractors or manual belts), along with occupant securements (passenger lap and shoulder belts), and four separate anchor points attached to the vehicle's floor. On the aisle side, attach belt with the female buckle to rear tie down pin connector ensuring buckle rests on passenger's hip. On the window side, attach belt with male tongue to rear tie down pin connector and insert into the female buckle. Attach shoulder belt by extending shoulder belt over the passenger's shoulder and across upper torso and fasten pin connector onto lap belt. Ensure belts are adjusted as firmly as possible but consistent with user comfort. Warning note indicated lap and shoulder belts should not be held away from passengers' body by wheelchair components or parts such as the wheelchairs wheels, armrests, panels, or frame. Review of an undated facility policy titled Resident Transport-Drivers revealed transport drivers would ensure a safe transport for residents, passengers and individuals operating any company motor vehicles while on company business. Additionally, drivers are to ensure operation of the vehicle and any components is as specified by the facility's vehicle use protocols and according to the manufacture guidelines. Loading, transporting, and unloading residents' safety from origin to destination, and if an incident occurs while on the road (i.e., resident slips out of wheelchair, becomes ill or distressed, or other unplanned events) immediately get off road to a safe spot, dial 911 and contact the nursing home and assist/comfort the resident until help arrives. This deficiency represents non-compliance investigated under Complaint Number OH00153374.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER Forest Hills Healthcare Center.		STREET ADDRESS, CITY, STATE, ZIP CODE 8700 Moran Road Cincinnati, OH 45244	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35770 Based on medical record review, staff interviews, review of employee files, review of job description and review of facility policy, the facility failed to ensure medications were administered by qualified staff. This affected four Residents (#17. #18, #27, and #50). The facility census was 100. Findings include: Review of the medical record for Resident #10 revealed the resident was admitted on [DATE] with diagnosis including, but not limited to, acute respiratory failure, diabetes, congestive heart failure, dementia, tachycardia, and iron deficiency anemia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #10 had severe cognitive deficits, required extensive assistance with all activities of daily living (ADLs). Review of the [DATE] medication administration record (MAR) for Resident #10, revealed Medication Technician (MT) #90 administered medications to Resident #10 on [DATE]. Review of the medical record for Resident #18 revealed the resident was admitted on [DATE] with diagnosis including, but not limited to, hemiparesis/hemiplegia, alcoholic liver disease, morbid obesity, dysphagia, anxiety, depression, and COVID-19. Review of the MDS assessment dated [DATE] revealed Resident #18 had no cognitive deficits. Review of the [DATE] MAR for Resident #18 revealed MT #90 administered medications to Resident #18 on [DATE]. Review of the medical record for Resident #27 revealed the resident was admitted on [DATE] with diagnosis including, but limited to, pulmonary edema, chronic kidney disease, lupus, and depression. Review of the MDS assessment dated [DATE] revealed Resident #27 had no cognitive deficits. Review of the [DATE] MAR for Resident #27 revealed MT #91 administered medications to Resident #27 on [DATE] and [DATE]. Review of the medical record for Resident #50 revealed the resident was admitted on [DATE] with diagnosis including, but not limited to, dysarthria, aphasia, hemiplegia/hemiparesis, bone density disorder, gout, anxiety, acute kidney failure, depression, low back pain, breast cancer, and chronic pain. Review of the MDS assessment dated [DATE] revealed Resident #50 had no cognitive deficits. Review of the [DATE] MAR for Resident #50 revealed MT #91 administered medications to Resident #50 on [DATE], [DATE], and [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366389	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER Forest Hills Healthcare Center.		STREET ADDRESS, CITY, STATE, ZIP CODE 8700 Moran Road Cincinnati, OH 45244	

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on [DATE] at 8:10 A.M. with the Administrator verified that MTs #90 and #91 did not have the correct certifications from the Ohio Board of Nursing (OBN) to administrator medications. The Administrator stated MTs #90 and #91 had certifications to administer medications in an Intermediate Care Facility (ICF) and he thought the certifications crossed over to Skilled Nursing Facilities (SNF). The Administrator verified that the MTs #90 and #91 had been administering medications to residents and should not have been handling or administering medications. The Administrator stated MTs #90 and #91 were hired prior to him being hired and he never thought to check their certifications. An interview on [DATE] at 11:22 A.M. with Unit Manager (UM) /Registered Nurse (RN) #70 reported MTs #90 and #91 had been hired around the same time and they have been administering medications. UM/RN #70 verified a Medication Technician must be certified through the OBN and MTs #90 and #91 did not have the proper certifications to handle and administer medications to residents. UM/RN #70 stated she has not identified or heard of any medication errors or incidents involving medications being administered from MTs #90 and #91. An interview on [DATE] at 11:24 P.M. with the Director of Nursing (DON) verified a Medication Technician was required to have the proper certifications through OBN to administer medications. The DON verified MTs #90 and #91 had been administering medications to the residents. The DON stated she had not identified or heard of any medication errors or incidents involving medications being administered by the MTs. Review of MT #90's employee file revealed the date of hire of [DATE] and had a State tested Nursing Assistant (STNA) certification that was in good standing. MT #90's employee file contained a document that was issued by the Department of Developmental Disabilities ([NAME]) as verification for the MT position and no documents for verification from the OBN. Review of MT #91's employee file revealed the date of hire was [DATE] and had an active STNA certification which was in good standing. MT #91's employee file contained an expired document that was issued by [NAME] as verification for the MT position and no documents for verification from the OBN. Review of the facility policy titled Medication Administration revised on [DATE], revealed only licensed or authorized personnel may administer prescribed medication. Review of the Certified Medication Technician job description dated [DATE] revealed the Medication Technician will provide medication administration and personal care for residents to assure the highest degree of quality resident care is maintained at all times. The Medication Technician will set up and administer medication in accordance with physicians' orders and state/federal regulations and maintain a successful completion of a state approved training course. This deficiency represents non-compliance investigated under Complaint Number OH00152738.