

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 02/10/2026
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation, staff interview, and policy review, the facility failed to ensure fall prevention interventions were implemented as care planned. This affected one (#74) of three residents sampled for falls. The facility census was 89. Findings include: Review of the medical record revealed Resident #74 was admitted to the facility on [DATE]. Diagnoses included multiple fractures of ribs (09/24/25), unspecified bipolar disorder, recurrent major depressive disorder, unspecified anxiety disorder, chronic pain syndrome, repeated falls, and stage IV chronic kidney disease. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander. Review of the care plan dated 08/14/24 revealed Resident #74 was at risk for falls related to the resident refusing to have environmental modifications in room to reduce falls, self-medicating, using alcohol, using mobility devices, and having clutter in the room. Interventions included cushion in wheelchair, anti-roll backs to wheelchair, encourage to use call light, new bed/mattress, educating on appropriate footwear, encouraging the resident to keep bed in lowest position, non-skid strips to floor next to the bed (09/24/25), and family to declutter room. Observation on 01/27/26 at 12:07 P.M. revealed Resident #74 did not have nonskid strips on the floor beside her bed. During an interview on 01/27/26 at 12:07 P.M. Certified Nursing Assistant (CNA) #151 verified Resident #74 had no non-skid strips on the floor beside her bed. During an interview on 01/27/26 at 3:54 P.M. Maintenance #204 verified Resident #74 did not have non-skid strips on the floor in her room and stated they would have to be ordered because there were none available in the facility. During an interview on 01/28/26 at 1:52 P.M. the Director of Nursing (DON) verified Resident #74 did not have non-skid strips on her floor at the bedside as care planned. Review of policy titled Comprehensive Person-Centered Care Plans dated March 2022 revealed each resident had a comprehensive care plan developed and implemented to meet the resident's physical, psychological, and functional needs. This deficiency represents noncompliance investigated under Complaint Number 2716105 and is a recite to the annual survey completed 12/23/25.</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
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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the hospital records, staff interview, and policy review, the facility failed to ensure timely treatment of a left leg fracture. This resulted in Actual Harm when Resident #91 complained of a new onset of left leg pain on 12/18/25. After examination, Nurse Practitioner (NP) #235 ordered X-rays for the wrong limb. Upon realizing the error, NP #235 ordered X-rays for the correct limb on 12/19/25; however, the X-rays were not completed until 12/21/25, revealing Resident #91 had a suspected bicondylar fracture of the left distal femur. Resident #91 was sent to the hospital for evaluation and treatment on 12/22/25 where the resident required surgery for an Open Reduction and Internal Fixation (ORIF) on 12/24/25. This affected one (#91) of three residents reviewed for care post fall. The facility census was 89. Findings include: Review of the medical record revealed Resident #91 was admitted to the facility on [DATE] and was discharged on 01/06/26. Diagnoses included unspecified nutritional deficiency, displaced fracture of the lateral condyle of the left femur, other fracture to the lower end of the left femur, major depressive disorder, ischemic cardiomyopathy, unspecified cerebral infarction of the right middle cerebral artery, type II diabetes, and unspecified heart failure. Review of the annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severely impaired cognition, had verbal behaviors, did not reject care, and did not wander. Resident #91 was dependent on staff for toileting, mechanical lift transfers, and bed mobility. Review of the care plan dated 10/04/24 revealed Resident #91 was at risk for pain. Interventions included evaluating the effectiveness of pain interventions. Review of a progress note dated 12/18/25 at an unspecified time revealed NP #235 documented she acutely evaluated Resident #91 for reports of a possible fall out of bed prior to the current shift. Resident #91 reported he rolled out of bed onto the floor on his right side with knees colliding together. There was no nursing documentation reflecting a fall or change-in-plane status. Notes pertaining to the left leg evaluation were contradictory. The documentation read, no crepitus or difficulty with range of motion (ROM) in the knee or the ankle with passive motion. Resident #91 reported pain with passive ROM and does not participate in active ROM. Completed adduction and abduction of left hip with continued complaints of discomfort. Left leg is stiff with upper leg muscle contractions. The assessment and plan included a possible fall occurring within the last 24 hours without supporting documentation from nursing staff. Resident #91 reported pain in the left leg with no participation in active ROM. No abnormalities with passive ROM. STAT (at once) imaging ordered. Verbal orders were given to the nursing staff for the resident to receive one gram of acetaminophen (pain reliever) now and apply Lidocaine (pain reliever) patch. Will re-evaluate Resident #91 in the morning. Review of a progress note dated 12/18/25 at 4:10 P.M. revealed Resident #91 reported an unwitnessed fall occurring on the previous shift. Resident #91 complained of pain to the left knee which upon assessment appeared swollen. Registered Nurse (RN) #104 notified NP #235 who assessed and found Resident #91 was unable to participate in ROM to the left leg due to pain. New orders were placed and entered by NP #235 for an X-ray to the left leg, a one-time dose for Tylenol (acetaminophen) and a lidocaine patch to the left leg. Pain medications were administered and were effective. Review of the medical record revealed Resident #91 had physician orders dated 12/18/25 for an X-ray of the right hip two views STAT for pain, acetaminophen 500 milligrams (mg) give two tablets by mouth for pain now, and Lidocaine External four percent patch topically to the right posterior hip for twelve hours and remove for twelve hours. Review of the X-ray results dated 12/18/25 revealed Resident #91 had an X-ray to the right knee completed at 9:00 P.M. and reported on 12/18/25 at 10:13 P.M. which revealed modest arthritis of the right knee. Additionally, on 12/18/25</p> <p>(continued on next page)</p>		

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