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	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at 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 - Many	Keep residents' personal and medical records private and confidential. Based on medical record review, resident interview, staff interview, and facility policy review, the facility failed to ensure staff provided verbal reports to one another in a manner to protect the residents' health information. This had the potential to affect all 92 residents residing in the facility. The census was 92. Findings include:A Resident Council meeting was held on 12/16/25 beginning at 3:00 P.M. During the meeting Resident #68 stated he knew diagnoses and medications of other residents and had been accused of, knowing too much; however, Resident #68 stated he knew these things due to overhearing the nurses and nurse aides talking. Resident #68 stated he had told staff it was a violation of the Health Insurance Portability and Accountability Act (HIPAA). During the meeting, Resident #27 stated she also knew medical information about other residents, including some of the medications other residents were taking. Resident #27 further stated another resident (Resident #32) also heard information about other residents through her open door.Review of Resident #68's annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 11/13/25, revealed Resident #68 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Review of Resident #27's quarterly MDS assessment, with an ARD of 10/01/25, revealed Resident #27 had a BIMS score of 15, which indicated the resident had intact cognition. During an interview on 12/20/25 at 10:24 A.M., Resident #32 stated when staff gave report to one another, the resident was able to hear other residents' health information. Resident #32 further stated she knew what protected heath information included since she was a former nurse. Review of Resident #32's quarterly MDS, with an ARD of 11/21/25, revealed Resident #32 had a BIMS score of 15, which indicated the resident had intact cognition. Licensed Practical Nurse (LPN) #3 was interviewed on 12/20/25 at 1:19 P.M. and stated shift report was held at the nurses' station, and she was sure residents overheard protected health information. LPN #3 stated she knew it was a HIPAA violation all day long. The Director of Nursing (DON) was interviewed on 12/21/25 at 10:28 A.M. and stated nurses completed shift report at the nurses' stations, but stated each nurses' station had an office area or a medication room that allowed the nurses to meet privately. The DON stated she would not have expected the nurses to discuss residents' illnesses or medications where the information could be overheard by other residents. The DON stated if other residents' information was overheard, it was a HIPAA violation. The Administrator was interviewed on 12/21/25 at 3:46 P.M. and stated she expected staff to keep medical information about residents confidential. Review of a facility policy titled, Dignity, revised 02/2021, indicated staff are to protect confidential clinical information. Examples included verbal staff-to-staff communication (e.g. [exempli gratia, for example], change of shift reports) are conducted outside the hearing range of residents and the public. This deficiency represents non-compliance investigated under Complaint Number 2650678.

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 0656 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Based on medical record review, interviews, review of facility investigation documents, and policy review, the facility failed to implement person-centered care planned interventions. This resulted in Actual Harm when Resident #97 was being bathed by one staff member, had a spasm in one leg, fell out of the bed, and sustained fractures in both legs. This affected one (Resident #97) of three residents reviewed for falls. The facility census was 92.Findings Included: Review of the medical record revealed the facility admitted Resident #97 on 07/04/19. Diagnoses included absolute glaucoma, binge eating disorder, abnormal posture, bariatric surgery status, muscle weakness, difficulty in walking, and the need for assistance with personal care. Review of an annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/25/25, revealed Resident #97 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff with toileting, showering/bathing, lower body dressing, rolling left and right, going from sitting on the side of the bed to lying flat on the bed, going from laying on their back to sitting on the side of the bed, going from sitting to standing, chair/bed-to-chair transfers, and with tub/shower transfers. Review of Resident #97's Care Plan Report included a focus area revised on 11/21/24, indicating the resident had a behavior problem related to impaired cognition, depression, dependence on others for care, anxiety, insomnia, and mood disorder. Interventions directed two staff to be in the residents' room for all care (initiated 11/21/24). Resident #97's Care Plan Report included a focus area revised on 11/21/24, indicating the resident had a self-care/mobility deficit. Interventions initiated 11/21/24 indicated the resident was dependent on staff for care related to bathing/showering and bed mobility. Review of Resident #97's Progress Notes dated 09/05/25 at 1:19 P.M. and electronically signed by Licensed Practical Nurse (LPN) #09, revealed LPN #09 was notified by an aide that Resident #97 had fallen while they were providing care. Upon entering the room, LPN #09 observed the resident lying on the floor. Emergency services were called, and the resident was transported to the local hospital. Review of the facility's investigation document related to Resident #97's fall on 09/05/25, indicated while Certified Nursing Assistant (CNA) #36 provided personal care to the resident, the resident's legs slipped off the bed in a jerking motion and went off to the side of the bed, resulting in the resident sliding off the bed onto their buttocks, with their legs bent outward. The investigation indicated after initial assessment, the resident was transferred back to bed. Resident #97 complained of pain in their right leg and requested to go to the emergency room. Emergency services were contacted, and the resident was taken to the emergency room. During a telephone interview on 12/19/25 at 9:32 A.M., CNA #36 stated that while providing Resident #97 a bed bath, the residents' legs went to the side and caused the resident to fall onto the floor in the split-like position. She stated Resident #97 screamed out in pain. CNA #36 stated she yelled for help, and approximately five staff members assisted the resident back to bed. CNA #36 stated Resident #97 required assistance from two staff members but stated she always provided care to Resident #97 by herself. CNA #36 stated no one there would help her. CNA #36 stated Resident #97 sustained fractures to both legs and never returned to the facility. During a telephone interview on 12/19/25 at 8:07 P.M., Resident #97 stated they were receiving a bed bath from CNA #36 when their leg kind of spasmed, went off the side of the bed, and caused them to fall onto the floor. The resident stated that it hurt and they were screaming. Resident #97 stated CNA #36 provided the bed bath without any other staff assistance. Resident #97 stated they were transferred to the local hospital following the incident and was diagnosed with fractures in both legs. Resident #97 stated they had not returned to the facility following the incident. During an interview on 12/19/25 at 10:12 A.M., LPN #09 stated they only worked at the facility as needed. LPN #09 stated they could not remember the specifics surrounding the incident involving Resident #97 but confirmed the resident was dependent on staff, requiring total assistance for all care. During an interview on 12/19/25 at 10:32 A.M., the MDS/Care Plan Coordinator (MDS Coordinator) stated based on Resident #97's care plan and MDS, the resident was dependent on staff and required assistance from two staff for all care. The MDS Coordinator stated she expected staff to follow the care planned interventions. During an interview on 12/22/25 at 8:50 A.M., the Director of Nursing (DON) stated dependent care meant the resident was not able to participate in assisting with their care. The DON stated Resident #97 required assistance from two staff for all care, and it was her expectation that all staff followed resident care planned interventions. Review of the facility policy titled, Falls-Clinical Protocol, revised 03/2018, indicated Treatment/Management included, 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on medical record review, staff interview, and facility policy review, the facility failed to ensure residents were taken to outside appointments when scheduled. This affected one (#98) of six residents reviewed for medical appointments. The census was 92.Findings include: Review of a medical record revealed the facility admitted Resident #98 on 07/09/25 and discharged the resident on 08/17/25. Diagnoses included unspecified paraplegia (paralysis to legs/lower body), autonomic dysreflexia (abnormal overreaction of nervous system to painful sensory input), neuromuscular dysfunction of the bladder, anxiety disorder, chronic pain syndrome, and recurrent major depressive disorder. Review of an admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/16/25, revealed Resident #98 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS assessment indicated the resident often needed someone to help when reading instructions, pamphlets, or other written material from the physician or pharmacy. The MDS assessment revealed Resident #98 required partial assistance from another person when planning regular tasks such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury. The MDS assessment revealed Resident #98 used a motorized wheelchair and had functional limitation in range of motion to both lower extremities. The MDS assessment indicated Resident #98 was dependent on staff for all aspects of mobility. Review of Resident #98's care plan report included a focus area, initiated 07/10/25, indicated the resident wanted to remain in the facility permanently. Interventions directed staff to arrange transportation as needed to medical appointments, initiated 07/10/25. Review of Resident #98's hospital continuity of care form dated 07/09/25, indicated the resident required stretcher transportation due to being bedbound. The form indicated Resident #98 was discharged from the hospital with two appointments scheduled, on 07/14/25 and 09/30/25. The form indicated the facility should call the orthopedic surgery office to schedule an appointment. Review of a prescriber-written order, dated 07/11/25 at 2:37 P.M., revealed an order to refer Resident #98 to physical medicine and rehabilitation with instructions to, Please arrange transportation. Registered Nurse (RN) #6 was interviewed on 12/18/25 at 3:23 P.M. and stated when a resident was admitted with appointments already made, she faxed the appointment information to the transportation manager and the transportation manager handled everything from there. RN #6 stated if a resident was admitted with orders to schedule an appointment, the admitting nurse was responsible for scheduling the appointment, and then the same process of faxing the appointment information to the transportation manager was followed. RN #6 stated there had been conflicts between what the nurse scheduled and what the transport manager scheduled, causing residents to miss appointments or resulting in appointments that needed to be rescheduled. RN #6 stated when transportation was scheduled, the transportation manager sent a fax to the nurse's station with the transportation information. RN #6 stated two different people setting up appointments and transportation caused residents to miss appointments. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Transportation Coordinator (TC) #62 was interviewed on 12/20/25 at 12:42 P.M. and stated she was not responsible for scheduling appointments and was only responsible for scheduling transportation. TC #62 stated nurses were responsible for scheduling appointments, and after the appointment was made, the nurse sent an Appointment Communication sheet that included the resident's name, the location of the appointment, the date and time of the appointment, and who was the payor source for transportation. TC #62 stated she used the information to make transportation arrangements. TC #62 stated when transportation arrangements had been made, she faxed the information back to the nurse to be placed in a log at the nurse's station. TC #62 stated it was up to the nursing staff to make sure the resident was ready for the appointment; she added that while transportation showed up, the residents sometimes refused to get out of bed or refused to go to the appointment. TC #62 reviewed Resident #98's orders and stated it would have been up to the nurse to make the appointments listed and to complete the transportation communication sheet for all the appointments listed on the continuity of care form. The Director of Nursing (DON) was interviewed on 12/21/25 at 10:38 A.M. and described the process for arranging residents' transportation and appointments. The DON stated if a resident was admitted with an appointment already scheduled, the nurse would complete a transportation communication form and send it to TC #62. The DON stated if the residents' orders included appointments to be made, the nurse would make the appointment and then send a transportation communication form to TC #62. The DON reviewed the admission note for Resident #98 and identified the admission nurse as LPN #1, who worked on day shift; the DON noted that Resident #98 had arrived close to shift change. The DON stated in this instance, the night shift nurse would have been responsible for sending the communication form to TC #62. The DON stated any day shift nurse could have scheduled the appointments that needed to be scheduled for Resident #98. The DON reviewed Resident #98's records and stated appointments for the resident had not been signed off, indicating the appointments were not made. During a follow-up interview on 12/21/25 at 11:47 A.M., TC #62 stated she had been unable to find any documentation that Resident #98 had attended appointments or that transportation was arranged. TC #62 stated that she knew Resident #98 had refused to get out of bed for a couple of appointments but knew it was not documented. The Administrator was interviewed on 12/21/25 at 3:28 P.M. and stated any appointments that were scheduled when a resident admitted to the facility were entered into the facility's electronic medical records system, and a transportation communication sheet was given to the transportation coordinator. The Administrator stated if there were orders for appointments to be made, that it was the primary responsibility of the nurses to make the appointments and then request transportation. On 12/22/25 at 8:52 A.M., the Administrator reported there was no information found regarding Resident #98's appointment for 07/14/25 or of an appointment with physical medicine and rehabilitation. The Administrator stated the different physicians' offices had been called, and there was no documentation Resident #98 had appointments scheduled with those providers. Licensed Practical Nurse (LPN) #1 was interviewed on 12/22/25 at 1:16 P.M. and stated that even though nurses faxed requests for transportation to TC #62, TC #62 stated the requests were not received, even with a fax confirmations that indicated faxes were successfully sent. LPN #1 stated TC #62 seemed to miss so many faxes requesting transportation that she placed a copy of the requests under the DON's door. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Practitioner (NP) #45 was interviewed on 12/22/25 at 2:21 P.M. and stated there had been concerns with residents missing appointments. NP #45 identified the problems as transportation falling through or staff not answering phone calls, and stated she was unaware of any negative consequences of missed appointments. Review of a facility policy titled, Transportation, Social Services, revised 12/2008, revealed the facility shall help arrange transportation for residents as needed. This deficiency represents non-compliance investigated under Complaint Number 2618734.

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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff and resident interview, review of facility investigation documents, and policy review, the facility failed to provide adequate supervision and assistance for a resident who was dependent on two staff for bathing. This resulted in Actual Harm when Resident #97 was being bathed by one staff member, had a spasm in one leg, fell out of the bed, and sustained fractures in both legs. This affected one (Resident #97) of three residents reviewed for falls. Additionally, the facility failed to ensure the environment was free of accident hazards. This affected four (Residents #80, #86, #45, and #13) of 37 sampled residents. The facility census was 92.Findings Included:Based on medical record review, observation, staff and resident interview, review of facility investigation documents, and policy review, the facility failed to provide adequate supervision and assistance for a resident who was dependent on two staff for bathing. This resulted in Actual Harm when Resident #97 was being bathed by one staff member, had a spasm in one leg, fell out of the bed, and sustained fractures in both legs. This affected one (Resident #97) of three residents reviewed for falls. Additionally, the facility failed to ensure the environment was free of accident hazards. This affected four (Residents #80, #86, #45, and #13) of 37 sampled residents. The facility census was 92.Findings Included:1. Review of the medical record revealed the facility admitted Resident #97 on [DATE]. Diagnoses included absolute glaucoma, binge eating disorder, abnormal posture, bariatric surgery status, muscle weakness, difficulty in walking, and the need for assistance with personal care. Review of an annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #97 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff with toileting, showering/bathing, lower body dressing, rolling left and right, going from sitting on the side of the bed to lying flat on the bed, going from laying on their back to sitting on the side of the bed, going from sitting to standing, chair/bed-to-chair transfers, and with tub/shower transfers. Review of Resident #97's Care Plan Report included a focus area revised on [DATE], indicating the resident had a behavior problem related to impaired cognition, depression, dependence on others for care, anxiety, insomnia, and mood disorder. Interventions directed two staff to be in the residents' room for all care (initiated [DATE]). Resident #97's Care Plan Report included a focus area revised on [DATE], indicating the resident had a self-care/mobility deficit. Interventions initiated [DATE] indicated the resident was dependent on staff for care related to bathing/showering and bed mobility. Review of Resident #97's Progress Notes dated [DATE] at 1:19 P.M. and electronically signed by Licensed Practical Nurse (LPN) #09, revealed LPN #09 was notified by an aide that Resident #97 had fallen while they were providing care. Upon entering the room, LPN #09 observed the resident lying on the floor. Emergency services were called, and the resident was transported to the local hospital. Review of the facility's investigation document related to Resident #97's fall on [DATE], indicated while Certified Nursing Assistant (CNA) #36 provided personal care to the resident, the resident's legs slipped off the bed in a jerking motion and went off to the side of the bed, resulting in the resident sliding off the bed onto their buttocks, with their legs bent outward. The investigation indicated after initial assessment, the resident was transferred back to bed. Resident #97 complained of pain in their right leg and requested to go to the emergency room. Emergency services were contacted, and the resident was taken to the emergency room. During a telephone interview on [DATE] at 9:32 A.M., CNA #36 stated that while providing Resident #97 a bed bath, the residents' legs went to the side and caused the resident to fall onto the floor in the split-like position. She stated Resident #97 screamed out in pain. CNA #36 stated she yelled for help, and approximately five staff members assisted the resident back to bed. CNA #36 stated Resident #97 required assistance from two staff members but stated she always provided care to Resident #97 by herself. CNA #36 stated no one there would help her. CNA #36 stated Resident #97 sustained fractures to both legs and never returned to the facility. During a telephone interview on [DATE] at 8:07 P.M., Resident #97 stated they were receiving a bed bath from CNA #36 when their leg kind of spasmed, went off the side of the bed, and caused them to fall onto the floor. The resident stated that it hurt and they were screaming. Resident #97 stated CNA #36 provided the bed bath without any other staff assistance. Resident #97 stated they were transferred to the local hospital following the incident and was diagnosed with fractures in both legs. Resident #97 stated they had not returned to the facility following the incident. During an interview on [DATE] at 10:12 A.M., LPN #09 stated they only worked at the facility as needed. LPN #09 stated they could not remember the specifics

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff and resident interviews, review of the hospital record, and policy review, the facility failed to ensure ordered pain medication was available for administration. This resulted in Actual Harm, when Resident #39 missed three days of methadone (a medication to treat severe pain) a total of nine doses, had increased pain, called nine-one-one (911), and went to the emergency room. This affected one (Resident #39) of two residents reviewed for pain medication use. The facility census was 92. Findings Include:Based on medical record review, staff and resident interviews, review of the hospital record, and policy review, the facility failed to ensure ordered pain medication was available for administration. This resulted in Actual Harm, when Resident #39 missed three days of methadone (a medication to treat severe pain) a total of nine doses, had increased pain, called nine-one-one (911), and went to the emergency room. This affected one (Resident #39) of two residents reviewed for pain medication use. The facility census was 92. Findings Include:Review of the medical record revealed Resident #39 admitted on [DATE]. Diagnoses included unspecified pain, low back pain, and chronic pain syndrome with opioid dependence. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/01/25, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received scheduled pain medication and had pain occasionally over the last five days of the assessment period that occasionally limited their participation in rehabilitation therapy sessions and day-to-day activities. Review of Resident #39's Care Plan Report included a focus area revised 11/10/25, indicating the resident was at risk for pain related to recent surgeries, major depressive disorder (MDD), gastroesophageal reflux disease (GERD), and chronic pain syndrome. Interventions directed staff to administer analgesics as per orders, initiated 04/17/25, and evaluate the effectiveness of pain interventions with each administration, revised 10/24/25. Review of Resident #39's Care Plan Report included a focus area revised 12/02/25, indicating the resident was at risk for fluctuations in mood and behaviors related to diagnoses of depression, chronic pain, immobility with potential side effects of medications with a history of opioid dependence. Interventions directed staff to administer medications and observe for adverse effects, and if noted, document and report to the physician; contact Social Services as needed; discuss with the resident ways to utilize present coping skills to deal with situations that arise; provide emotional support; and investigate the need for psychological support. During an interview on 12/18/25 at 12:57 P.M., Resident #39 stated there had been many times when the facility had not been able to get their prescribed methadone and the resident had to call 911 to go to the emergency room due to increased pain. The resident stated the facility would tell them that it was due to insurance issues. During a follow-up interview on 12/18/25 at 2:47 P.M., Resident #39 stated when they went without their methadone, their whole body cramped up, their stomach cramped up, and they would get nauseated and nervous. The resident stated they would call 911 even if they only missed a few doses because they were worried they would end up going into withdrawal. Review of Resident #39's physician orders revealed an order dated 09/30/25 for methadone five milligrams (mg) by mouth three times a day related to chronic pain syndrome. Review of Resident #39's October 2025 Medication Administration Record (MAR) and Controlled Drug Record for methadone revealed the following: On 10/01/25, the 12:00 A.M. dose of methadone was signed out on the MAR as being administered; however, there was not a Controlled Drug Record to indicate the medication was available to administer; the 8:00 A.M. and 4:00 P.M. doses of methadone were coded with the number 9 indicating to see the Nurses Notes. Resident #39's Progress Notes dated 10/01/25 at 11:31 A.M. and 7:25 P.M. indicated the facility was waiting on the pharmacy to dispense the resident's methadone and the physician was aware. The MAR indicated the residents' pain level for the day and evening shifts on 10/01/2025 was zero. On 10/02/25 and 10/03/25, the 12:00 A.M. doses of methadone were signed out on the MAR as being administered but were not signed out on the Controlled Drug Record. The pain level indicated zero. On 10/05/25 at 4:00 P.M. and 10/06/25 8:00 A.M. and 4:00 P.M., the methadone was coded with the number 9. Resident #39's Progress Notes dated 10/05/25 at 5:16 P.M. indicated the facility was waiting on the pharmacy to dispense the resident's methadone and the physician was aware. The Progress Notes dated 10/06/25 at 11:58 A.M. and 5:42 P.M. indicated the methadone would be administered when available from the pharmacy. The pain level indicated zero. On 10/06/25, the 12:00 A.M. dose of methadone was signed out on the MAR as being administered; however

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	365044	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at 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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interview, and facility policy review, the facility failed to ensure there was ongoing communication with dialysis providers. This affected two (Resident #05 and #68) of two residents reviewed for dialysis. The facility census was 92. Findings Include:1. Review of the medical record revealed Resident #05 admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), chronic diastolic congestive heart failure, and end stage renal disease (ESRD). Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/02/25, revealed Resident #05 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS revealed the resident received dialysis while they were a resident at the facility. Review of Resident #05's Care Plan Report included a focus area revised on 08/22/25, indicating the resident needed hemodialysis related to ESRD. Interventions directed staff to encourage the resident to go to their scheduled dialysis appointments and the resident received dialysis three times a week. Review of Resident #05's electronic medical record (EMR) and hard (paper) chart revealed no documentation of communication between the dialysis center and the facility. During an interview on 12/16/25 at 10:05 A.M., Licensed Practical Nurse (LPN) #01 stated the facility was not obtaining any information from the dialysis center when the resident returned from dialysis. During an interview on 12/19/25 at 8:09 A.M., Registered Nurse (RN) #14 stated he used to send dialysis communication sheets with the resident to dialysis, but he had not seen the sheets in a long time. RN #14 stated that instead he would send the resident demographic record and a copy of the physician ' s order with the resident to dialysis. During an interview on 12/19/25 at 11:59 A.M., LPN #07 stated the facility did not send any information with the resident to the dialysis center when the resident went to dialysis. LPN #07 stated that if the resident returned with information, it was typically for laboratory work. She stated that the facility received no information from the dialysis center for them to review, and vitals were obtained when the resident returned from dialysis. During an interview on 12/21/25 at 11:20 A.M., LPN #15 stated the facility had no dialysis binder that she was aware of for Resident #05. During an interview on 12/22/25 at 1:32 P.M., the Dialysis Charge Nurse #16 stated the dialysis center had not received any information from the facility since the summer. She stated Resident #05 had no paperwork with them when they arrived for treatment. 2. Review of the medical record revealed Resident #68 admitted to the facility on [DATE]. Diagnoses included hypertensive chronic kidney disease with stage V chronic kidney disease or end stage renal disease, dependence on renal dialysis, and type II diabetes mellitus. Review of an annual MDS, with an ARD of 11/13/25, revealed Resident #68 BIMS score of 14 indicating the resident had intact cognition. The MDS indicated that the resident had renal insufficiency, renal failure, or end stage renal disease, and was dependent on dialysis. Review of Resident #68's Care Plan Report included a focus area revised on 04/08/25 indicating the resident needed hemodialysis three times a week related to end stage renal failure which the resident refused at times. Interventions directed staff to encourage the resident to go for the scheduled dialysis appointments and educate on the need to go to dialysis appointments and the possible health consequences of not going for treatment. Review of the EMR and paper chart revealed no documentation of communication between the dialysis center and the facility. During an interview on 12/19/25 at 12:47 P.M., the Director of Nursing (DON) stated that sometimes the facility received nothing from the dialysis center, and they would have to call the dialysis center regarding a dialysis communication sheet that was sent with the resident from the facility. The DON stated nurses were responsible for completing the sheet, and she expected the sheet to be completed and sent with the resident for every treatment. The DON stated that the dialysis communication sheet, when returned to the facility, should be uploaded to the resident ' s electronic medical chart and placed in the resident ' s hard (paper) chart. Review of a facility policy titled, End-Stage Renal Disease, Care of a Resident with, revised 09/2010, revealed, 4. Arrangements between this facility and the contracted ESRD [end stage renal disease] facility include all aspects of how the resident ' s care will be managed, including: a. how the care plan will be developed and implemented; b. how information will be exchanged between the facilities.This deficiency represents non-compliance investigated under Complaint Number 2618734.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on medical record review, staff interview, and facility policy review the facility failed to ensure medications were administered as ordered, resulting in significant medication errors. This affected three (#56, #100, and #101) of six residents reviewed for medications. The census was 92.Findings include:1. Review of the medical record revealed the facility admitted Resident #56 on 10/13/23. The resident had a diagnoses of allergic rhinitis. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/03/25, indicated Resident #56 had a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. Review of Resident #56's care plan included a focus area, revised on 09/30/24, that indicated the resident had multiple chronic conditions and severely impaired vision affecting his independence and ability to care for himself. An intervention directed staff to administer medications as ordered. Review of Resident #56's order summary report included a physician's order dated 07/10/24 for the corticosteroid medication prednisolone acetate (Prednisone) ophthalmic suspension one (1) percent (%), to instill one drop in both eyes once daily. Review of Resident #56's eye examination summary dated 11/04/25 indicated the resident was seen by the optometrist and was prescribed Prednisone, with one drop to be administered to the resident's right eye each morning. Review of Resident #56's medication administration records (MARs) dated November and December 2025 indicated the resident received prednisolone acetate ophthalmic suspension 1%, one drop in both eyes once daily at 9:00 AM. There was no documentation on the MARs of the 11/04/25 order for Prednisone, one drop to the right eye each morning. During an interview on 12/18/25 at 11:15 A.M., Licensed Practical Nurse (LPN) #7 stated if a resident received new orders, the nurse assigned to the resident was responsible for updating the orders. LPN #7 reviewed Resident #56's medical record and confirmed the resident was seen by the optometrist on 11/04/25 and there was a change in the resident's eye drop orders that did not get transcribed/updated on the MARs. During an interview on 12/21/25 at 1:39 P.M., LPN #10 stated the nurse who was assigned to a resident was responsible for taking off any orders that were received for that resident. During an interview on 12/21/25 at 2:30 P.M., the Director of Nursing (DON) stated she expected the nurses to update the orders and to follow them. The DON reviewed the order from Resident #56's optometry appointment and confirmed the facility's nursing staff had not updated the resident's eye drop orders. The DON stated she expected her staff to give medications as ordered. During an interview on 12/21/25 at 2:54 P. M., the Administrator stated she expected the staff to give medications as ordered. 2. Review of the medical record revealed the facility admitted Resident #101 on 10/10/25. Diagnoses included chronic viral hepatitis C, opioid dependence, and human immunodeficiency virus disease (HIV). Review of a MDS assessment, with an ARD of 10/15/25, revealed Resident #101 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS assessment indicated Resident #101 received both antianxiety medication and antipsychotic medication. Review of Resident #101's care plan report included a focus area, initiated on 10/16/25, that revealed the resident had a history of substance abuse and a focus area initiated on 10/20/25 that indicated Resident #101 had a behavior problem related to non-compliance and attention seeking behaviors. An intervention directed staff to encourage the resident to express feelings appropriately (10/20/25). Review of a continuity of care form dated 10/09/25 indicated Resident #101 had a physician's order for quetiapine (an antipsychotic medication) 50 mg to be taken nightly at 9:00 P.M., with the last recorded dose documented as taken at 9:41 P.M. Review of Resident #101's October 2025 MAR indicated quetiapine 50 mg was added to the MAR on 10/11/25 to be given at 9:30 A.M., instead of 9:00 P.M. as ordered by the physician. The order was discontinued on 10/15/25 and re-entered on the MAR as quetiapine 50 mg to be given at 9:00 P.M. Review of Resident #101's progress notes for the timeframe from 10/10/25 through 10/15/25 were reviewed, and there was no documentation that indicated the resident had been overly sedated or lethargic due to receiving the medication in the morning. Review of a progress note dated 10/11/25 at 6:52 P.M. revealed Resident #101 tried to sign out of the facility and was educated that they were unable to go to the store with a peripherally inserted central catheter (PICC) in place. Review of notes on 10/12/25 at 11:11 A.M. indicated Resident #101 was alert and oriented to person, place, time, and situation. Review of progress notes dated 10/14/25, and signed by the nurse practitioner (NP), indicated Resident #101 received quetiapine 50 mg, but no time of administration was documented. The NP documented the resident's mood and affect were appropriate. LPN #2 was interviewed on 12/19/25 at 11:58 P.M. and, after reviewing Resident #101's October 2025 MAR, stated the quetiapine had been ordered daily

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Arc at Cincinnati	4001 Rosslyn Drive Cincinnati, OH 45209

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and facility document and policy review, the facility failed to ensure expired medications were discarded. In addition, the facility failed to ensure a thermometer was available to monitor the temperatures of one of two medication refrigerators and the facility failed to ensure staff monitored the temperatures of two of two medication refrigerators daily. This had the potential to affect all residents residing on the [NAME] and Elm units. The facility was census was 92. An observation of the [NAME] Unit medication room on 12/16/2025 at 10:40 A.M. revealed 25 expired heparin lock flush solutions 50 United States Pharmacopoeia (USP) per 5 milliliters (ml); 12 had expiration dates of 07/2022, nine had expiration dates of 04/2023, and four had expiration dates of 03/2023. All items were unopened but available for use during the observation. Additional observation of the [NAME] Unit medication refrigerator on 12/16/2025 at 11:00 A.M. revealed there was no thermometer available to monitor the medication refrigerator temperatures. The following medications were observed stored in the medication refrigerator: nine Lantus SoloStar 100 units/ml flex pens, nine insulin aspart 100 units/ml flex pens, four Bonsity (medication to treat osteoporosis) injection pens, three Trulicity (an injectable diabetic medication) 0.75 milligram (mg)/0.5 ml flex pens, and five Basaglar (a type of long-acting insulin) 100 units/ml flex pens. An observation of the medication cart located on the Elm Unit on 12/16/2025 at 11:25 AM revealed one house-stock tube of Solosite wound gel that expired on 09/01/2025, one enema saline laxative box that expired 11/2025, and one zinc oxide ointment 20 percent (%) that expired 10/2025. Review of the 11/2025 Medication Refrigerator Temperature Log for the [NAME] Unit specified, to be documented every shift. The log revealed the temperature was documented as checked on 11/08/2025 at 8:00 A.M. and 11/09/2025 at 9:00 A.M. The 12/2025 Medication Refrigerator Temperature Log for the [NAME] Unit contained no documented temperature monitoring for the timeframe from 12/01/2025 through 12/15/2025. The 11/2025 Medication Refrigerator Temperature Log for the Elm Unit revealed staff documented temperature monitoring on 11/01/2025 through 11/19/2025; however, the document revealed there was no documentation of temperature monitoring for the timeframe from 11/20/2025 through 11/30/2025. The 12/2025 Medication Refrigerator Temperature Log for the Elm Unit revealed there was no documentation of temperature monitoring for the timeframe from 12/01/2025 through 12/15/2025 or 12/18/2025 through 12/23/2025. During an interview on 12/16/2025 at 11:10 A.M., Licensed Practical Nurse (LPN) #1 stated the night shift was responsible for checking the medication refrigerators nightly to ensure the medication refrigerators contained a thermometer and to document the temperatures on the temperature logs. She stated all nurses were responsible for monitoring for expired medications. During an interview on 12/16/2025 at 3:55 P.M., the Director of Nursing (DON) stated the night shift nurses were responsible for checking the medication refrigerator temperatures and documenting on the logs each day. She further stated each night, staff should check to ensure a thermometer was located inside the medication refrigerators. The DON stated she was unsure whether staff were trained on who was responsible for checking the medication refrigerators and medication rooms for expired items. During an interview on 12/18/2025 at 7:35 A.M., LPN #33 stated the responsibility to check the medication refrigerators had previously been a joint effort shared by the dayshift and nightshift nurses; however, she was recently notified that night shift nurses would be responsible for the monitoring. Review of a facility policy titled, Medication Labeling and Storage, revised 02/2023, revealed , the facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls and the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The policy continues to read, if the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.

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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. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, interview, and facility policy review, the facility failed to ensure accurate documentation on the Medication Administration Record (MAR) for one (Resident #39) of 37 sample residents. The facility census was 92. Review of an admission Record indicated the facility admitted Resident #39 on 03/14/2025. According to the admission Record, the resident had a medical history that included unspecified pain, low back pain, and chronic pain syndrome with opioid dependence. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/01/2025, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident received scheduled pain medication and had pain occasionally over the last five days of the assessment period that occasionally limited their participation in rehabilitation therapy sessions and day-to-day activities. Review of Resident #39's Care Plan Report, included a focus area revised 11/10/2025, that indicated the resident was at risk for pain. Interventions directed staff to administer analgesics as per orders, (initiated 04/17/2025), and evaluate the effectiveness of pain interventions with each administration (revised 10/24/2025). Review of Resident #39's Care Plan Report, included a focus area revised 12/02/2025, that indicated the resident was at risk for fluctuations in mood and behaviors related to diagnoses of depression, chronic pain, immobility with potential side effects of medications with a history of opioid dependence. Interventions directed staff to administer medications and observe for adverse effects, and if noted, document and report to the physician; contact Social Services as needed; discuss with the resident ways to utilize present coping skills to deal with situations that arise, provide emotional support; and investigate the need for psychological support. Review of the Resident #39's physician orders revealed an order dated 09/30/2025 for methadone 5 milligrams (mg) by mouth three times a day related to chronic pain syndrome. Review of Resident #39's October 2025 Medication Administration Record (MAR) revealed methadone was signed on the MAR as being administered but there was not a Controlled Drug Record [narcotic sheet] to indicate the medication was available to administer on 10/01/2025, 10/02/2025, 10/03/2025, 10/06/2025, 10/10/2025, 10/11/2025, and 10/26/2025 at 12:00 A.M. Review of Resident #39's November 2025 MAR revealed methadone was signed on the MAR as being administered but there was not a Controlled Drug Record to indicate the medication was available to administer on 11/18/2025 at 12:00 A.M. and 4:00 P.M., and on 11/22/2025 at 9:00 A.M. and 9:00 P.M. During an interview on 12/18/2025 at 12:57 P. M., Resident #39 stated that there have been many times the facility had not been able to get their methadone from the pharmacy. During an interview on 12/20/2025 at 7:40 P.M., Registered Nurse (RN) #14 confirmed that he did sign Resident #39's MAR that the methadone was administered on 10/11/2025, 10/26/2025 and 11/22/2025 . RN #14 also confirmed there was no narcotic sheet, adding then he must have signed the MAR by accident making it an inaccurate MAR. During a phone interview on 12/22/2025 at 11:24 A.M., Licensed Practical Nurse (LPN) #22 stated that she signed the methadone as administered on Resident #39's MAR by accident on 11/22/2025 because if she had given it, she would have signed it out on the narcotic sheet. During an interview on 12/23/2025 at 9:24 A.M., the Director of Nursing (DON) stated that the nurses should not be signing off that a medication was administered if it was not given. She stated the resident ' s record would not be accurate if they documented that medication was given when it was not. During an interview on 12/23/2025 at 10:44 A.M., the Administrator stated the nurses should not be documenting that a medication was given it was not, and it would make the MAR inaccurate. A facility policy titled, Administering Medications, revised 04/2019, indicated, medications are administered in a safe and timely manner, and as prescribed. The policy revealed, the individual administering the medication initials the resident ' s MAR on the appropriate line after giving each medication and before administering the next one. As required or indicated for a medication, the individual administering the medication records in the resident ' s medical record to include the date and time the medication was administered, the dosage, the route of administration, the injection site (if applicable), any complaints or symptoms for which the drug was administered, any results achieved and when those results were observed, and the signature and title of the person administering the drug. This deficiency represents non-compliance investigated under Complaint Number 2650678.

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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 - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on medical record review, observation, and interview, the facility failed to ensure staff did not discard used towels on the shower room floor or designate bath/shower items for individual resident use in one (Willow Unit) of two shower rooms observed. In addition, the facility failed to store respiratory equipment properly when not in use. This affected two (Resident #06 and #37) of four residents reviewed for respiratory care. The facility census was 92.Findings Included:1. During an observation of the [NAME] Unit shower room on 12/19/25 at 9:12 A.M., multiple dirty towels were observed on the floor, and large bottles of shower supplies and brushes were not designated for individual resident use. During an interview on 12/19/25 at 10:32 A.M., Housekeeper #05 stated the Certified Nursing Assistants (CNAs) were responsible for cleaning the shower rooms between residents; however, Housekeeper #05 stated she cleaned the shower room daily. She stated when towels were left on the floor, she picked them up before she cleaned the shower room. Housekeeper #05 stated any unlabeled shower items, such as soaps, deodorants, and shampoo, were placed in the cabinet in the shower room and she returned labeled items to the correct residents' rooms. During a concurrent observation and interview on 12/21/25 at 11:21 A.M., CNA #30 stated she had not utilized the shower room during the current week. CNA #30 then observed the shower room and stated she was unsure to whom the two unlabeled hairbrushes belonged. CNA #30 stated all the bottles of shower products labeled with the name of the unit were used by the CNAs for all of the residents. CNA #30 stated she was not sure which resident the unlabeled shower items belonged to and stated she had been taught that using the same soaps, shampoos, body washes, deodorants, and hairbrushes on multiple residents posed an infection control concern. During a concurrent observation and interview on 12/21/25 at 11:27 A.M. , Licensed Practical Nurse (LPN) #15 observed the [NAME] Unit shower room and stated she had no idea who the unlabeled hairbrushes belonged to and she was unable to verify if the brushes had been used for more than one resident. LPN #15 stated the facility expected each resident to have their own bath supplies labeled with their name. LPN #15 stated several residents using the same bottles of shower/bath supplies was an infection control concern. LPN #15 also verified there was a towel on the floor and stated the last person that used the shower room should not have thrown the towel on the floor. During an interview on 12/22/25 at 1:39 P.M., CNA #31 stated most of the residents she was assigned to care for could shower themselves, but she did go in the shower room to set up the shower and turn the water on. CNA #31 stated she had noticed all the bottles of bath accessories and the brush and tried to move them into a cabinet. She stated that staff were always throwing towels on the floor and leaving them and she would pick them up. During an interview on 12/22/25 at 1:06 P.M., the Director of Nursing (DON) stated she expected each resident to have their own bottle of body wash, deodorant, shampoo, and their own hairbrush labeled with their name. During an interview on 12/21/25 at 4:04 P.M., the Administrator stated items in the shower room should be labeled with a resident's name. The Administrator stated if all residents used the same deodorant, hairbrush, or body wash it could spread infection. 2. Review of the medical record revealed the facility admitted Resident #06 on 10/28/22. Diagnoses included persistent vegetative state (brain injury where the patient may seem awake but shows no signs of awareness to self or surroundings), chronic obstructive pulmonary disease (COPD), chronic respiratory failure with tracheostomy (an opening in the neck to facilitate breathing) status. Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/15/25, revealed Resident #06 was in a persistent vegetative state with no discernible consciousness. The MDS indicated the resident received oxygen therapy, suctioning, and tracheostomy care. Review of Resident #06's Care Plan Report included a focus area initiated 12/10/24 and revised 07/21/25, indicating the resident had a potential for respiratory infection. Review of Resident #06's physician's orders included an order dated 02/27/25 for albuterol sulfate 0.083 percent (%) nebulization solution 2.5 milligrams (mg)/3 milliliters (mL) via nebulizer every six hours and an order dated 07/18/24 for sodium chloride 3% (4 mL) via nebulizer every 12 hours. Review of Resident #06's December 2025 Medication Administration Record (MAR) revealed the resident was scheduled to receive the albuterol sulfate every six hours at 12:00 A.M., 6:00 A.M., 12:00 P.M. and 6:00 P.M. and the sodium chloride every 12 hours at 6:00 A.M. and 6:00 P.M. During observations on 12/15/25 at 11:15 A.M., 12/16/25 at 9:36 A.M., 12/17/25 at 2:47 P.M., 12/18/25 at 8:45 A.M. and 12:36 P.M., and 12/19/25 at 11:35 A.M., revealed a nebulizer machine on Resident #06's over-the-bed table with the medication cannister and connectors lying on top of the table not stored in a bag. During an interview on 12/19/25 at 1:26 P.M., Licensed Practical

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	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at 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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on employee file reviews, staff interview and policy review, the facility failed to ensure four (Registered Nurse (RN) #4, RN #6, Licensed Practical Nurse (LPN) #9, and LPN #15) of eight sampled employees received training on abuse, neglect, and exploitation during orientation and annually as required by facility policy. This had the potential to affect all residents. The facility census was 92.A review of employee files revealed the facility hired Registered Nurse (RN) #4 on 04/12/2023, RN #6 was hired on 03/18/2024, and Licensed Practical Nurse (LPN) #9 on 02/15/2023. The employee files and in-service trainings revealed no documented evidence of abuse/neglect training within the past 12 months for RN #4, RN #6, or LPN #9.Review of LPN #15's employee file revealed the facility hired the LPN on 06/02/2025. There was no documentation in LPN #15 ' s employee file or in-service trainings that the facility had provided abuse neglect training for the LPN. During an interview on 12/22/2025 at 8:50 A.M., the Director of Nursing (DON) stated they expected all staff to attend and complete all required in-services. The DON further stated that they expected the facility management team to monitor employee files to ensure compliance with the requirements. During an interview on 12/22/2025 at 9:11 A.M., the Administrator stated they expected all staff to complete all required in-services and trainings. During an interview on 12/22/2025 at 1:53 P.M., Human Resources Director (HRD) #61 revealed she was responsibility for ensuring all required employee trainings were completed. HRD #61 revealed the required abuse training for the four nurses were missing, and she could not explain why they were not completed. A facility policy titled, Abuse Prevention/Reporting Policy and Procedure, updated 05/09/2018, revealed abuse prevention procedures included training which indicated:1. All new employees will receive training on the abuse policy.2. All employees will attend training during orientation, mandatory annual training and more often as determined by the facility.3. Training classes include at a minimum: a. Definitions of abuse, neglect, exploitation, and misappropriation of resident property. b. Reporting requirements regarding allegations of abuse, without fear of reprisals from any other individual whether they are staff, management, residents or visitors. c. Appropriate interventions to deal with aggressive and catastrophic reactions to residents. d. Recognition of and appropriate interventions for burnout, frustration and stress that could lead to reactions resulting in abusive situations.This deficiency represents non-compliance investigated under Complaint Number 2656167 and Complaint Number 2618734.