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	04/03/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on observations, staff interviews, and policy review, the facility failed to ensure the resident's electronic medical records (EMR) which contained private and confidential health information were secured and kept confidential. This affected one (#17) of the four residents reviewed for privacy of medical records. The facility census was 92. Findings include: Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type two (DM II), vascular dementia, and major depressive disorder. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 12. Observation on 03/27/25 at 8:15 A.M., revealed Registered Nurse (RN) #30 left Resident #17's EMR with private and confidential health information open and facing the hallway in plain view for other staff and residents to see while he administered medications in the resident's room. Interview on 03/27/25 at 8:19 A.M. with RN #30, verified he left Resident #17's EMR open with private and confidential health information and facing the hallway for others to see while he administered medications in the resident's room. Review of the facility policy titled, Medical Record Policy, dated February 2024 revealed medical information contained in the resident's medical record was confidential and shall be disclosed only to authorized persons with the resident's consent. Unless required by law, medical information shall not be released without a written authorization for release information, signed by the resident or his legal party responsible.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on medical record review, staff interview, observations, review of facility policy, and review of the guidelines from the National Pressure Injury Advisory Panel (NPIAP) website, the facility failed to adequately assess residents' skin, initiate prompt and timely treatment for residents' with pressure ulcers (a pressure ulcer is a localized injury of the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), provide ongoing monitoring of pressure ulcers and failed to timely implement physician ordered interventions to prevent the development of pressure ulcers and/or aid in the healing of existing pressure ulcers. This resulted in Actual Harm when a resident who was at risk for development of pressure ulcers and subsequently developed avoidable, facility acquired pressure ulcers which were not identified until they had reached an advanced stage. Resident #11 developed a pressure ulcer on the coccyx which was first identified as a stage IV pressure ulcer on 01/31/25 and a pressure ulcer on the left buttock which was first identified as unstageable on 01/31/25. This affected one (#11) of the three residents reviewed for pressure ulcers. The facility census was 92. Findings include: Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnoses included diabetes mellitus type 2, cerebral infarction, vascular dementia, and major depressive disorder. Review of the care plan dated 09/27/24 revealed Resident #11 had a potential for skin breakdown related to impaired mobility, diabetes, incontinence, and impaired cognition. Interventions included barrier ointment applied after incontinent care, instruct and assist the resident in shifting weight in wheelchair frequently, monitor nutritional status, and a pressure reduction mattress with a low-air loss mattress (LALM) to the bed. Review of a physician order dated 10/14/24, revealed Resident #11 was ordered a skin assessment weekly on Mondays every night shift (7:00 P.M. to 7:00 A.M.). Review of the January 2025 Certified Nursing Assistant (CNA) documentation survey report for Resident #11, revealed there was no documentation for rolling the resident from left to right on the following dates: 01/01/25 (day and night shifts); 01/02/25 (day and night shifts); 01/03/25 (day and night shifts); 01/04/25 (day shift); 01/05/25 through 01/14/25 (day and night shifts); 01/15/25 and 01/16/25 (night shift); 01/17/25 (day shift); 01/18/25 through 01/19/25 (day and night shifts); 01/20/25 (night shift); 01/21/25 through 01/24/25 (day and night shifts); 01/25/25 through 01/26/25 (night shift); 01/27/25 through 01/29/25 (day and night shifts); 01/30/25 (night shift); and 01/31/25 (day and night shifts). Review of the weekly skin assessments for Resident #11, revealed no documented evidence of any weekly skin assessments being completed for the month of January 2025. Review of the January 2025 Medication Administration Record (MAR) revealed all weekly skin assessments ordered for 01/06/25, 01/13/25, 01/20/25, and 01/27/25 were recorded with a nine, which indicated to see progress note. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the progress notes for Resident #11 dated 01/06/25, 01/13/25, 01/20/25, and 01/27/25, revealed there was no progress note related to the weekly skin observations. Review of the shower sheets for Resident #11 dated 01/21/25 and 01/24/25, revealed the shower sheets were not accurately completed and did not identify if the resident's skin was intact. Review of a progress note for Resident #11 dated 01/25/25 at 2:45 P.M., revealed the resident had a new skin concern located on the sacrum. The measurements were 5.0 centimeters (cm) in length by 4.0 cm in width. A second wound on the left buttock measured 3.0 cm in length by 2.5 cm in width. Treatments included cleaning with normal saline, pat dry, apply wound gel and cover with dry dressing. Resident #11 did not complain of pain. The physician and family were notified. Review of a physician order for Resident #11 dated 01/25/25, revealed the resident was ordered to have coccyx and left gluteal cleansed with normal saline, patted dry, wound gel applied, and covered with a dry dressing twice daily. Review of the January 2025 Treatment Administration Record (TAR) revealed Resident #11 had a nine marked on the morning treatments for 01/28/25 and 01/29/25. There was no documentation on 01/29/25 (evening treatment), 01/30/25 (morning and evening treatments), and 01/31/25 (morning treatment). Review of the progress notes for Resident #11 dated 01/28/25 and 01/29/25, revealed no documentation regarding the wound treatments marked with a nine. Review of a Wound Nurse Practitioner (WNP) progress note for Resident #11 dated 01/31/25 revealed the resident was assessed for a new skin impairment and a wound consultation. The findings included: Wound one was on the resident's coccyx and was categorized as a new, stage IV pressure ulcer. Measurements were 4.0 cm in length and 3.3 cm in width, with 50 percent (%) granulation (the formation of new connective tissue and tiny blood vessels on a wound's surface during the healing process) and 50 % slough (a layer of dead, yellow or gray tissue that separates from the underlying healthy skin), subcutaneous, adipose, and muscle tissue exposed, attached wound edges, with ecchymosis (bruising), scant amount of purulent and serosanguineous (a fluid that contains both blood and serum) drainage. Treatment plan consisted of cleansing the wound with normal saline, Dakins moistened gauze applied to the base of the wound and secured with a bordered foam twice daily and as needed. Wound two was on the resident's left buttock and was categorized as a new, unstageable pressure ulcer. Measurements were 6.2 cm in length by 0.3 cm in width by 0.5 cm in depth, with 20 % slough (a soft, yellow or white, dead tissue that accumulates on the surface of a wound or ulcer) and 80 % eschar (a thick, dry crust of dead tissue that forms over a wound), wound edges attached, erythema (redness), with scant amount of serosanguineous drainage. Treatment plan was to cleanse with normal saline, Hydrogel Calcium alginate applied to the base of wound, secured with bordered foam, and change daily as needed. Recommended ongoing and new interventions included: ongoing pressure reduction and turning/repositioning precautions per protocol, pressure reduction to the heels and all bony prominences, LALM for pressure reduction, and floating heels in bed with use of heel boots. Recommend washing peri-area with soap and water and pat dry thoroughly. Keep areas clean and dry, prevent skin to skin contact, prevent excessive moisture and apply barrier protections as needed. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Five-Day Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 was not able to complete a Brief Interview for Mental Status (BIMS) because she was rarely/never understood. The resident was assessed to require substantial assistance with Activities of Daily Living (ADLS). Observation on 03/27/25 at 10:41 A.M., revealed Licensed Practical Nurse (LPN) #22 performed wound care with the assistance of Registered Nurse (RN) #30 to Resident #11's sacral and left buttock wounds. Wound bed of the sacral wound was about a softball in size with granulation tissue and slough present. LPN #22 cleansed the wound with normal saline, applied a layer of Santyl to the wound bed covered with Dakins moistened gauze to base of wound, covered with bordered foam and secured with tape. The wound bed of the left buttock was approximately the size of a quarter. LPN #22 cleansed the wound with normal saline, applied a layer of Santyl to the wound bed, covered with Dakins moistened gauze to base of wound, covered with bordered foam and secured with tape. Interview on 04/01/25 at 11:43 A.M. with the Director of Nursing (DON), verified the weekly skin assessments for Resident #11 were not completed as ordered. The DON also verified the lack of documentation for turning and repositioning a dependent resident (Resident #11). Interview on 04/01/25 at 3:19 P.M. with Wound Nurse Practitioner (WNP) #60, verified she was consulted to see Resident #11. WNP #60 stated she assessed the resident on 01/31/25 with a stage IV pressure ulcer on the resident's sacral region and an unstageable pressure ulcer to the left buttock. WNP #60 reported the wounds were pressure related and should have been avoided with proper turning and repositioning and timely incontinence care. Review of the facility policy titled, Skin Condition Assessment and Monitoring - Pressure and Non-Pressure, dated October 2024 revealed guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries, and other non-pressure skin conditions and assuring interventions were implemented. Residents identified would have a weekly skin assessment by a licensed nurse. Each resident would be observed for skin breakdown daily during care and on the assigned bath day by the certified nursing assistant (CNA). Changes shall be promptly reported to the charge nurse who will perform the detailed assessment. Review of the NPIAP guidelines dated 2014 pages at https://npiap.com/general/custom.asp?page=2014Guidelines revealed facilities should educate health professionals on how to undertake a comprehensive skin assessment that included the techniques for identifying blanching response, localized heat, edema, and induration. Further review of the guidelines revealed ongoing assessment of the skin was necessary in order to detect early signs of pressure damage. Visual assessment for erythema (redness of the skin) was the first component of every skin inspection. Skin redness and tissue edema resulting from capillary occlusion was a response to pressure, especially over bony prominences. Staff should conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels and each time the patient was repositioned was an opportunity to conduct a brief skin assessment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the NPIAP website (https://npiap.com/page/PressureInjuryStages), revealed skin and soft tissue assessment is the basis of pressure injury prevention and treatment. Skin and tissue assessment is an essential component of any pressure injury risk assessment and should be conducted as soon as possible after admission and as a component of a full risk assessment. Each time the individual's clinical condition changes, a comprehensive skin and tissue assessment should be conducted to identify any alterations to skin characteristics or integrity, and to identify any new pressure injury risk factors. A comprehensive skin and soft tissue assessment consists of a head-to-toe assessment with particular focus on skin overlying bony prominence's including the sacrum, ischial tuberosities, greater trochanters and heels. In addition to comprehensive skin assessment, a brief skin assessment of the pressure points should be undertaken during repositioning. Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury is an obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. This deficiency represents non-compliance investigated under Complaint Number OH00161929.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on observations, staff interviews, and policy review, the facility failed to ensure controlled substances were accounted for and signed out after administration. This affected one (#80) of four residents reviewed for medication administration. The facility census was 92. Findings include: Review of the medical record for Resident #80 revealed an admitted [DATE]. Diagnoses included cerebral infarction, generalized anxiety disorder (GAD), peripheral vascular disease (PVD), and chronic respiratory failure. Review of the physician order dated 07/09/24 revealed Resident #80 was ordered Lorazepam (controlled substance [schedule IV] used for anxiety) 0.5 milligrams (mg), give one tablet by mouth two times a day for GAD. Review of the physician order dated 07/09/24 revealed Resident #80 was ordered Modafinil (controlled substance [schedule IV] used for excessive sleepiness associated with narcolepsy and/or obstructive sleep apnea) 100 mg, give one tablet by mouth one time a day for supplement. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #80 was not able to complete a Brief Interview for Mental Status (BIMS) because he was rarely or never understood. This resident required substantial assistance with activities of daily living (ADLs). Observation on 03/26/25 at 9:06 A.M., revealed Licensed Practical Nurse (LPN) #20 administered Lorazepam 0.5 mg and Modafinil 100 mg to Resident #80. LPN #20 did not verify the count when the controlled medications were pulled or sign out the medications from the controlled substance log after the medications administration. Interview on 03/26/25 at 9:23 A.M., with LPN #20 verified she did not ensure the controlled medication counts were accurate prior to administering Lorazepam 0.5 mg and Modafinil 100 mg. LPN #20 also verified she did not sign out these medications from the controlled substance log. Review of the facility policy titled, Medication Administration Policy, dated October 2024 revealed medications should be prepared, administered, and recorded by the same licensed nurse. Documentation of medication administration was recorded on the medication administration record (MAR) or treatment record and included the date, time, and initials of the licensed nurse who administered the medication. When class two medications were administered, the medication was recorded on the MAR by a licensed nurse and accounted for on the resident's individual control substance record by a licensed nurse.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on observations, staff interviews, and policy review, the facility failed to ensure medication error rate was less than five percent. This affected one (#80) of four residents reviewed for medication administration. The facility census was 92. Findings include: Review of the medical record for Resident #80 revealed an admitted [DATE]. Diagnoses included cerebral infarction, generalized anxiety disorder (GAD), peripheral vascular disease (PVD), gastroesophageal reflux disorder (GERD) and chronic respiratory failure. Review of the physician order for Resident #80 dated 07/09/24 revealed the resident was ordered Stress B/Zinc Oral tablet (B-Complex with Vitamin C & Vitamin E plus Zinc), give one tablet by mouth in the morning for supplement. Review of the physician order dated 07/09/24 revealed Resident #80 was ordered Famotidine oral suspension reconstituted 40 milligrams (mg) per five milliliters (ml), give 2.5 ml by mouth in the morning for GERD. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #80 was not able to complete a Brief Interview for Mental Status (BIMS) because he was rarely/never understood. This resident was assessed to require setup with eating, dependent with toileting, dressing, and transfers, and substantial assistance with bathing. Observation on 03/26/25 at 9:06 A.M. revealed LPN #20 administered medications to Resident #80 but two medications were unavailable and not administered including Stress B/Zinc Oral tablet and Famotidine. Interview on 03/26/25 at 9:12 A.M. with LPN #20 verified she did not administer Stress B/Zinc tablet or Famotidine because they were not available. Observations on 03/26/25 and 03/27/25 revealed 26 medications were administered to four Residents (#17, #80, #81, and #85) by three nurses (Licensed Practical Nurse [LPN] #20, LPN #21, and Registered Nurse [RN] #30) where two medication errors were omitted resulting in a medication error rate of 7.7 percent (%). Review of the facility policy titled, Medication Administration Policy, dated October 2024 revealed medications must be administered in accordance with a physician's order, e.g., the right resident, right medication, right dosage, right route, and right time. If a medication and/or treatment error occurred, the licensed nurse would immediately notify the attending physician, describe the error and the resident's response in the nurse's notes, complete an incident report, identify the error on the 24-hour report, and monitor the resident's status. This deficiency represents non-compliance investigated under Complaint Numbers OH00162274 and OH00161929.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44412 Based on observations, staff interviews, and policy review, the facility failed to ensure infection control practices were followed during medication administration and failed to ensure Enhanced Barrier Precautions (EBP) were followed during a resident's dressing change. This affected three (#11, #17, and #80) residents of the four reviewed for infection control practices. The facility census was 92. Findings include: 1) Review of the medical record for Resident #11 revealed an admitted [DATE]. Diagnoses included diabetes mellitus, cerebral infarction, vascular dementia, and major depressive disorder. Review of the care plan dated 09/27/24, revealed Resident #11 had a potential for skin breakdown related to impaired mobility, diabetes, incontinence, and impaired cognition. Interventions included barrier ointment applied after incontinent care, instruct and assist the resident in shifting weight in wheelchair frequently, monitor nutritional status, a pressure reduction mattress with a low-air loss mattress (LLAM) to the bed. Review of the Five-Day Medicare Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 was not able to complete a Brief Interview for Mental Status (BIMS) because she was rarely/never understood. This resident was assessed to require substantial assistance with Activities of Daily Living (ADLS). Observation on 03/27/25 at 10:41 A.M., revealed Licensed Practical Nurse (LPN) #22 performed wound care with the assistance of Registered Nurse (RN) #30 to Resident #11's sacral and left buttock wounds. Resident #11 was in EBP related to her wound. RN #30 did not don an isolation gown when assisting with wound care. Interview on 03/27/25 at 11:01 A.M. with RN #30, verified Resident #11 was in EBP due to the wounds. RN #30 verified he did not wear an isolation gown when assisting with Resident #11 dressing changes. RN #30 verified he should have been wearing a gown while assisting with wound care. Review of the facility policy titled, Enhanced Barrier Precautions, dated April 2024 revealed EBP recommendations included the use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multi-drug-resistant organism status. Standard precautions must be followed with all cares. Additionally, gown and gloves must be worn when providing the following cares: dressing, bathing/showering, providing hygiene, changing linens, incontinence care, medical device care, and wound care. 2) Review of the medical record for Resident #17 revealed an admitted [DATE]. Diagnoses included diabetes mellitus, vascular dementia, and major depressive disorder. Review of the MDS assessment dated [DATE], revealed Resident #17 had moderate cognitive impairment as evidenced by a BIMS score of 12. The resident was independent with ADLs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/27/25 at 8:15 A.M., revealed RN #30 administered medications to Resident #17. During medication administration, RN #30 popped medications from the containers directly into his bare hands then placed the medication into pill cup. RN #30 administered those medications to Resident #17. Interview on 03/27/25 at 8:18 A.M. with RN #30, verified he placed medications directly in his bare hands then put the medications into a pill cup prior to administering medications to Resident #17. 3) Review of the medical record for Resident #80 revealed an admitted [DATE]. Diagnoses included cerebral infarction, generalized anxiety disorder (GAD), peripheral vascular disease (PVD), and chronic respiratory failure. Review of the Annual MDS assessment dated [DATE], revealed Resident #80 was not able to complete a BIMS because he was rarely/never understood. The resident was dependent or required substantial assistance with ADLS. Observation on 03/26/25 at 9:06 A.M., revealed Licensed Practical Nurse (LPN) #20 administered medications to Resident #80. During administration, LPN #20 dropped Magnesium oxide 400 milligrams (mg) onto the medication cart and picked this medication up with her gloved hand on and placed into medication cup. LPN #20 administered medications to Resident #80. Continued observation revealed LPN #20 completed the medication administration for Resident #80 and prepped and administered medications to another resident without completing any hand hygiene. Interview on 03/26/25 at 9:13 A.M. with LPN #20, verified she picked up the medication off of the medication cart and placed it into medication cup to administer to Resident #80. LPN #20 verified she administered the medications to Resident #80. LPN #20 also verified she did not perform any hand hygiene after leaving Resident #80's room and before starting on another medication administration. Review of the facility policy titled, Hand Hygiene/Handwashing, dated October 2024 revealed hand hygiene meant cleaning your hands by using either handwashing (washing hands with soap and water) antiseptic hand wash, or antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel). When hands were not visibly dirty, alcohol-based hand sanitizers were the preferred method for cleaning your hands in the healthcare setting. When to perform hand hygiene included before and after having direct contact with a patient's intact skin (taking a blood pressure, performing physical examination, or lifting the patient).