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	01/31/2025

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37100 Based on medical record review, staff interview, and facility policy review, the facility failed to provide copies of resident records as requested and per requirements. This affected one (Resident #110) of three residents reviewed for medical records request. The census was 108. Findings Include: Resident #110 was admitted to the facility on [DATE]. Her diagnoses were other specified fracture of left pubis, unspecified fall, anemia, hypertension, cognitive communication deficit, hypothyroidism, hyperlipidemia, syncope and collapse, osteoporosis, vitamin D deficiency, osteoarthritis, hypotension, and muscle weakness. Review of her minimum data set (MDS) assessment, dated 07/31/24, revealed she was cognitively intact. Review of Resident #110 progress notes, dated 07/25/24 to 08/21/24, revealed she was discharged from the facility on 08/21/24. There was no documentation to support a request of medical records. Review of facility Authorization for the Release of Health Information form, dated 01/13/25, revealed Resident #110 signed this document to request a copy of her complete medical records. The records were to be sent to an attorney's office. There was no documentation to support this request had been addressed and/or completed. Interview with Administrator on 01/31/25 at 2:50 P.M. confirmed the request had not been completed. She confirmed the facility received a request for Resident #110's complete medical records, which was signed by Resident #110, on 01/13/25. She confirmed the facility's typical process was to receive a written request for medical records, have the request sent to their legal department to verify the authenticity of the request/signature(s), and then within 30 days, start processing the medical records request. (continued on next page)

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Releasing Clinical Records procedures, undated, revealed the facility will only release confidential information to authorized persons/entities, and only in accordance with facility policy, federal, and state laws. The procedure includes the following: a written request if required, requires a properly executed authorization unless not required by law, complete the Authorization for Release of Health Information form, and the requested documents are produced and released in compliance with HIPAA regulations. The Authorization for Release of Health Information form is to be completed and emailed back to the facility. The resident may access his/her electronic record. A staff member is to accompany the resident during the inspection process. If a resident requests a copy of his/her record, the record will be provided in compliance with regulations. If a family member is the legal representative, the records will be released to him/her by the company's attorney. Release of confidential information to a third party with properly executed authorization. Third party includes attorneys. Unless otherwise specified by state statute, a valid authorization form must include at least the following: name of the individual, name of organization which is to make the disclosure, name of individual or organization requesting information, purpose of need for disclosure, statement that consent is subject to revocation at any time except to extent that action has been taken, statement that authorization will expire on a specific date or at least 90 days from the date of the signature by individual or authorized person, and signature of individual or authorized person. The facility will verify authenticity of signature by comparing it to other documents signed by that individual in your facility's records. This deficiency represents non-compliance investigated under Complaint Number OH00161560.