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	04/30/2026

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of Resident Council minutes, resident interview, and staff interview, the facility failed to respond to resident concerns expressed during Resident Council meetings. This affected (Residents #4, #7, #17, #24, #48, #67, #91, #96, #101, #107, #108, #118 and #132) who have attended Resident Council in the previous three months and had the potential to affect all of the residents residing in the facility. The facility census was 112 residents. Findings include: Review of the Resident Council Minutes dated January 2026, February 2026, March 2026 revealed residents expressed the following concerns: noise at night, aides not staying on task on nightshift, not being assisted out of bed in time for activities, bathrooms not being cleaned properly, running out of food ordered, rooms not being cleaned on the weekends. Review of the minutes revealed no follow-up to the concerns expressed by the residents in the Resident Council meetings. Interview on 04/29/26 at 10:59 A.M. with Resident #132, the Resident Council President, with Resident #20 and with Resident #96 confirmed Resident Council meetings were no longer well attended. Resident #132 stated several residents who had regularly come to Resident Council have reported they stopped coming to the meetings because they felt nothing ever changed when they expressed concerns. Interview on 04/29/26 at 11:13 A.M. with Resident #132 confirmed the former facility cook came to a meeting several months ago and listened to the food concerns expressed. The cook told the residents he was going to make some changes to the menus and the preparation process to try to improve the flavor and presentation of the meals. Resident #132 stated nothing had changed and the food continued to be lacking flavor and was frequently cold. Interview on 04/29/26 at 11:20 A.M. with Resident #96 verified concerns had been raised in Resident Council regarding staff using their cell phones during work time which caused a slow response to call lights and other assigned tasks. Resident #96 stated no changes had had been regarding cell phone usage by the staff, and she did not believe the concern had been addressed. Interview on 04/29/26 at 3:12 P.M. with the Administrator confirmed the facility had no standard method of addressing concerns that were brought up in Resident Council meetings. The Administrator verified concerns were addressed once the minutes of the meeting were completed but communication didn't get back to the residents. The Administrator confirmed communication could be improved and done in a manner where information was formally disseminated to the residents, so they would know action had been taken on their concerns.This deficiency represents noncompliance investigated under Complaint Number 294964 and Complaint Number 2968329 and Complaint Number 2963128 and Complaint Number 2646120.

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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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and policy review, the facility failed to implement a baseline care plan which included information regarding resident activities of daily living (ADL) care needs. This affected one (Resident #16) of 13 residents reviewed for baseline care plans. The facility census was 112 residents.Findings include: Review of the medical record for Resident #16 revealed an admission date of 04/09/26 with diagnoses including postprocedural intestinal obstruction and dementia. The resident transferred to the hospital on [DATE] and had not yet returned to the facility. Review of the Minimum Data Set (MDS) assessment for Resident #16 dated 04/13/26 revealed the resident had severely impaired cognition and required staff assistance with activities of daily living (ADLs.) Review of the baseline care plan for Resident #16 dated 04/09/26 revealed the resident had an ADL self-care performance deficit due to her comorbidities. The care plan did not include further details regarding the basic ADL care needs of the resident. Interview on 04/29/26 at 12:37 P.M. with MDS Licensed Practical Nurse (LPN) #377 verified the information included in the chart for the baseline care plan did not include the basic information needed to care for the resident. Review of the facility policy titled Baseline Care Plan/48 Hour Care Plan dated 03/01/26, revealed the baseline care plan would include information regarding the resident needs for assistance with activities of daily living. This deficiency represents noncompliance investigated under Complaint Number 2963128.

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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. Based on medical record review, staff interview, and policy review, the facility failed to ensure a resident's limited range of motion was addressed in the comprehensive care plan. This affected one (Resident #1) of one resident reviewed for limited range of motion. The facility identified eight residents who had a limited range of motion. The facility census was 112 residents. Findings include: Review of the medical record for Resident #1 revealed an admission date of 03/09/26 with diagnoses including anoxic brain damage, persistent vegetative state, and type two diabetes mellitus. Review of the Minimum Data Set (MDS) assessment for Resident #1 dated 03/16/26 revealed the resident was in a persistent vegetative state with no discernible consciousness, was dependent on staff for all activities of daily living (ADLs), and had impaired range of motion to all extremities. Review of the care plan for Resident #1 dated 04/27/26 revealed it did not include interventions related to the resident's impaired range of motion. Interview on 04/29/26 at 12:37 P.M. with MDS Licensed Practical Nurse (LPN) #377 verified Resident #1's limited range of motion was not addressed on the care plan. MDS LPN #377 stated the information should be on the care plan, so the staff are aware of the limitations. Review of the facility policy titled Plan of Care Overview undated revealed the care plan was the written treatment provided for a resident and the provision of optimal personalized care and services to enable the resident to live with dignity. This deficiency represents noncompliance investigated under Complaint Number 2963128.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure all residents received adequate assistance with activities of daily living (ADLs). This affected two (Residents #1 and #113) of five residents reviewed for ADLs. The facility census was 112 residents.Findings include: 1.Review of the medical record of Resident #113 revealed an admission date of 09/12/25 with diagnoses including type two diabetes mellitus, legal blindness, and adult failure to thrive. Review of the Minimum Data Set (MDS) assessment for Resident #113 dated 03/22/26 revealed the resident had intact cognition and required partial/moderate assistance with bathing and personal hygiene. Observation on 04/27/26 at 11:50 A.M. revealed Resident #113's fingernails were long and extended approximately one half inch beyond the fingertip. Interview 04/27/26 at 11:50 A.M. with Resident #113 confirmed he did not like having his fingernails so long because it interfered with his ability to press buttons on his tv remote. Interview on 04/27/26 at 12:06 P.M. with Activity Director (AD) #370 verified Resident #113's fingernails were long and needed to be trimmed. Observation on 04/28/26 at 10:14 A.M. revealed Resident #113's fingernails remained long and extended approximately one half inch beyond the fingertip. Interview at 04/28/26 at 10:14 A.M. with Resident #113 confirmed no one had offered to cut his fingernails since the previous day. 2. Review of the medical record for Resident #1 revealed an admission date of 03/09/26 with diagnoses including anoxic brain damage, persistent vegetative state, and type two diabetes mellitus. Review of the MDS assessment for Resident #1 dated 03/16/26 revealed the resident was in a persistent vegetative state with no discernible consciousness, was dependent on staff for all activities of daily living, and had impaired range of motion to all extremities. Observation on 04/28/26 at 2:14 P.M. with Licensed Practical Nurse (LPN) # 309 revealed Resident #1's fingernails were long and extended approximately one quarter inch beyond the fingertip. Interview on 04/28/26 at 2:14 P.M. with LPN #309 verified Resident #1's fingernails were long and needed to be trimmed. Review of the facility policy titled Routine Resident Care undated revealed the facility would provide routine daily care including assistance with activities of daily living. This deficiency represents noncompliance investigated under Complaint Number 2804249 and Complaint Number 2966392 and Complaint Number 2964964 and Complaint Number 2799354 and Complaint Number 2738678 and Complaint Number 2673312 and Complaint Number 2704933 and Complaint Number 2968329.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on medical record review, resident interview, and staff interview the facility failed to ensure medications were available for administration per physician order. This affected two (Residents #17 and #55) of 23 facility-identified residents with orders for routine opioid analgesics. The facility census was 112 residents.Findings include: 1.Review of the medical record for Resident #17 revealed an admission date of 08/27/25 with diagnoses including wedge compression fractures of T1, T7-T8 and T11-T12, muscle weakness and chronic obstructive pulmonary disease. Review of the Minimum Data Set (MDS) assessment for Resident #17 dated 02/13/26 revealed the resident had intact cognition and required staff assistance with activities of daily living (ADLs). Review of the physician's orders for Resident #17 revealed an order dated 03/27/26 for oxycodone 10 milligrams (mg) every six hours. Review of the Medication Administration Record (MAR) for Resident #17 revealed the 6:00 P.M. evening dose of oxycodone for 04/27/26 was not signed off as administered. Interview on 04/29/26 at 4:30 P.M. with Resident #17 confirmed the facility had run out of his routine oxycodone recently and he had missed a dose of scheduled pain medication. Interview on 04/30/26 at 11:44 A.M with the Director of Nursing (DON) confirmed Resident #17 did not receive his 6:00 P.M. dose of oxycodone on 04/27/26 because the medication was not available for administration. 2.Review of the medical record for Resident #55 revealed an admission date of 09/20/23 with diagnoses including polyneuropathy, diabetes mellitus type two, prostate cancer and anxiety disorder. Review of the MDS assessment for Resident #55 dated 09/28/25 revealed resident had intact cognition and required staff assistance with ADLs. Review of the physician's orders for Resident #55 revealed an order dated 02/19/26 for oxycodone-acetaminophen 5-325 mg one tablet every six hours. Review of the MAR for Resident #55 revealed the 6:00 P.M. evening dose of oxycodone-acetaminophen was not signed off as administered. Interview on 04/27/26 at 10:05 A.M. with Resident #55 confirmed in the previous month there was a day where he did not receive his scheduled pain medication because it was not available. Interview on 04/29/26 at 4:00 P.M. with the DON confirmed Resident #55 did not receive his 6:00 P.M. dose of oxycodone-acetaminophen on 03/16/26 because the medication was not available for administration.This deficiency represents noncompliance investigated under Complaint Number 2704502 and Complaint Number 2656097 and Complaint Number 2673312.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, resident interview, and policy review, the facility failed to store food in a manner to prevent against the potential spread of foodborne illness. This had the potential to affect 109 of 112 residents in the facility. The facility identified three residents (#01, #05, and #37) who did not receive food from the kitchen. The facility census was 112. 1.Observation on 04/27/26 at 8:22 A.M. with Director of Dietary Services (DDS) #505 of the walk-in cooler revealed it contained the following items:two cartons of heavy whipping cream opened and partially used, with no open date, a cart with two bins of individually poured and covered beverages with no date, a tray of individual fruit cocktail bowls which were covered but did not have a date, a large pan of pasta with ground meat with the serving scoop inside, resting on the food, covered with plastic wrap and not dated. A cart containing a 22-quart container of a dark liquid with no label or date, a pink plastic pitcher next to the bin resting directly on the cart which was coated with a dark unidentified material, a box of bacon on the floorInterview on 04/27/26 at 8:23 A.M. with DDS #505 verified there were undated, unlabeled and improperly stored food items in the walk -in cooler. 2. Observation on 04/27/26 at 8:27 A.M. with DDS #505 of the walk-in freezer revealed it contained the following items: a bag frozen chicken breasts which were not sealed or dated, a bag of pork pizza topping which was not sealed or dated.Interview on 04/27/26 at 8:28 A.M. with DDS #505 verified there were undated and unsealed items in the walk -in freezer. 3. Observation on 04/27/26 at 8:35 A.M. with DDS #505 revealed the reach-in cooler next to the counter utilized for tray line had a variety of pre-poured juices, milk, thickened beverages, and tea which were covered but were not dated. Interview on 04/27/26 at 8:35 A.M. with DDS #505 verified there were undated items in the reach-in cooler. 4. Observation on 04/30/26 at 9:26 A.M. with Licensed Practical Nurse (LPN) #380 revealed the refrigerator at the [NAME] nurses' station contained the following items: a plastic bag of food labeled with Resident #112's name and dated 04/21/26, three half-sandwiches wrapped in plastic but not dated. Interview on 04/30/26 at 9:27 A.M. with LPN #380 verified the bag of Resident #112's food was dated 04/21/26 and the three sandwiches did not have a date. Review of the facility policy titled Food Storage: Cold Foods dated February 2026 revealed all foods would be stored six inches above the floor and all foods would be stored wrapped or in covered containers, labeled, and dated. 5. Observation on 04/30/26 at 9:16 A.M. revealed the personal refrigerator in Resident #20's room contained three undated bags of grapes with visible mold. Interview on 04/30/26 at 9:17 A.M. with Certified Nursing Assistant (CNA) #314 verified the three bags of grapes were moldy and undated. Review of the facility policy titled Storage of Resident Food undated revealed resident refrigerators would be monitored daily, food would be labeled appropriately, and unsafe foods, including food with mold, would be discarded. This deficiency represents noncompliance investigated under Complaint Number 2708220.