

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  365044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/25/2025
NAME OF PROVIDER OR SUPPLIER  Arc at Cincinnati		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0559</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.</p> <p>Based on medical record review and staff interview the facility failed to properly notify residents/resident representatives of room changes. This affected one (Residents #194) of three residents reviewed for room changes. The facility census was 94 residents. Findings include: Review of the medical record for Resident #194 revealed an admission date of 09/04/15 with diagnosis including dementia, spinal stenosis, injury of cervical spine, neuromuscular dysfunction, bipolar disorder, history of opioid abuse and alcohol abuse and a discharge date of 07/31/25.</p> <p>Review of Minimum Data Set (MDS) assessment for Resident #194 dated 06/20/25 revealed the resident was cognitively impaired and was dependent on staff assistance with activities of daily living (ADLs.)</p> <p>Review of the medical record for Resident #194 revealed it did not include documentation of the room changes for the resident 06/03/25, 06/05/25 and 06/19/25 regarding the reasons for moves nor of notification to the resident and resident's representative of the moves.</p> <p>Interview on 08/18/25 at 1:17 P.M. with the Administrator confirmed Resident #194 had room changes on 06/03/25, 06/05/25 and 06/19/25. The Administrator confirmed the facility had no documentation of notification to the resident and the resident's representative of the reasons for the recent room moves.</p> <p>Interview on 08/18/25 at 4:10 P.M. with Resident #194's representative confirmed the facility had not notified her of the resident's recent room changes on 06/03/25, 06/05/25, and 06/19/25.</p> <p>Interview on 08/20/25 at 12:35 P.M. with Social Services Director (SSD) #62 confirmed Resident #194 had room moves on 06/03/25, 06/05/25, and 06/19/25 but the resident's record did not include documentation of the reason for the room moves nor of notification to the resident and resident's representative of the moves.</p> <p>This represents noncompliance investigated under Complaint Number OH00167216 (iQIES 1331101).</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 365044
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on medical record review, staff interview, and review of the facility policy, the facility failed to appropriately monitor resident blood pressures. This affected one (Resident #10) of 15 residents reviewed for blood pressures. The facility census was 94 residents. Findings include:Review of the medical record for Resident #10 revealed an admission date of 06/19/23 with diagnoses including chronic obstructive pulmonary disease, chronic kidney disease, and hypertension. Review of the Minimum Data Set (MDS) assessment for Resident #10 dated 06/17/25 revealed the resident had moderately impaired cognition and required staff assistance with activities of daily living (ADLs.)Review of the progress note for Resident #10 dated 05/21/25 at 9:31 A.M. revealed the resident's blood pressure was 91/40. There was no documentation of rechecking the blood pressure and/or of physician or provider notification of the low blood pressure reading. Resident of the progress note for Resident #10 dated 07/01/25 at 8:29 A.M. revealed the resident's blood pressure was 203/99. There was no documentation of rechecking the blood pressure and/or of physician or provider notification of the elevated blood pressure reading. Interview on 08/18/25 at 1:59 P.M with Nurse Practitioner (NP) #356 confirmed the facility staff did not notify him of Resident #10's abnormal blood pressure readings on 05/21/25 and on 07/01/25. NP #356 confirmed staff should have rechecked Resident #10's blood pressure on 05/21/25, because the blood pressure was low and should have rechecked the blood pressure on 07/01/25 because the blood pressure was high. Interview on 08/18/25 at 2:05 P.M with Licensed Practical Nurse (LPN) #114 stated that she rechecks residents with abnormal blood pressure readings only if she has time and she doesn't notify the medical provider of abnormal blood pressures.Interview on 08/18/25 at 2:05 P.M with Registered Nurse (RN) #36 confirmed if a resident had an abnormal blood pressure she would immediately take the blood pressure on the opposite arm. If the resident was asymptomatic, she would wait 30 minutes to an hour to recheck the blood pressure. If the resident was symptomatic, she would initiate interventions and contact the medical provider. If the blood pressure was still abnormal for the asymptomatic resident she would recheck in 30 minutes to an hour and then phone the medical provider if the blood pressure was still abnormal. Interview on 08/18/25 at 3:05 P.M. with the Director of Nursing (DON) confirmed that the nursing staff were expected to recheck abnormal blood pressures within 2 hours. If the resident was symptomatic staff should contact the medical provider immediately and start interventions. If the resident was asymptomatic with abnormal blood pressures, staff should notify the medical provider.Interview on 08/18/25 at 9:45 A.M with Physician #358 confirmed if a resident had an abnormally high or low blood pressure reading the staff should recheck the blood pressure and if it was still abnormally low or high, the staff should notify the physician or provider. Review of the facility policy titled Measuring Blood Pressure dated September 2010 revealed hypertension was defined as a blood pressure over 140/90. The policy revealed hypotension (low blood pressure) was a reading of less than 100/60. If a resident had an abnormal blood pressure reading it should be reported to the physician and staff should record readings taken at different times of the day. This deficiency represents noncompliance investigated under Complaint Number 2571103.</p>		