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	12/20/2024

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 - 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 42731

Based on medical record review, staff interview, Nurse Practitioner (NP) interview, and policy review, the facility failed to ensure neurological (neuro) checks were completed when resident's had unwitnessed falls and falls involving the head. This affected two (#63 and #85) of three residents reviewed for falls. This had the potential to affect all 108 residents in the facility.

Findings include:

1) Review of the medical record of Resident #63 revealed an admitted [DATE]. Diagnoses included metabolic encephalopathy, dementia, type two diabetes mellitus, and obstructive sleep apnea (OSA).

Review of the quarterly Minimum Data Set (MDS) assessment for Resident #63 dated 09/20/24; revealed the resident had severely impaired cognition.

Review of a fall investigation for Resident #63 dated 11/15/24, revealed, at approximately 4:30 A.M., Resident #63 was found sitting on the floor close to his geriatric (geri) chair. The resident was assessed with no injuries. The on-call physician was notified of the fall at 7:30 A.M. and the resident's son was notified of the fall at 8:11 A.M.

Review of neuro-checks for Resident #63 dated 11/15/24; revealed the first four 15-minute checks and first hour check was not signed off as complete until 11/22/24, by the Director of Nursing (DON).

Interview with the DON on 12/17/24 at 4:14 P.M., verified the first four 15-minute checks and first hour check was not signed off until 11/22/24. The DON stated he had no doubt the checks were being done; however, he found staff were not signing them off as complete at the time they were due, so he had to go back and ensure they were completed.

2) Review of the medical record of Resident #85 revealed an admitted [DATE]. Diagnoses included right ulnar fracture, resistant hypertension, dysphagia, and a history of falling.

Review of the comprehensive MDS assessment for Resident #85 dated 10/15/24, revealed the resident had moderately impaired cognition. The resident required partial/moderate assistance with bed mobility, substantial/maximal assistance with bathing and was dependent on staff for toileting, dressing, and transfers.

(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 12/20/2024
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing progress note for Resident #85 dated 10/21/24, revealed the nurse witnessed Resident #85 attempting to pick something up off the floor in the hallway and fell on her face. The resident sustained abrasions to her left eye and nose and lost a lens of her glasses during the fall. The physician was notified, and an x-ray of the face was ordered. Review of the medical record revealed no evidence of neuro-checks being completed following Resident #85's fall on 10/21/24. Interview with the DON on 12/18/24 at 10:35 A.M., verified no neuro-checks were completed following Resident #85's fall on 10/21/24. The DON stated NP #405 assessed the resident after the fall and ordered an x-ray of the face but did not order any neuro-checks. Upon review of the policy with the DON, the DON verified the type of fall Resident #85 sustained, should have included neuro-checks following the incident. Interview with NP #405 on 12/18/24 at 3:49 P.M., revealed she assessed Resident #85 following a fall on 10/21/24 and ordered a facial x-ray. NP #405 stated neuro-checks should have been completed per the facility's protocol as Resident #85's head was involved with her fall, evidenced by her broken glasses and significant bruising on her left side. Review of the facility policy titled, Neurological checks, undated, revealed neurological assessment should be completed for falls with suspected head injury, falls with unknown head injury, and blows to the face every 15 minutes, then hourly, then daily for four days. This deficiency represents non-compliance investigated under Complaint Number OH00160169.

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review and staff interview, the facility failed to ensure residents were free from unnecessary medications. This affected one (#59) of three residents reviewed for infection. This had the potential to affect all 108 residents in the facility. Findings include: Review of the medical record of Resident #59 revealed an admitted [DATE]. Diagnoses included cellulitis, insomnia, cognitive communication deficit, and dysphagia. Review of a nursing progress note for Resident #59 dated 11/23/24 revealed new orders were received to discontinue Miralax (laxative) due to diarrhea and check the resident's stool for Clostridium difficile (C.diff). Per report obtained from the hospital, the resident had one episode of diarrhea that morning, but this was due to the administration of Miralax. Review of the physician orders for Resident #59 revealed an order dated 11/24/24 to check the resident's stool for C.diff. Orders on 11/27/24 revealed the resident was ordered Vancomycin (antibiotic) oral solution 25 milligrams (mg) per milliliter (mL) to give five ml (125 mg) every six hours for C.diff for 10 days. The medication was completed 12/07/24. Review of the comprehensive Minimum Data Set (MDS) assessment for Resident #59 dated 11/28/24 revealed the resident had severely impaired cognition. Review of the medical record revealed no documented evidence of Resident #59's stool being checked for C. diff as ordered. Interview with the Director of Nursing (Don) on 12/19/24 at 11:12 A.M., verified Resident #59 was given 10 days of Vancomycin without having positive C.diff culture results. The DON stated the medication should not have been prescribed without written positive results and, through an investigation, discovered a nurse had verbally told the Nurse Practitioner (NP) that Resident #59 had positive C.diff results and the NP gave a verbal order for antibiotics without reviewing the written results. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42731 Based on medical record review and staff interview, the facility failed to ensure laboratory (lab) tests were drawn as ordered by the physician. This affected two (#59 and #109) of three residents reviewed for labs. This had the potential to affect all 108 residents in the facility. Findings include: 1) Review of the medical record of Resident #59 revealed an admitted [DATE]. Diagnoses included cellulitis, insomnia, cognitive communication deficit, and dysphagia. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severely impaired cognition. Review of a nursing progress note for Resident #59 dated 11/23/24, revealed new orders were received to discontinue Miralax (laxative) due to diarrhea and check the resident's stool for Clostridium difficile (C.diff). Per a report obtained from the hospital, the resident had one episode of diarrhea that morning, but this was due to the administration of the Miralax. Review of physician orders for Resident #59 dated 11/24/24, revealed orders for the resident to have stool tested for C.diff. Review of the medical record revealed no documented evidence of Resident #59's stool being tested for C. diff as ordered. Interview with the Director of Nursing (DON) on 12/19/24 at 11:12 A.M., verified there was no documented evidence of Resident #59's having a stool culture for C.diff completed as ordered. 2. Review of the medical record of Resident #109 revealed an admitted [DATE]. The resident transferred to the hospital on 11/17/24 and returned to the facility on [DATE]. Diagnoses included dysarthria, aphasia, hemiplegia and hemiparesis following cerebral infarction, anxiety, depression, vascular dementia, breast cancer. Review of the quarterly MDS assessment for Resident #109 dated 12/09/24 revealed the resident had intact cognition. The resident utilized a walker for mobility. Review of a nursing progress note for Resident #109 dated 11/14/24, revealed the resident complained of feeling weak and more tired than usual. Nurse Practitioner (NP) #405 was notified and gave orders for a complete blood count (CBC) on 11/15/24. Review of a NP #405 progress note dated 11/14/24 revealed the resident was not feeling well and recommended for the resident have a CBC completed. Review of the physician orders revealed an order dated 11/14/24 for the resident to have a CBC with differential on 11/15/24. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #109 revealed no documented evidence of the labs being completed as ordered. Interview with the DON on 12/18/24 at 1:38 P.M., verified a CBC for Resident #109 was not completed per orders on 11/15/24. The DON stated the facility changed lab companies during that week and Resident #109's labs were missed. This deficiency represents non-compliance investigated under Complaint Number OH00160169.