STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365044	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcat Cincinnati	4001 Rosslyn Drive Cincinnati, OH 45209

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25908 Based on closed record review, staff interview and review of facility policy, the facility failed to ensure they discharged a resident in a safe and orderly manner. This affected one (#90) resident of the five residents reviewed for discharge. The facility census was 87. Findings include: Review of the closed medical record for Resident #90, revealed an admitted [DATE]. Diagnosis included surgical after-care for knee, bipolar and schizophrenia. Resident #90 was discharged to a homeless shelter on 01/16/25 per his Caseworkers request then immediately returned to the facility after the homeless shelter refused to accept the resident due to his behaviors during previous stays. Resident #90 was discharged again on 01/17/25 with Caseworker #500 and taken to hospital where he had been recently discharged . Resident was listed as his own person and did not have a Guardian. Review of a statement by the Administrator dated 01/09/25, revealed the management staff were informed Resident #90 was being admitted as a skilled resident for therapy due to a recent knee surgery. The hospital notes were scanned into the electronic medical record (EMR) and when the Administrator was going over some notes, she noticed the resident had some violent incidents while hospitalized . The Administrator was unaware of these incidents. The Administrator started looking at the emails sent by admissions and the hospital notes were not in the emails. The only thing shared was the medication list and continuity of care and nothing about the incidents in the hospital. By the time the incidents were discovered, the resident was already admitted . Review of the progress notes for Resident #90 from 01/12/25 to 01/17/25 revealed no behaviors were recorded while the resident resided in the facility. The Resident refused care daily. Review of a facility document titled Care Conference dated 01/14/25, revealed Resident #90 had plans for a discharge. Social Service Designee (SSD) #101 notified Caseworker #500 and Caseworker Manager #501 who came up with a discharge plan for the resident to go back to a shelter. The resident stated he was onboard with the discharge plans. SSD #101 interviewed the resident and noted his discharge plans could take place this week and the resident understood the plan. (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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of therapy notes for Resident #90 dated 01/14/25, revealed physical therapy (PT) and occupational therapy (OT) completed their initial assessments on the resident. PT attempted to see the resident at 10:30 A.M. and the resident requested PT to come back at 2:30 P.M. The resident was initially agreeable to an assessment; however, during the assessment, the resident became adamant he could not do any mobility due to increased left knee pain. Maximum encouragement was used for the resident to participate with the evaluation when the resident became more agitated and stated he could not move his left leg due to pain. When PT attempted to work with the resident for leg for movement, the resident refused and stated he did not want to complete any therapy until his leg was healed and he had no pain. The OT assessment was mostly the same and the resident was only agreeable to bed level activities of daily living (ADLs) and would only move the right leg. The resident had minimal participation of both PT and OT and it was the opinion of PT, the resident would not participate well in therapy due to frequent refusals in the future and was discharged from therapies due to refusal. Review of the facility's Summary of Events completed by the Administrator revealed the following: a) On 01/14/25, Caseworker #500 came to see the resident. Caseworker #500 spoke with the Administrator and informed her Resident #90 had violent unprovoked behaviors and should not be in the facility. The facility started fifteen-minute checks on the resident due to the reported violent behaviors. Caseworker #500 stated he informed the hospital of the resident's behaviors prior to discharge. b) On 01/16/25, Resident #90 was discharged with little notice to a homeless shelter per Caseworker #500. The facility agreed to take the resident to the shelter in the facility's van. When the facility discharged the resident to the homeless shelter he wore a hospital gown wrapped in blankets due to not having any clothes. The homeless shelter refused the resident due to resident's violent behaviors and setting fires at shelters in the past, therefore ,the facility staff returned the resident to the facility. The facility called Caseworker #500 and informed him of what happened at the shelter. Caseworker #500 noted he would return to the facility on [DATE] to find the resident placement. On 01/17/25 Caseworker #500 returned to the facility and brought the resident some clothes and stated he was taking the resident to a group home. It was then determined due to the resident needing medical care and assistance with ambulation he should not go to a group home. Caseworker #500 then decided he would take the resident back to the hospital and make them admit him. Caseworker #500 told the facility he would take full responsibility for the resident without a confirmed placement for the resident. Caseworker #500 signed for medications and instructions. Review of a facility document titled Care Conference dated 01/16/25, revealed Resident #90 and SSD #101 attended a meeting for a discharge plan. SSD #110 notified the resident that Caseworker #500 and Caseworker Manager #501 wanted the resident to go to the shelter today. Resident #90 declined the facility's services and equipment at this time. Review of a progress note for Resident #90 dated 01/16/25, revealed the resident was taken to a homeless shelter. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a statement by Director or Nursing (DON) dated 01/17/25 at 11:00 A.M., revealed she escorted Caseworker #500 to the resident's room to assist in discharging the resident to a group home due to his issues transferring and showing signs of paranoia along with other psychological issues of hearing voices. It was determined that Resident #90 would be discharged into the care of Caseworker #500 who was going to accompany the resident to the hospital to be admitted for psychological. Resident #90 was dressed and assisted on the facility bus and was followed to the hospital by Caseworker #500. Review of a statement by Licensed Practical Nurse (LPN) #03 dated 01/17/25, revealed Resident #90 was being discharged to a facility where his psychiatric needs along with his nursing needs could be met. LPN #03 met with Caseworker #500 about the discharge. The resident was helped by LPN #03 and two other staff members in a transportation wheelchair because the resident stated he could not walk or stand. The resident stated he was hearing voices like the devil, and they wouldn't stop. Caseworker #500 stated Resident #90 could be released in his care and he would take the resident back to the discharging hospital. Resident #90 was informed of what was happening and the resident understood. LPN #03 and the DON assisted the resident to the facility bus and the bus drove off with Caseworker #500 following. Review of Resident #90's discharge Minimum Data Set (MDS) assessment dated [DATE], revealed the resident was cognitively intact, required minimal assistance with care and ambulation was impaired due to recent survey. Resident #90 needed daily wound care and had staples in his knee. Review of a progress note for Resident #90 dated 01/17/25, revealed the resident was discharged in care of Caseworker #500 with discharge instructions, future appointments, medications and belongings. Interview with the SSD #110 on 01/22/25 at 9:30 A.M., verified Resident #90 was not provided with a thirty day discharge notice nor did she try to find the resident alternative placement. SSD #100 noted Caseworker #500 set everything up and the facility just followed the plan. Interview with Caseworker Manager #501 via phone on 01/22/25 at 2:00 P.M., revealed Resident #90 was improperly placed in the facility on 01/12/25 by the hospital. Caseworker Manager #501 noted she was not court appointed, and her agency assisted with placement and help for patients to get mental health services. Caseworker Manager #501 stated Caseworker #500 should have never taken responsibility for Resident #90 on 01/16/25. Caseworker Manager #501 stated on 01/17/25, the resident was returned to the discharging hospital, and they refused to accept the resident. Caseworker #500 took the resident to another hospital, and they refused to accept him. Caseworker #500 then returned to the resident to the original hospital who discharged him, and they finally admitted him. Interview with the SSD #110 on 01/22/25 at 9:30 A.M. revealed Resident #90 was not given a thirty-day notice, nor did she try to find proper placement for the resident. SSD#110 noted Caseworker #500 set everything up. Interview with the Administrator on 01/22/25 at 12:00 P.M. revealed Resident #90 did not exhibit any violent behaviors while he resided in the facility. The Administrator noted she was only following Caseworker #500's lead with the discharge. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the homeless shelter staff on 01/22/25 at 2:50 P.M., revealed the shelter would not accept Resident #90 even if he did not have the previous violent behaviors. The shelter staff stated they had no medically trained employees to give medications or provide dressing changes. Review of facility policy titled Notice of Transfer and discharged dated 10/24, revealed the facility provide a reason for the discharge, effective date of discharge, location to where resident is being transferred or discharged to, a statement of the resident's rights to appeal, the name and number of the state ombudsman and will be made at least 30 days before the resident is discharged . This deficiency represents non-compliance investigated under Complaint Number OH00161716.