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	11/06/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, staff interview and review of the facility policy, the facility failed to maintain the confidentiality of residents' medical records. This affected one (Resident #178) and had the potential to affect all of the residents residing in the facility. The facility census was 122 residents. Findings include:Observation on 11/05/25 at 11:07 A.M. revealed the laptop on top of the medication cart in the 400 hall was open and displayed Resident #178's name and medication list. The cart was unattended by staff and Resident #178's private health information was viewable by residents, staff, and visitors passing by the cart. Interview on 11/05/25 at 11:10 A.M. with Registered Nurse (RN) #825 confirmed she had left the laptop on top of the 400-hall medication cart unattended with Resident #178's private health information visible to residents, staff, and visitors passing by the cart. Observation on 11/05/25 at 11:14 A.M. revealed the laptop on top of the medication cart in the 400-hall was open and displayed multiple resident records. The cart was unattended by staff and multiple resident records were accessible to residents, staff, and visitors passing by the cart. Interview on 11/05/25 at 11:17 A.M. with RN #825 confirmed she had left the laptop on top of the 400-hall medication cart unattended with multiple resident records accessible to residents, staff, and visitors passing by the cart. Interview on 11/06/25 at 1:55 P.M. with the Administrator confirmed all nursing staff are to lock their laptop screens when walking away from the medication cart to ensure the privacy of resident health information. Review of the facility policy titled Health Insurance Portability and Accountability Act undated revealed staff should ensure computer screens are turned off so a passerby would not see or have access to residents' private health information. Staff should not walk away from open medical records.

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on medical record review, staff interview, resident interview, and review of the facility policy, the facility failed to ensure residents received vision services as needed. This affected one (Resident #186) of three residents reviewed for ancillary services. The facility census was 122 residents.Findings include:Review of the medical record for Resident #186 revealed an admission date of 03/04/20 diagnoses including Alzheimer's disease, major depressive disorder, and hypertension. Review of the physician's orders for Resident #186 revealed an order dated 04/03/23 for the resident to be seen by an outside eye doctor as needed. Review of the Minimum Data Set (MDS) assessments for Resident #186 dated 12/06/24, 03/08/25, and 06/08/25 revealed the resident had adequate vision and did have corrective lenses. Review of the physician's orders for Resident #186 revealed an order dated 01/05/25 revealed Latanoprost eye drops at bedtime for glaucoma. Review of the care plan for Resident #186 initiated 03/25/25 revealed the resident had impaired visual function and had a diagnosis of glaucoma. Interventions included the following: arrange consultation with and eye care practitioner as needed, observe/document/report acute eye problems to the medical provider. Review of the care conference progress note for Resident #186 dated 06/30/25 revealed the Social Services Designee (SSD) educated the resident on the availability of ancillary services available to residents. Resident #186 wanted to be seen by the facility eye doctor. SSD sent a referral in for Resident #186 to be seen. Review of the MDS assessment for Resident #186 dated 09/08/25 revealed Resident #186 had severely impaired cognition, required staff assistance with activities of daily living (ADLs.), had adequate vision and was not coded for use of corrective lenses. Interview on 11/06/25 at 9:50 A.M. with Director of Social Services (DSS) #335 confirmed the facility had sent in a referral for Resident #186 to be seen by the facility eye doctor in June 2025 but the resident had not been seen by an eye doctor since her admission to the facility in 2020. Interview on 11/06/25 at 9:55 A.M. with Resident #186 confirmed she wore glasses, but she did not know where they were. Interview on 11/06/25 at 1:15 P.M. with Certified Nursing Assistant (CNA) #775 confirmed the aide had worked for the facility for nine months and had never seen Resident #186 wearing glasses. Interview on 11/06/25 at 1:55 P.M. with the Administrator confirmed the staff were unable to find glasses Resident #186's glasses. The Administrator confirmed Resident #186 had not been seen by the facility eye doctor since her admission to the facility. Review of the facility policy titled Social Services dated 2017 revealed the facility would ensure residents were referred for eye care appointments as needed. This deficiency represents noncompliance investigated under Complaint Number 2655929.