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	05/16/2025

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 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, interview, review of facility policy, and review of the 2022 Food Code, the facility failed to ensure dietary staff performed hand hygiene as directed by the facility policy, and failed to ensure milk was held on the tray line at 41 degrees Fahrenheit (F) or less. This had the potential to affect all residents. The facility census was 102. Findings include: 1. During an observation of the lunch tray line on 05/13/2025 from 12:09 P.M. to 12:12 P.M., Dietary Aide (DA) #18, while waiting for the meal tray line to begin, scratched the left side of her head with her left hand, scratched the right side of her head with her right hand, put her hands in her pockets, then touched a plate, touched her face, and took a plate from the cook and put it on a meal tray. DA #18 proceeded to scratch her face, touch her clothes, and then took a sandwich from the refrigerator next to the meal tray line, placed the sandwich on plate on a meal tray. DA #18 did not perform hand hygiene during this time. During a concurrent observation and interview on 05/13/2025 at 12:17 P.M., DA #18 touched her pants and scratched her head and then continued to participate on the lunch line without completing hand hygiene. The Dietary Manager (DM) #19 stated DA #18 should wash her hands. During an observation of breakfast tray line on 05/15/2025 at 7:38 A.M., DA #18 touched her face and then the top of a plate and put the meal tray with the plate on the cart. DA #18 did not wash her hands after touching her face. At 7:41 A.M., DA #18 touched her pants and her hair and continued to prepare plates for residents' breakfast meal and put the plates on a meal cart. At 8:01 A.M., DA #18 spooned cream of wheat into a container, put a top on it, and then put it on a meal tray. DA #18 proceeded to wipe her hands on her pants. DA #18 did not complete hand hygiene during the observation. During an interview on 05/15/2025 at 7:24 A.M., DA #18 stated she should wash her hands if she stepped away from the meal tray line or touched anything. During an interview on 05/16/2025 at 11:49 A.M., the Director of Nursing stated he expected staff to sanitize their hands after touching clothing and things of that nature. During an interview on 05/16/2025 at 11:13 A.M., the Administrator stated she expected staff to complete hand hygiene according to the policy. (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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of an undated facility policy titled, Handwashing Procedure for Dining Services revealed, hand hygiene continues to be the primary means of preventing the transmission of infection. The handwashing procedure revealed, the following is a list of some situations that require hand hygiene, which included, after blowing your nose, coughing, sneezing, or touching your hair, face, or clothes. 2. During a concurrent interview and observation of the breakfast tray line on 05/15/2025 at approximately 8:18 A.M., Dietary Aide (DA) #18 poured lactose free milk into seven cups to be served to residents. DA #18 placed the seven glasses on the tray line and did not hold cups of milk in ice to maintain the temperature. At the request of the surveyor, at 8:28 A.M., the Dietary Manager took the temperature of the milk of the lactose free milk in each of the seven cups. The DM stated the temperature of the milk was 43 degrees Fahrenheit (F). and further added the facility could not serve the milk. During an interview on 05/16/2025 at 11:49 A.M., the Director of Nursing stated his expectation was the food was adequately heated, and the milk was at an appropriate temperature. During an interview on 05/16/2025 at 11:13 A.M., the Administrator stated her expectation was the food and drink temperatures were kept within acceptable and required temperature ranges. Review of the 2022 Food Code published by the United States Food and Drug Administration, indicated, (3-501.16) temperature control for the safety and hot and cold holding stated hot food shall be maintained at 135 degrees Fahrenheit or higher and cold food items at 41 degrees Fahrenheit or less.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interview, the facility failed to transcribe a change of an advance directive order. This affected one Resident (#2) of three residents reviewed for advance directives. The facility census was 102. Findings include: Review of the medical record for Resident #2 revealed an admission date of [DATE]. According to the admission record, Resident #2's code status was listed as a full code, meaning the resident wanted cardiopulmonary resuscitation (CPR). A quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Review of Resident #2's current orders as of [DATE], revealed Resident #2 had an order dated [DATE], indicating the resident's code status was a full code. Review of Resident #2's care plan included a focus area for code status initiated [DATE] and revised [DATE], that indicated Resident #2's code status was Do Not Resuscitate (DNR), Comfort Care. Interventions directed staff to obtain the medical provider order for the residents' code status. Review of Resident #2's DNR] Order Form, dated [DATE], indicated the resident's code status was DNR Comfort Care. Interview on [DATE] at 11:01 A.M., Resident #2 stated they were their own responsible party and wished to have a DNR code status. The resident stated they no longer wanted to have full code status. Interview on [DATE] at 3:23 P.M., Registered Nurse (RN) #1 stated a change in a resident's code status should be updated by the management staff immediately in the resident's electronic health record (EHR). RN #1 stated when she would receive a change in code status order, she notified the nurse practitioner, the Director of Nursing (DON), and changed the order in the resident's EHR. Interview on [DATE] at 7:36 P.M., the Director of Social Services (DSS) stated advanced directives were reviewed with each resident annually to determine if they were still accurate. She stated if a resident wished to change from full code to DNR, she met with the resident, consulted with responsible parties, and sent the form to the physician. She stated changing a resident's code status in the EHR should be completed by the nurses. She stated the resident's code status was changed a couple of weeks before she started employment at the facility. She stated she expected the change in code status to be documented by the social worker who was responsible and the paperwork to be forwarded to the nursing staff and physician so the residents' orders and medical record could be updated. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 8:57 A.M., the DON stated that he expected a resident's code status to be updated in the resident's EHR when the resident decided to change it. He stated the DSS was responsible for making sure any change in code status were given to the nursing staff after all the forms were completed. He stated Resident #2 signed their DNR in June of 2024 when the facility did not have a DSS. He stated it was signed a couple of weeks before the current DSS started, and Resident #2's change in code status was missed. He stated the former medical records nurse should have uploaded the resident's DNR form and changed their status in the EHR at that time and was unsure why it was not completed. Interview on [DATE] at 8:26 A.M., the Administrator stated she expected any changes to a resident's code status should be updated in the EHR at that time.