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

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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 - 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 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	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. 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 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	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. 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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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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 surrounding the incident involving Resident #97 but confirmed the resident was dependent on staff, requiring total assistance for all care. During an interview on [DATE] 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 [DATE] 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 subsequent falls and to address the risks of clinically significant consequences of falling. 2. Review of the medical record revealed the facility admitted Resident #80 on [DATE]. Diagnoses included hemiplegia and hemiparesis following a stroke affecting the dominant right side, anxiety disorder, paranoid schizophrenia, and absolute glaucoma. Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed Resident #80 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident had intact cognition. The MDS indicated Resident #80 rejected care four to six days during the assessment look-back period. The MDS indicated Resident #80 had no functional limitation in range of motion of the lower extremities or the upper extremities. Resident #80 required set up or clean up assistance from staff for eating and supervision or touching assistance from staff for completion of all other activities of daily living. The MDS indicated Resident #80 required set up or clean-up assistance from staff with rolling left and right in bed, moving from sitting to lying, moving from lying to sitting on the side of the bed, moving from sitting to standing, toilet transfers, and chair/bed-to-chair transfers. Review of Resident #80's Care Plan Report included a focus area revised on [DATE], revealed Resident #80 had a behavior problem related to refusing medications and care. Interventions directed the staff to intervene as needed to protect the rights and safety of others, approach/speak in a calm manner, divert attention, and remove from the situation and take to an alternate location as needed. Resident #80's Care Plan Report did not include a focus area for small electrical appliances in the resident's room. Observation of Resident #80's room on [DATE] at 9:57 A.M., revealed a small electric coffee pot on the counter that was plugged into the electrical outlet, and the resident was not in the room. Interview on [DATE] at 10:38 A.M., Resident #80 stated the electric coffee pot had been in the room for a while, and the resident offered no information about where the electric coffee pot came from. During a concurrent observation and interview on [DATE] at 3:11 P.M., Registered Nurse (RN) #06 stated residents were not allowed to have coffee pots or pots to heat water. RN #06 stated these appliances were forbidden because the resident may burn themselves or leave the appliance on and cause a fire. RN #06 stated she had not seen any electrical appliances in a resident's room. RN #06 went to Resident #80's room and saw that the electric coffee pot plugged in. The coffee pot was observed heavy when lifted and made a sloshing sound as if fluid were inside. RN #06 stated she was unaware Resident #80 had the coffee pot in their room since the resident met her in the hall for medications and would not allow staff in the room. RN #06 stated Resident #80 was independent with care and the CNAs did not go into (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the resident's room. The RN #06 stated Resident #80 broke facility rules. An interview was held with the DON on [DATE] at 10:00 A.M. The DON stated residents were not allowed to have coffee pots or electrical appliances to heat water in their rooms. The DON stated this policy was reviewed on admission and she expected staff to notify her if an electrical appliance was seen in a resident's room. The DON stated no one had reported Resident #80's coffee pot. The Administrator was interviewed on [DATE] at 3:28 P.M. and stated Resident #80 should not have had the coffee pot in their room because the electrical coffee pot could be a hazard or the resident could burn themselves. 3. Review of the medical record revealed the facility admitted Resident #86 on [DATE] and readmitted the resident on [DATE]. Diagnoses included age related macular degeneration of the left eye, bipolar disorder, generalized anxiety, Parkinson's disease, and unspecified allergic rhinitis (inflammation of nose, throat, and/or eyes). Review of the quarterly MDS, with an ARD of [DATE], revealed Resident #86 had a BIMS score of nine which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #86 used corrective lenses. The MDS indicated Resident #86 had impaired vision and was able to see large print but not regular print in newspapers or books. The MDS indicated Resident #86 had no functional limitation in range of motion. Review of Resident #86's Care Plan Report included a focus area initiated [DATE], indicating the resident had impaired safety awareness. Interventions directed staff to administer medications as ordered. Review of Resident #86's Kardex (a form used by the CNAs to guide care for the resident), dated [DATE], revealed in the section Safety that staff was to cue, reorient, and supervise as needed and ensure/provide a safe environment. Review of Resident #86's Physician Order Summary Report, with active orders as of [DATE], included orders for fluticasone propionate nasal suspension (Flonase, a nasal steroid) 50 micrograms per actuation spray, one spray in each nostril in the morning for allergies and ketoconazole external shampoo 2 percent (an antifungal) to be applied to the resident's face, ears, nose topically every Monday and Thursday for dry skin. Review of the 12/2025 Medication Administration Record (MAR), revealed fluticasone had been administered on [DATE] and [DATE] at 9:00 A.M. by the assigned nurse. The MAR indicated ketoconazole was administered on [DATE] at 6:00 A.M. and 8:00 P.M. and on [DATE] at 6:00 A.M. A concurrent observation and interview on [DATE] at 11:16 A.M., revealed an opened bottle of Flonase at the resident's bedside with a dispense date of 2023 and a clear medication cup containing a creamy white substance. Resident #86 stated the white creamy substance was for the moles on their face. Observation of Resident #86's room on [DATE] at 11:52 A.M. revealed a clear medication cup containing a creamy white substance and a bottle of Flonase. A concurrent observation and interview on [DATE] at 8:48 A.M. revealed a nurse took Resident #86's morning medication into the resident's room but did not remove a clear medication cup with a creamy substance. Resident #86 stated he was unsure where the nasal spray went, and the nurses applied the white cream to their face. Registered Nurse (RN) #06 was interviewed on [DATE] at 3:19 P.M. RN #06 stated she had seen the bottle of nasal spray in Resident #86's room and had thrown the bottle away since the medication had expired. RN #06 stated she had seen the bottle of nasal spray in Resident #86's room before and could give no reason why she had not removed the nasal spray sooner. RN #06 stated she had not taken the cup of white cream into Resident #86's room and had no idea what the cream was. RN #06 stated the cream should not be stored in an unlabeled cup. An observation on [DATE] at 8:46 A.M. revealed a clear medication cup of white cream on Resident #86's bedside table. RN #04 was interviewed on [DATE] at 12:23 P.M. and stated medication should not be taken out of the original container and placed in an unlabeled clear medication cup. RN #04 went to Resident #86's room and removed a medication cup containing a creamy substance. The DON was interviewed on [DATE] at 10:06 A.M. and stated medications were not allowed to stay on bedside tables because of safety concerns, and medications should be stored securely. The DON stated a few residents may have rescue inhalers kept by their beds, but those residents had to have orders for the self-administration of medication, orders for the medication to be kept at the bedside, and have been assessed and care planned for medication self-administration. The (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	DON stated medications should not be removed from the original containers and placed at a resident's bedside in a clear medication cup because there would be no way to know what the medication was. The DON stated Resident #86 had no orders to keep medications at their bedside or self-administer medications. The Administrator was interviewed on [DATE] at 3:28 PM. The Administrator stated medication should not be left at the resident's bedside, and nurses should remove medication left at the bedside. The Administrator stated ointments and creams should not be removed from original containers and left in the resident's room with no name and instruction as there would be no way to know who the medication was for, what it was, or what it was for. 4. Review of the medical record revealed the facility admitted Resident #13 on [DATE]. Diagnoses included unspecified encephalopathy and hypertension. Review of the admission MDS, with an ARD of [DATE], indicated Resident #13 had a BIMS score of 14, which indicated the resident had intact cognition. The MDS revealed Resident #13 had adequate vision and hearing and had no functional limitations in range of motion of the upper extremities or lower extremities. The MDS indicated Resident #13 was independent with oral hygiene and needed set up or clean up assistance from staff for eating. Review of Resident #13's Care Plan Report, with an initiation date of [DATE], revealed no documentation related to self-administration of medication. Review of Resident #13's Physician Order Summary Report with active orders as of [DATE], revealed no evidence of a physician's order allowing Resident #13 to keep medication at the bedside or to self-administer medication. Review of Resident #13's 12/2025 MAR indicated Resident #13 had medications scheduled to be given at 8:00 A.M. and 9:00 A.M. The MAR revealed there were no medications scheduled for the timeframe from 9:45 A.M. to 10:45 A.M. The MAR indicated that on [DATE] medications had been administered to Resident #13 by Licensed Practical Nurse (LPN) #02. During an observation and interview on [DATE] at 10:43 A.M., Resident #13 had medication in their room in a clear medication cup. Resident #13 sat up in bed, took the medications, and stated it was usual for the nurses to leave the medication in the room for them to take when they woke up. Resident #13 stated they were okay with the practice of leaving the medications to be taken upon waking up. During an interview on [DATE] at 3:09 P.M., LPN #02 stated she left the medication in Resident #13's room and walked out because Resident #13 had the medication cup in their hand and was ready to take the medication as she walked out. LPN #02 stated she knew she was not supposed to leave medication in a resident's room and knew she was supposed to make sure the resident had taken the medication before leaving the room. LPN #02 stated that the resident must have placed the medication back on the table and laid down again. During an interview on [DATE] at 10:06 A.M., the DON stated for residents that self-administered medications there had to be physician's orders to keep the medications at bedside, residents had to be assessed for self-administration, and care planned for self-administration. The DON stated medications were not allowed to sit at bedside tables because of safety concerns. The DON stated that nurses were not expected to leave medications at bedside for residents to take when they awoke. The nurse reviewed the physician's orders for Resident #13 and stated that the resident had no orders for self-administration of medication. The Administrator was interviewed on [DATE] at 3:18 PM and stated she was unaware of any resident in the facility that had been approved for self-administration of medications, and she expected medications not to be left in residents' rooms. The Administrator stated she expected the nurse to stay in the resident's room until medications were taken. Review of a facility policy titled, Self-Administration of Medications, dated 2001, indicated As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.5. Review of the medical record revealed the facility admitted Resident #45 on [DATE]. Diagnoses included traumatic subdural hemorrhage with loss of consciousness, cerebral infarction (stroke) due to unspecified occlusion or stenosis of an unspecified cerebral artery, and aphasia (a language disorder from brain damage that impaired speaking understanding, reading, or writing). Review of an annual MDS, with an ARD of (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **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 (continued on next page)

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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

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F 0697 Level of Harm - Actual harm Residents Affected - Few	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, there was not a Controlled Drug Record to indicate the medication was available to be administered. The pain level indicated zero. From 10/10/25 to 10/12/25, Resident #39 missed three days (nine doses) of their ordered methadone. Pain levels were documented as zero on the MAR on these dates. On 10/10/2025 and 10/11/2025, 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 be administered. On 10/10/2025, 10/11/2025, and 10/12/2025 the 8:00 A.M. and 4:00 P.M. doses of methadone were coded as the number 9 on the MAR. Resident #39's Progress Notes dated 10/10/25 at 9:53 A.M. and 5:58 P.M. indicated the facility was waiting on the pharmacy for the methadone to be dispensed and the physician was aware. Progress Notes dated 10/11/25 at 8:31 A.M. and 3:49 P.M. indicated the methadone was not available. Progress Notes dated 10/12/25 at 9:07 A.M. and 3:08 P.M. revealed no documentation of why the medication was not administered. On 10/12/2025, the space on the MAR for the scheduled 12:00 A.M. dose of methadone was blank. Review of Resident #39's Progress Notes dated 10/12/25 at 6:05 P.M. indicated the resident called 911 to be sent to the emergency room for complaints of pain. Review of an Emergency Department After Visit Summary (AVS) dated 10/12/25 indicated Resident #39 was seen for methadone withdrawal and was given a one-time dose of methadone 20 mg to help with withdrawal symptoms and Zofran for nausea. The summary indicated the larger dose of methadone was to help the resident until the care facility could address the delivery of the methadone. Review of Resident #39's October 2025 MAR was coded the number 9 for the 8:00 A.M. dose due on 10/13/25, and a Progress Note dated 10/13/25 at 9:22 A.M. indicated the methadone would be administered when available from the pharmacy and the Nurse Practitioner (NP) was aware. Review of Resident #39's Progress Notes dated 10/13/25 at 10:57 A.M. revealed the resident was transferred to the hospital for a colorectal procedure. Progress Note dated 10/24/25 revealed the resident was readmitted to the facility, and the orders were verified and sent to the pharmacy. Review of a hospital Discharge summary dated [DATE] indicated Resident #39 was admitted to the hospital on [DATE] underwent an open-end colostomy (surgical procedure to take the end of the colon and bring it through the abdominal wall to allow stool to exit the body) and a simple cystectomy with colonic creation (surgical procedure to remove the urinary bladder and create a new pathway for urine to exit the body) on 10/20/2025. The Discharge Summary indicated medications at discharge included methadone five mg by mouth three times a day. Review of Resident #39's October 2025 MAR and Controlled Drug Record for methadone revealed that after returning from the hospital following the surgical procedures, the resident missed two days (six doses) of their methadone: On 10/25/25 at 12:00 A.M., the scheduled dose of methadone was coded the number 5 which indicated to hold/see nurses notes. The 8:00 A.M. and 4:00 P.M. doses were coded the number 9. Resident #39's Progress Notes dated 10/24/25 at 11:59 P.M. revealed no documentation to indicate why the medication was not administered. Progress Notes dated 10/25/25 at 8:31 A.M. and 4:51 P.M. indicated the methadone was not available. There was no documentation of follow up with the physician or the pharmacy. On 10/26/25 the 12:00 A.M., the scheduled dose of methadone was signed out on the MAR as administered; however, there was not a Controlled Drug Record to indicate the medication was available to be administered. The 8:00 A.M. and 4:00 P.M. methadone doses were coded the number 9 on the MAR. The resident's pain level was documented as five on a scale of one to 10 with 10 being the worst pain, on the MAR for the day shift on 10/26/25. Resident #39's Progress (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Notes dated 10/26/25 at 3:27 P.M. indicated the methadone was not available; the pharmacy was contacted, and the medication was to be sent out immediately. A Progress Note dated 10/26/25 at 5:04 P.M. indicated the methadone was not available; the pharmacy was contacted and informed the facility a new prescription was required. Review of Resident #39's Progress Notes revealed a note dated 10/27/25 indicated the resident called an ambulance and requested to be taken to the hospital around 8:30 P.M. on 10/26/25 for withdrawal since the resident had not received several doses of methadone. Review of the Emergency Department (ED) Provider Notes dated 10/27/25 indicated Resident #39's chief complaint was drug withdrawal, leg pain, and nausea. The note indicated the resident presented with vague symptoms of pain and some mild nausea but had a clinical opiate withdrawal scale (COWS) score of 6, with a score of 5 to 12 indicating mild withdrawal. Review of Resident #39's October 2025 MAR revealed the methadone doses were coded the number 9 on 10/27/25 at 8:00 A.M. and 4:00 P.M. Resident #39's Progress Notes dated 10/27/25 at 6:09 P.M. indicated the methadone would be administered when available from the pharmacy and the NP was aware. The resident's pain level on the morning of 10/28/25 was documented as an eight. During an interview on 12/19/25 at 5:12 P.M., the Nurse Practitioner (NP) #45 stated when she took over Resident #39's care on 07/01/25, she found out Resident #39 was supposed to be on a weaning process from their methadone, so some of the time, because of the changes, there was an issue with receiving the up-to-date prescription from the pharmacy. She stated when the facility changed pharmacies in September 2025, the weaning process had to be thoroughly explained to the new pharmacy, and the new pharmacy had an issue with dispensing the methadone because it had an opioid addiction diagnosis on the prescription. She stated it had to be changed to chronic pain. She stated when she was notified, she would change the diagnosis on the prescription and resend it to the pharmacy. She stated she worked in the facility Monday through Friday from 8:00 A.M. until 5:00 P.M. and after that, there was an on-call service available. She stated she checked for all prescription renewals before she left on Fridays. During an interview on 12/20/25 at 12:07 P.M., the Pharmacy Case Manager #44 stated on 10/01/25 and 10/06/25, the pharmacy sent nine tablets of methadone each day with a note that said they could not fill the prescription with the opioid-dependent diagnosis. She stated per the pharmacist, they could not fill a prescription with an opioid dependency diagnosis, and the resident would have to go to a methadone clinic as part of their treatment. She stated when the facility sent the prescription with the appropriate diagnosis, they were able to fill the prescription. During an interview on 12/20/25 at 1:10 P.M., Licensed Practical Nurse (LPN) #09 stated she only worked as needed (PRN) at the facility but did remember once when she went to get Resident #39's methadone it was not in the cart. She stated she called the pharmacy and was told the resident needed a new prescription. She stated when she told the resident, they refused all their medications and then called 911 to be sent to the emergency room before she was able to follow-up on the prescription. She stated she was not aware the resident called 911 until emergency medical services arrived. During an interview on 12/20/25 at 7:40 P.M., Registered Nurse (RN) #14 stated if a medication was not available to administer, then he would call the pharmacy to find out about it. He stated if they needed a prescription, he would contact the physician to get the prescription and would fax it to the pharmacy. He verified he signed that the methadone was given on 10/11/25, 10/26/25 and 11/22/25, but if there was not a narcotic sheet, then he must have signed off the MAR in error. During an interview on 12/20/25 at 8:00 P.M., RN #23 stated if Resident #39's methadone was not available, he would call the pharmacy, and if a prescription was needed, he would call the physician, notify the medication was not available, and have them send the prescription to the pharmacy. He stated this should be documented in a progress note. During an interview on 12/20/25 at 8:10 P.M., RN #11 stated she worked at the facility PRN. She stated if medication was not available, she would contact the pharmacy and the physician. She stated if it was a narcotic and a prescription was needed, then they would need to call the physician and they would send the prescription to the pharmacy. She stated she remembered that the previous nurse had told her that Resident #39's (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	methadone was going to be delivered on the next pharmacy run that night, but before she knew it, the resident called 911. She stated she thought that the resident had complained of back pain but could not remember.During an interview on 12/21/25 at 8:05 A.M., RN #11 stated she would reorder a resident's medication when there were five pills or less unless it was something that the resident took more often, like every four hours, then the nurse should use common sense and order before there were only 10 pills left. She stated she only worked PRN at the facility, and medications not being available happened a lot when she worked. She stated the previous nurse either did not order or follow-up on the medication and then the resident would get upset and call 911. She stated the NP only worked Monday through Friday until 5:00 PM, so if it happened on the weekend, they would have to call the on-call provider, but the on-call provider would not refill narcotic prescriptions and would say that it had to be done by the primary provider on Monday. She stated sometimes, they were able to get an emergency prescription for a few tablets to pull from the emergency kit, but the on-call provider usually said they had to wait until Monday. She further stated methadone was not available in the emergency kit. During an interview on 12/21/25 at 2:22 P.M., Certified Nursing Assistant (CNA) #26 stated she had been working in the building with Resident #39 when the resident called 911 to be sent out because their medications were not available. She stated the resident would tell the nurses they were in pain so that they would take them to the emergency room, but the resident did not complain of pain to her and the resident had not appeared to be in pain. During an interview on 12/22/25 at 11:24 A.M., LPN #22 stated Resident #39 ran out of methadone a couple of times when she worked. She stated she would call the pharmacy and was told it was an insurance issue. She stated she did not witness Resident #39 with any adverse effects from not getting the methadone, but he would get aggravated and upset. She stated the Nurse Practitioner (NP) was aware when the resident was out of methadone. During a telephone interview on 12/22/25 at 11:52 A.M., RN #25 stated the reason they had trouble getting Resident #39's methadone was because the insurance would not pay, and they needed the Director of Nursing (DON) to authorize it. He stated he would always text the DON when there was an issue with Resident #39's methadone. During a telephone interview on 12/22/25 at 2:20 P.M., the Pharmacy Director of Clinical Services #46 stated their pharmacy started providing services at the facility on 09/08/25. She stated Resident #39 was taking different doses of the methadone, and the facility did not get them all refilled at once since they had them previously filled at a different pharmacy, so they would have to wait for a new prescription to come in before they could fill it. She stated they would send a small amount of pills after receiving the new prescription in order to get the resident by for a few days until the facility could change the diagnosis on the prescription, since it said opioid dependence they legally could not fill the prescription with that diagnosis, but the resident did have a diagnosis of chronic pain that could be used. During an interview on 12/22/25 at 2:40 P.M., LPN #02 stated it was the pharmacy's fault that they could not get Resident #39's methadone. She stated it would take them a long time to send the medication out due to insurance reasons, needing prior authorization, or needing a new prescription. She stated when a new prescription or preauthorization was needed, she would call the NP, and the NP would send a prescription to the pharmacy. During a follow-up interview on 12/23/25 8:20 A.M., the NP #45 stated she had not been able to assess Resident #39 when they had gone without their methadone. She stated the nurses should reorder narcotic medication a minimum of three to five days before the medication ran out. She stated she did final rounds at 3:00 P.M. on Fridays and had the nurses check their narcotic cards to make sure that they had enough medications for the weekend. She stated part of the problem with getting the methadone from the pharmacy was the nurses would reorder the methadone off an older prescription that had the wrong diagnosis, and it would stall the delivery of the medication. During an interview on 12/23/25 at 9:24 A.M., the DON stated the nurse and the pharmacy were responsible to ensure medications were available for administration and if they were not available, then the nurse should reorder the medication, get it from the emergency kit if available, and notify the physician if the resident missed a dose. She stated if it was a routine (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	medication, the resident should not miss more than one dose. She stated she was not sure why they were not getting Resident #39's methadone timely but knew that one of the issues was the diagnosis of opioid dependence. She stated that when a resident was on routine medication, the nurse should order the medication three to five days before the medication was gone. During an interview on 12/23/25 at 10:44 A.M., the Administrator stated the pharmacy filled the medication and the nurse checked it. If they were missing a medication, then they should check the emergency kit and if it was not available, then the nurse should notify the pharmacy so they could send it and call the provider if needed. She stated if they did not get a resolution, then the nurse should call the DON. She stated if the resident was taking a routine narcotic, an acceptable time for the resident to go without it would depend on the reason for the medication. She stated she knew there were issues with getting Resident #39's methadone but she did not remember the details. Review of the facility policy titled, Pain Assessment and Management, revised 04/2025, indicated Implementing Pain Management Strategies 6. The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications. The policy also specified, Monitoring and Modifying Approaches 4. If the resident is prescribed opioid analgesics, monitor for the following side effects: b. Physical dependence which causes symptoms of withdrawal when opioid medication is stopped, or a dose is held or missed. 5. Contact the provider immediately if the resident's pain or medication side effects are not adequately controlled.This deficiency represents non-compliance investigated under Complaint Number 2618734.

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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.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and facility document review, the facility failed to ensure essential kitchen equipment was maintained in safe operating condition for one of one dishwasher. This had the potential to affect all residents. The facility census was 92. A tour of the kitchen conducted on 12/15/2025 at 9:09 A.M. with [NAME] (CK) #34, revealed an area of standing water that was approximately four feet wide by 12 feet long by one inch deep was covering an area of the floor near the dishwasher. During an interview on 12/15/2025 at 9:11 A.M., CK #34 stated the dishwasher had been broken for over a year. CK #34 stated that there was a problem with the drain and every time the dishwasher drained, it flooded the whole floor. CK #34 stated that management was aware and had repeatedly informed staff that they were going to have it repaired. During an interview on 12/15/2025 at 9:13 A.M., CK #35 stated the dishwasher had been broken for the entire duration of their 6-month employment and management was aware of the issue. Per CK #35, every time the dishwasher drained, it flooded the floor. CK #35 stated there was always standing water on the floor. A follow-up observation of the kitchen was conducted on 12/16/2025 at 10:41 A.M. with the Dietary Manager (DM) #60. During the observation water was observed pouring from the dishwasher and/or drain line onto the floor. Approximately one to two inches of water was observed covering one-half of the floor in the dishwashing area. During an interview on 12/16/2025 at 10:41 A.M., DM #60 revealed the dishwasher drain had been backed up since their promotion to the management position seven months prior. Per the DM #60, numerous vendors had attempted to clear the line, but it had never resolved the issue. During a follow-up interview on 12/19/2024 at 4:24 P.M., DM #60 stated that they had been having issues with the dishwasher properly draining for the past 18 months. DM #60 stated that they had voiced concerns regarding the dishwasher during facility morning meetings as recently as two weeks prior. She stated that she had also directly reported the issue to the Maintenance Director #55 since being promoted to the management position seven months prior. During an interview on 12/19/2025 at 5:02 P.M., the Maintenance Director #55 revealed that the facility had been having issues with the dishwasher for a while, but the most recent issue had been going on for approximately four to six weeks. Maintenance Director #55 stated the dishwasher was not draining correctly due to a collapsed/clogged pipe and when the dishwasher drained, the water covered the floor. Maintenance Director #55 also revealed that they had discussed and provided estimates for repairs to the facility Administrator. During an interview on 12/22/2025 at 9:11 AM, the Administrator stated she was unaware of any current dishwasher concerns and believed that all previous issues had been resolved. The Administrator stated that it was their expectation that staff would utilize the facility work order management system or communicate concerns directly to Maintenance Director #55. Per the Administrator, all kitchen equipment should be properly maintained and working at all times. The Administrator stated that any issues that could not be resolved should be communicated to them immediately for resolutionDuring an interview on 12/22/2025 at 8:50 P.M., the Director of Nursing (DON) revealed she was aware that there were problems with drainage in the kitchen. The DON stated that the DM had voiced concerns about the dishwasher during the facility morning meetings. A bill to the facility dated 10/29/2025 revealed a plumbing company found significant issue with [the facility] floor drain that services your dish machine. The drain is severely clogged, and our initial attempts to clear it using a jetting hose were only partially successful. During this process we observed considerable amounts of sand and cast-iron debris coming from the drain, indicating deterioration of the existing plumbing system. The bill also revealed an estimate for removing a section of the floor around the drain, excavating approximately four feet from the floor drain to locate and replace the damaged section, and inspecting the line to ensure proper flow. There was no documented evidence that the facility authorized the service to repair the drain line. A letter to the facility, dated 11/21/2025, from a mechanical contractor regarding the dishwasher hub drain, revealed an estimate was provided to excavate the concrete around the hub drain down to the P-trap to determine where (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the piping issue was for the dishwasher drain line. Again, there was no documented evidence that the facility accepted the proposal.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 two (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. Findings Include:A review of employee files revealed the facility hired Licensed Practical Nurse (LPN) #9 on 02/15/2023. The employee file and in-service trainings revealed no documented evidence of abuse/neglect training within the past 12 months for 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.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and facility policy review, the facility failed to maintain resident equipment in good repair, specifically, a fall mat used for one (#3) of 37 sampled residents was torn and stained and a shower bench located in one (Willow Unit) of two shower rooms was observed with a worn, cracked surface. The census was 92.Findings include:1. Review of the medical record revealed Resident #3 admitted to the facility on [DATE]. Diagnoses included altered mental status, muscle weakness, vascular dementia, syncope and collapse, and history of falling. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 11/21/25, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of seven (7), which indicated the resident had severe cognitive impairment. An observation of Resident #3's room on 12/15/25 at 9:43 A.M. revealed the resident's fall mat was torn across the middle, which exposed foam with black stains. An observation of Resident #3's room on 12/16/25 at 11:57 A.M. revealed the resident's fall mat was torn with black stains. An observation of Resident #3's room on 12/18/25 at 9:00 A.M. revealed the resident's fall mat was torn with black stains. During an interview on 12/18/25 at 2:15 P.M., Certified Nurse Aide (CNA) #31 stated Resident #3's fall mat had been in the same condition for the two weeks she had worked in the facility, but she had not reported the mat to anyone. During an interview on 12/18/25 at 2:43 P.M., Registered Nurse (RN) #6 stated she noticed Resident #3's fall mat and stated the resident needed a new mat, but she had not requested a new mat for the resident. During an interview on 12/19/25 at 12:05 P.M., CNA #19, who also served as the central supply manager, stated as the central supply manager, he oversaw distribution of fall mats. CNA #19 stated he had replaced Resident #3's fall mat on 12/18/25 and described the mat that was previously in the resident's room as tattered and ripped. CNA #19 stated the mat should have been replaced sooner. During an interview on 12/21/25 at 9:45 A.M., the Director of Nursing (DON) stated she expected staff to report the condition of Resident #3's fall mat with the split and exposed foam because she wanted all equipment to function properly. During an interview on 12/21/25 at 3:16 P.M., the Executive Director (ED) stated she expected staff to notify someone when a fall mat was torn or had exposed foam. 2. During a concurrent observation and interview on 12/21/25 at 11:15 A.M., Maintenance Director (MD) #55 observed the [NAME] Unit shower room and described the shower bench as having cracked vinyl and exposed foam. MD #55 further stated the cushion of the bench needed to be replaced, but no one had reported the condition of the shower bench to him. 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 described the shower bench as torn and tattered. LPN #15 stated she had not been notified of the condition of the shower bench and acknowledged she would not want to sit on it in its current condition. During an interview on 12/22/25 at 1:39 P.M., CNA #31 stated she noticed the shower bench on the [NAME] Unit was worn and had cracked vinyl; however, CNA #31 stated the bench had been in that condition for two years, so she assumed someone else had reported it. She stated she had not personally reported the condition of the shower bench. During an interview on 12/22/25 at 1:06 P.M., the DON stated she expected staff to report any issues with equipment used for residents, such as the tattered and torn shower bench, to the maintenance department for replacement. During an interview on 12/21/25 at 4:04 P.M., the Administrator stated she expected staff to report a shower bench with the torn vinyl or exposed foam. Review of a facility policy titled, Assistive Devices and Equipment, revised 01/2020, revealed device condition- devices and equipment are maintained on schedule and according to manufacturer's instructions. Defective or worn devices are discarded or repaired.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on medical record review, staff interview, facility document review, facility policy review, and review of the State of Ohio Board of Pharmacy Terminal Distributor Licensure of Prescriber Practices and Ohio Secretary of State Certification, the facility failed to ensure intravenous (IV) therapy was administered in accordance with professional standards of practice and Ohio state requirements, as evidenced by failure to ensure criteria to determine medical necessity for the provision of IV hydration with micronutrients was established, monitored, and documented and failure to ensure the contracted ancillary provider (IV Therapy Company #1) had the appropriate State of Ohio-required credentials for the provision of such services for three (#82, #39, and #1) of three residents reviewed for IV therapy provided by IV Therapy Company #1. Based on a review of all residents' physician orders, the failed practice had the potential to affect 21 current residents and three discharged residents including but not limited to Resident #14, Resident #26, Resident #56, Resident #64, and Resident #94 received services from IV Therapy Company #1. The facility census was 92.Findings include: 1. Review of an admission Record indicated the facility admitted Resident #82 on 09/16/15. According to the admission Record, the resident had a medical history that included diagnoses of anoxic (absence of oxygen) brain damage, paraplegia (partial or complete paralysis of the legs and lower body), diabetes mellitus (DM), and congestive heart failure (CHF). Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 09/29/25, revealed Resident #82 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS assessment indicated the resident had intravenous (IV) access, received parenteral (IV) feeding, and received an average fluid intake of 500 cubic centimeters (cc) or less per day via IV or tube feeding. Review of Resident #82 's Care Plan Report, included a focus area initiated 08/22/25, that indicated the resident was participating in IV Therapy Company #1 ' s program to promote IV infusion as evidenced by paraplegia, major depression, and DM. Interventions directed staff to monitor for adverse reactions to IV therapy and if noted, notify the physician, monitor the IV access site for redness, swelling, hot to touch, etc., and report adverse findings to the physician, provide aroma therapy, provide IV therapy as ordered, provide music therapy, and provide a relaxing environment. Review of a provider progress note dated 06/20/25 indicated IV hydration was medically indicated for Resident #82 to support fluid balance and prevent dehydration-related complications in the context of limited oral intake and ongoing risk factors. The note indicated to see the Physician Order Form for IV Hydration Therapy. This form was requested but not provided by the facility for the month of June 2025. Review of Resident #82's June 2025, Documentation Survey Report, revealed the resident's average fluid intake with meals was 573 milliliters (mL) per day. This documentation did not include information as to what the resident received between meals or with medications. The report indicated Resident #82's June 2025 urinary catheter output revealed an average output of 1,258 mL per day. Review of Resident #82's laboratory reports revealed no laboratory testing completed during the month of June 2025. Resident #82's Order Recap Report revealed the following orders for June 2025: - May enter peripheral IV insertion during scheduled infusions one time only for IV infusions until 06/26/2025, enter site insertion in supplementary documentation, ordered 06/25/2025. - Hydration + [and] Skin Infusion - one time (500 milliliters) 0.9% normal saline at 500 milliliters (mL) an hour, (total additive volume 14.4 mL) Vitamin C 5 grams (gm), B Complex (B1-Thiamine 200 milligrams [mg], B2-Riboflavin 4 mg, B3-Niacin 200 mg, B5-Pantothenic Acid 4 mg, B6-Pyridoxine 4 mg), Biotin 10 mg, Zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational deficit one time only for micronutrient hydration therapy until 09/25/2025, one time only for hydration and nutritional wellness secondary to wounds, administration time may vary based on clinic, ordered 06/25/2025. - 72-hour post monitoring evaluation for scheduled infusion every shift for three days and enter a progress note for any signs and symptoms of infection or (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adverse reactions, ordered 06/26/2025. Review of Resident #82's progress notes revealed a nursing note dated 06/26/25 that indicated a peripheral IV was inserted to the right antecubital (front of the elbow) space using a 24-gauge needle. Pre-infusion vital signs were taken, and the registered nurse (RN) initiated the IV Therapy Company #1's IV therapy micronutrient infusion per provider order. The note indicated the infusion started at 8:10 AM and was completed at 9:15 A.M. Post-infusion vital signs were obtained. The IV was discontinued, and a pressure dressing was applied per protocol. Review of Resident #82's, IV Hydration Resident Risk Screening Tool, signed by the previous Director of Nursing (DON) on 07/20/25, indicated the resident had persistent low fluid intake despite efforts to support adequate oral hydration due to diagnoses of paraplegia, major depression, and diabetes. The standard interventions implemented were to ensure the availability and accessibility of fluids and identify and provide the resident ' s preferred beverage. Conditions present that reduced the resident ' s capacity to maintain adequate fluid balance included difficulty communicating needs, functional/activities of daily living (ADL) impairment, depression or anxiety, malnutrition or at risk for malnutrition, and medications such as diuretics and laxatives. Factors that could be caused by, contribute to, or be complicated by chronic fluid deficit included recent or recurrent urinary tract infection (UTI) or other infection, and new/existing pressure ulcer/chronic wounds. The tool indicated the resident had no special considerations for IV fluid administration. The Physician Order Form: IV Hydration Therapy section of the tool was signed by the physician on 07/21/2025 and included an order for IV hydration for prevention of dehydration as indicated in the assessment above. The orders indicated, Fluid type: Normal Saline 0.9%; Fluid Volume: 500 mL; Infusion rate: 500 mL/hr.; Start peripheral IV; Hydration + [and] B-complex: (B1) 200 mg, (B2) 4 mg, (B5) 4 mg, (B6) 4 mg, (B3) 200 mg; vitamin C 5,000 mg; methyl-cobalamin B12 2,000 mcg [microgram]; zinc 10 mg with skin support (biotin B7 10 mg). Review of Resident #82's July 2025, Documentation Survey Report, indicated the resident ' s average fluid intake with meals was 700 mL per day. The report did not reflect fluid taken between meals or with medications. The report indicated Resident #82 ' s July 2025 urinary catheter output averaged 1,255 mL per day. Review of Resident #82's laboratory reports revealed no laboratory testing completed during the month of July 2025. Review of Resident #82's Order Recap Report revealed the following orders for July 2025: - (IV Therapy Company #1) - May enter peripheral IV insertion during scheduled infusions one time only for IV infusions until 07/24/25, enter site insertion in supplementary documentation, ordered 07/23/25. - Hydration + skin infusion - one time (500 milliliters) 0.9% normal saline at 500 milliliters (mL) an hour, (Total additive volume 14.4 mL) vitamin C 5 gm, B complex (B1-thiamine 200 milligrams, B2-riboflavin 4 mg, B3-niacin 200 mg, B5-pantothenic acid 4 mg, B6-pyridoxine 4 mg), biotin 10 mg, zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational deficit one time only for micronutrient hydration therapy until 09/25/25, one time only for difficulty communicating needs, functional ADL impairment, depression/anxiety, malnutrition, medications such as diuretics and laxatives, etc., ordered 07/23/25. - (IV Therapy Company #1) IV - 72-hour post monitoring evaluation every shift for three days and enter a progress note for any signs and symptoms of infection or adverse reactions, ordered 07/23/25. Review of Resident #82's progress notes revealed a nursing note dated 07/24/2025 that indicated a peripheral IV was inserted to the right hand using a 24-gauge needle. Pre-infusion vital signs were taken, and the RN initiated IV Therapy Company #1 ' s IV therapy micronutrient infusion per provider order. The note indicated the infusion started at 8:10 A.M. and was complete at 9:10 A.M. Post-infusion vital signs were obtained. The IV was discontinued and a pressure dressing was applied per protocol. Review of Resident #82's, IV Hydration Resident Risk Screening Tool, indicated the resident had persistent low fluid intake despite efforts to support adequate oral hydration due to paraplegia, major depression, and diabetic diagnoses. Standard interventions were to ensure the availability and accessibility of fluids and identify and provide the resident's preferred beverage. Conditions present that reduced the resident ' s capacity to maintain (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	adequate fluid balance included difficulty communicating needs, functional/ADL impairment, depression or anxiety, malnutrition or at risk for malnutrition and medications such as diuretics and laxatives. Factors that could be caused by, contribute to, or be complicated by chronic fluid deficit included recent or recurrent UTI or other infection, and new/existing pressure ulcer/chronic wounds. The tool indicated the resident had no special considerations for IV fluid administration. This section was not signed or dated by facility nursing staff. The Physician Order Form: IV Hydration Therapy section of the tool was signed by the nurse practitioner on 08/27/25 and included an order for IV hydration for prevention of dehydration as indicated in the assessment above. The tool indicated the orders as follows: Fluid type: Normal Saline 0.9%; Fluid Volume: 500 mL; Infusion rate: 500 mL/hr.; Start peripheral IV; Hydration + B-complex: (B1) 200 mg, (B2) 4 mg, (B5) 4 mg, (B6) 4 mg, (B3) 200 mg; vitamin C 5,000 mg; methyl-cobalamin B12 2,000 mcg; zinc 10 mg; magnesium chloride 600 mg; calcium chloride 100 mg with skin support (biotin B7 10 mg). Review of Resident #82's August 2025, Documentation Survey Report, indicated the resident ' s average daily fluid intake with meals was 728 ml. The report did not indicate the resident ' s fluid intake between meals or with medications. The report indicated the resident's urinary catheter output averaged 1,241 mL per day. Review of Resident #82's laboratory reports revealed no laboratory testing completed during the month of August 2025. Review of Resident #82's Order Recap Report revealed the following orders for August 2025: - May enter peripheral IV insertion during scheduled infusions one time only for IV infusions until 08/28/2025, enter site insertion in supplementary documentation, ordered 08/28/25. - Hydration + skin infusion-one time (500 milliliters) 0.9% normal saline at 500 mL an hour, (total additive volume 14.4 mL) vitamin C 5 grams (gm), B complex (B1-thiamine 200 milligrams [mg], B2-riboflavin 4 mg, B3-niacin 200 mg, B5-pantothenic acid 4 mg, B6-pyridoxine 4 mg), biotin 10 mg, zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational deficit one time only for micronutrient hydration therapy until 09/25/2025, one time only for hydration and nutritional wellness secondary to wounds, administration time may vary based on clinic, ordered 08/27/25. - (IV Therapy Company #1) IV - 72-hour post monitoring evaluation every shift for three days and enter a progress note for any signs and symptoms of infection or adverse reactions, ordered 08/28/25. Review Resident #82's progress notes revealed a nursing note dated 08/28/25 that indicated a peripheral IV was inserted to the left hand using a 24-gauge needle. Pre-infusion vital signs were taken, and the RN initiated IV Therapy Company #1's IV therapy micronutrient infusion per provider order. The note indicated the infusion started at 9:00 A.M. and was completed at 10:00 A.M. Post-infusion vital signs were obtained. The IV was discontinued and a pressure dressing was applied per protocol. Review of Resident #82's IV Hydration Resident Risk Screening Tool indicated the resident had persistent low fluid intake despite efforts to support adequate oral hydration due to paraplegia, major depression, and diabetic diagnoses. Standard interventions were to ensure the availability and accessibility of fluids and identify and provide the resident ' s preferred beverage. Conditions present that reduced the resident ' s capacity to maintain adequate fluid balance included difficulty communicating needs, functional/ADL impairment, depression or anxiety, malnutrition or at risk for malnutrition, and medications such as diuretics and laxatives. Factors that could be caused by, contribute to, or be complicated by chronic fluid deficit included recent or recurrent UTI or other infection, and new/existing pressure ulcer/chronic wounds. The tool indicated the resident had no special considerations for IV fluid administration. This section of the assessment was not signed or dated by a nurse. The Physician Order Form: IV Hydration Therapy section of the tool was signed by the Nurse Practitioner on 09/22/2025 and included an order for IV hydration for prevention of dehydration as indicated in the assessment above. The orders indicated: Fluid type: Normal Saline 0.9%; Fluid Volume: 500 mL; Infusion rate: 500 mL/hr.; Start peripheral IV; Hydration + B-complex: (B1) 200 mg, (B2) 4 mg, (B5) 4 mg, (B6) 4 mg, (B3) 200 mg; vitamin C 5,000 mg; methyl-cobalamin B12 2,000 mcg; zinc 10 mg; magnesium chloride 600 mg; calcium chloride 100 mg with skin support (biotin (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B7 10 mg). Review of Resident #82's, Documentation Survey Report, for September 2025 indicated the resident ' s fluid intake with meals averaged 766 mL per day. This did not include fluids taken between meals or with medications. The report indicated the resident ' s urinary catheter output averaged 1,149 mL day. Review of Resident #82's laboratory reports revealed no laboratory testing completed during the month of September 2025. Review of Resident #82's Order Recap Report revealed the following orders for September 2025: - (IV Therapy Company #1) - May enter peripheral IV insertion during scheduled infusions one time only for IV infusions until 09/25/25, enter site insertion in supplementary documentation, ordered 09/24/25. - Hydration + skin Infusion-one time (500 milliliters) 0.9% normal saline at 500 milliliters (mL) an hour, (total additive volume 14.4 mL) vitamin C 5 grams (gm), B complex (B1-thiamine 200 milligrams [mg], B2-riboflavin 4 mg, B3-niacin 200 mg, B5-pantothenic acid 4 mg, B6-pyridoxine 4 mg), biotin 10 mg, zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational deficit one time only for micronutrient hydration therapy until 09/25/25, one time only for hydration and nutritional wellness secondary to wounds, administration time may vary based on clinic, ordered 09/24/25. - There was no order for 72-hour post monitoring evaluation after the infusion in September 2025. Review of Resident #82's progress notes revealed a nursing note dated 09/25/25 that indicated a peripheral IV was inserted to the left wrist using a 24-gauge needle. Pre-infusion vital signs were taken, and the RN initiated IV Therapy Company #1's IV therapy micronutrient infusion per provider order. The note indicated the infusion started at 9:48 AM and was completed at 11:48 AM. Post-infusion vital signs were obtained. The IV was discontinued and a pressure dressing was applied per protocol. During an interview on 12/19/25 at 5:12 P.M., Nurse Practitioner (NP) #45 stated IV Therapy Company #1 had their own protocol, so she was not sure why they changed what Resident #82 was getting. She stated she was minimally involved and that she signed the orders monthly but that was all. 2. Review of the medical record indicated the facility readmitted Resident #39 on 04/10/25. According to the record, the resident had a medical history that included diagnoses of paraplegia (partial or total paralysis of the legs and lower body), chronic hepatitis C, and stage 4 pressure ulcer of the sacral region. Review of a quarterly MDS assessment, with an ARD of 07/01/25, revealed Resident #39 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS assessment indicated that the resident had IV access, received parenteral/IV feeding, and received an average fluid intake of 500 cubic centimeters (cc) or fluid or less per day via IV or tube feeding. Review of Resident #39's, Care Plan Report, did not include a focus area that indicated the resident participated in IV Therapy Company #1 ' s program. Review of Resident #39's progress notes revealed a nurse practitioner ' s note dated 06/19/25 that indicated the resident would be receiving IV hydration with supplemental micronutrients due to a prior medical history of pressure ulcers, a wound to the lower back and pelvis, and neurogenic bladder with frequent UTIs, making the resident susceptible to dehydration. Review of Resident #39's June 2025, Documentation Survey Report, revealed the resident's fluid intake with meals averaged 700 mL per day. This did not include the fluids the resident received between meals or with medications. The report revealed Resident #39's urinary catheter output was not monitored and documented for the month of June 2025. Review of Resident #39's laboratory reports revealed no laboratory testing completed during the month of June 2025. Review of Resident #39's, Order Recap Report, revealed the following orders for June 2025: - May use existing peripherally inserted central catheter (PICC) line during scheduled infusions, one time only for IV infusions until 06/26/25 and enter site insertion in supplementary documentation, ordered 06/25/25. - Hydration + skin infusion-one time (500 milliliters) 0.9% normal saline at 500 mL an hour, (Total additive volume 14.4 mL) vitamin C 5 gm, B complex (B1-thiamine 200 mg, B2-riboflavin 4 mg, B3-niacin 200 mg, B5-pantothenic acid 4 mg, B6-pyridoxine 4 mg), biotin 10 mg, zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	deficit one time only for micronutrient hydration therapy until 06/26/25, one time only for hydration and nutritional wellness secondary to wounds, administration time may vary based on clinic, ordered 06/25/25. - 72-hour post monitoring evaluation for scheduled infusion every shift for three days and enter a progress note for any signs and symptoms of infection or adverse reactions, ordered 06/25/25. Review of Resident #39's progress notes revealed a nursing note dated 06/26/25 that indicated the resident's right upper arm PICC line was accessed and that the RN initiated IV Therapy Company #1 ' s IV therapy micronutrient infusion per provider order. The note indicated pre-infusion vital signs were obtained and the infusion started at 8:05 AM and was completed at 9:00 A.M. Post-infusion vital signs were obtained and the PICC line was de-accessed per protocol. Review of Resident #39's, IV Hydration Resident Risk Screening Tool, signed by the previous DON on 07/20/25, indicated the resident had persistent low fluid intake despite efforts to support adequate oral hydration due to paraplegia, hepatitis C, and a stage 4 wound. Standard interventions were to ensure the availability and accessibility of fluids and identify and provide the resident ' s preferred drink. Conditions present that reduced the resident ' s capacity to maintain adequate fluid balance included functional/ADL impairment. Factors that could be caused by, contribute to, or be complicated by chronic fluid deficit included headaches and new/existing pressure ulcer/chronic wounds. The tool indicated the resident had no special considerations for IV fluid administration. The Physician Order Form: IV Hydration Therapy section of the tool was signed by the physician on 07/21/2025 and included an order for IV hydration for prevention of dehydration, as indicated in the assessment above. The orders indicated: Fluid type: Normal Saline 0.9%; Fluid Volume: 500 mL; Infusion rate: 500 mL/hr.; Start peripheral IV; Hydration + B-complex: (B1) 200 mg, (B2) 4 mg, (B5) 4 mg, (B6) 4 mg, (B3) 200 mg; vitamin C 5,000 mg; methyl-cobalamin B12 2,000 mcg; zinc 10 mg with skin support (biotin B7 10 mg). Review of Resident #39's July 2025, Documentation Survey Report, revealed the resident ' s fluid intake with meals averaged 588 mL per day. This did not include the fluids the resident received between meals or with medications. The report revealed Resident #39's urinary catheter output was not monitored and documented for the month of July 2025. Review of Resident #39's laboratory results dated as completed on 07/21/25 revealed no comprehensive micronutrient panel to measure the resident ' s vitamin and mineral levels. Review Resident #39's Order Recap Report revealed the following orders for July 2025: - May enter peripheral IV insertion during scheduled infusions one time only for IV infusions until 07/24/2025, enter site insertion in supplementary documentation, ordered 07/23/25. - Hydration + Skin Infusion-one time (500 milliliters) 0.9% normal saline at 500 mL an hour, (Total additive volume 14.4 mL) vitamin C 5 gm, B complex (B1-thiamine 200 mg, B2-riboflavin 4 mg, B3-niacin 200 mg, B5-pantothenic acid 4 mg, B6-pyridoxine 4 mg), biotin 10 mg, zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational deficit one time only for micronutrient hydration therapy until 06/26/2025, one time only for functional and ADL impairment, ordered 07/2/325. - 72-hour post monitoring evaluation for scheduled infusion every shift for three days and enter a progress note for any signs and symptoms of infection or adverse reactions, ordered 07/23/25. Review of Resident #39's progress notes revealed an electronic Medication Administration Record (eMAR)-Medication Administration Note dated 07/24/25 that indicated the resident ' s vein was not able to be accessed for IV therapy. Review of Resident #39's progress notes revealed a Nursing Note dated 07/24/25 that indicated a peripheral IV was inserted to the right forearm using a 24-gauge needle. Pre-infusion vital signs were taken, and the RN initiated IV Therapy Company #1 ' s IV therapy micronutrient infusion per provider order. The note indicated the infusion started at 10:10 A.M. and, at 10:25 A.M., the IV site was noted to be infiltrated. The note indicated a second attempt to place a peripheral IV line was unsuccessful and a warm compress and pressure dressing were applied. 3. Review of an admission Record indicated the facility admitted Resident #1 on 08/08/25. According to the admission Record, the resident had a medical history that included diagnoses of diabetes mellitus (DM), hemiplegia (paralysis on one side of the body), major (continued on next page)

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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

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	depressive disorder, and epilepsy. Reviwe of an admission MDS assessment, with an ARD of 11/18/25, revealed Resident #1 had a BIMS score of 12, which indicated the resident had moderative cognitive impairment. Review of Resident #1's, Care Plan Report, included a focus area initiated 09/17/25, that indicated the resident was participating in IV Therapy Company #1 ' s program to promote IV infusion as evidenced by recent sepsis, diabetes mellitus, depression, history of urinary tract infection (UTI), history of a stroke, hemiplegia, and epilepsy. Interventions directed staff to monitor adverse reactions to IV therapy and, if noted, notify the physician, monitor the IV access site for redness, swelling, hot to touch, etc., and report adverse findings to the physician, provide IV therapy as ordered, and provide a relaxing environment. Review of Resident #1's, IV Hydration Resident Risk Screening Tool, indicated the resident had persistent low fluid intake despite efforts to support adequate oral hydration due to recent sepsis, diabetes mellitus, depression, history of UTI, history of stroke, hemiplegia, and epilepsy. Standard interventions were to ensure the availability and accessibility of fluids and identify and provide the resident ' s preferred drink. Conditions present that reduced the resident ' s capacity to maintain adequate fluid balance included functional/ADL impairment, malnutrition or at risk for malnutrition and medications such as diuretics and laxatives, psychotropic medications, or polypharmacy (>5 medications). Factors that could be caused by, contribute to, or be complicated by chronic fluid deficit included recent falls or increased fall risk. The tool indicated the resident had no special considerations for IV fluid administration. This section of the assessment was not signed or dated by a nurse. The Physician Order Form: IV Hydration Therapy section of the tool was signed by the Nurse Practitioner on 09/22/2025 and included an order for IV hydration for prevention of dehydration as indicated in the assessment above. The orders indicated: Fluid type: Normal Saline 0.9%; Fluid Volume: 1,000 mL; Infusion rate: 500 mL/hr.; Start peripheral IV; Hydration + B-complex: (B1) 200 mg, (B2) 4 mg, (B5) 4 mg, (B6) 4 mg, (B3) 200 mg; vitamin C 5,000 mg; methyl-cobalamin B12 2,000 mcg; zinc 10 mg. Review of Resident #1's September 2025, Documentation Survey Report, revealed the resident ' s fluid intake with meals averaged 676 mL per day. This did not include the fluids the resident received between meals or with medications. The resident ' s urinary catheter output was not monitored or documented on the form. Review of Resident #1's laboratory report dated as completed 09/24/25 did not include a comprehensive micronutrient panel to measure the resident ' s vitamin and mineral levels. Review of Resident #1's Order Recap Report revealed the following orders for September 2025: - (IV Therapy Company #1) - May enter peripheral IV insertion during scheduled infusions one time only for IV infusions until 09/25/25, enter site insertion in supplementary documentation, ordered 09/24/25. - Hydration + Skin Infusion-one time (1,000 mL) 0.9% normal saline at 500 mL an hour, (total additive volume 13.4 mL) vitamin C 5 grams (gm), B complex (B1-thiamine 200 milligrams [mg], B2-riboflavin 4 mg, B3-niacin 200 mg, B5-pantothenic acid 4 mg, B6-pyridoxine 4 mg), biotin 10 mg, zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational deficit one time only for micronutrient hydration therapy until 09/25/25, one time only for hydration, ordered 09/24/25. - There was no order for 72-hour post monitoring evaluation after the infusion in September 2025. Review of Resident #1's progress notes revealed a nursing note dated 09/25/25 that indicated a peripheral IV was inserted to the left wrist using a 24-gauge needle. Pre-infusion vital signs were taken, and the RN initiated IV Therapy Company #1 ' s IV therapy micronutrient infusion per provider order. The note indicated the infusion started at 8:30 AM and was completed at 10:30 AM. Post-infusion vital signs were obtained. The IV was discontinued and a pressure dressing was applied per protocol. Review of the, IV Therapy Services Agreement, signed by IV Therapy Company #1's Chief Operating Officer and the facility ' s corporate Chief Reimbursement Officer on 04/28/25, revealed IV Therapy Company #1 had not yet filed with the Ohio Secretary of State at the time the contract was signed. Additionally, the name of the IV therapy company on the agreement did not match the company name listed on the Ohio Board of Pharmacy License to Distribute Dangerous Drugs provided by the facility. During an interview on (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/19/25 at 5:12 P.M., Nurse Practitioner (NP) #45 stated IV Therapy Company #1 had their own protocol. She stated she was not sure why they were not doing the program for the facility's residents anymore. She stated she was minimally involved and that she signed the orders monthly but that was all. During an interview on 12/22/25 at 11:03 A.M., Chief Reimbursement Officer (CRO) #70, who signed the contract with IV Therapy Company #1, stated she did not have any information to provide regarding the contract and suggested the surveyor speak to Corporate Nurse Consultant (CNC) #71 in Ohio to get more information. She stated she could not say whether IV Therapy Company #1 was licensed to work in the state of Ohio. During an interview on 12/22/25 at 3:58 P.M., CNC #71 stated IV Therapy Company #1 informed them that they had an IV therapy service they wanted the facilities to start using, so they had the regional consultant go through the charts to determine who would benefit from the services. She stated if the resident had a wound, increased falls, or a change of condition, then a list was sent to the Medical Director or physician, and the physician would determine if the resident would benefit from increased hydration. She stated the order form would be filled out, and the orders placed into the electronic health record system. She stated when the clinic day was set, the physician would document the reasons for the hydration, and then they would have the clinic. She stated the residents were allowed to have three consecutive treatments monthly. She stated the residents signed a consent, and the physician or nurse practitioner would determine what the orders would be and what micronutrients were added, and then they provided monitoring after the treatment. She stated they were no longer providing the services because they were told the services were considered experimental treatment in Ohio. She stated she was not aware of any issues with the contract. During an interview on 12/23/25 at 8:20 A.M. NP #45 stated again that she had minimal involvement with IV Therapy Company #1's program. She stated she never got to see the staff or talk to them about the services and never saw any policies or procedures related to the services. She stated the assessments and orders were already filled out when she received them, and she signed the orders, but that was the extent of her involvement. She stated she did feel the residents would benefit from extra hydration and nutrition but could not say what protocols or criteria were used to make that determination. During an interview on 12/23/25 at 9:24 A.M, the DON stated she did not have any information about IV Therapy Company #1. She stated she did help with obtaining consents for the treatments in September 2025, but she did not fill out the screening or the orders. She stated she was not sure who completed those. She stated she did not know the criteria for determining the necessity for the treatments but did know that there were different standards for different diagnoses, such as a resident with wounds would get different nutrients. Copies of the signed consents for IV Therapy Company #1's services were requested from the facility but were not provided by the end of the survey. During an interview on 12/23/25 at 10:44 A.M., the Administrator stated the facility used IV Therapy Company #1's services to help residents who had wounds and other issues because, depending on what the resident had going on, it could help their healing. She stated she was not familiar with all the details of the program and she was not aware of any issues with t[TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on medical record review, staff interview, and facility document review, the facility failed to develop intravenous (IV) therapy procedures that were compliant with state requirements and accepted standards of practice for three (Residents #82, #39, and #1) of three residents reviewed for IV medications provided by IV Therapy Company #1. Based on a review of all residents' physician orders, the failed practice had the potential to affect 21 current residents and three discharged residents including but not limited to Resident #14, Resident #26, Resident #56, Resident #64, and Resident #94 received services from IV Therapy Company #1. The facility census was 92.Findings include: 1. Review of an admission Record indicated the facility admitted Resident #82 on 09/16/15. According to the admission Record, the resident had a medical history that included diagnoses of anoxic (absence of oxygen) brain damage, paraplegia (partial or complete paralysis of the legs and lower body), diabetes mellitus (DM), and congestive heart failure (CHF). Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 09/29/25, revealed Resident #82 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS assessment indicated the resident had intravenous (IV) access, received parenteral (IV) feeding, and received an average fluid intake of 500 cubic centimeters (cc) or less per day via IV or tube feeding. Review of Resident #82's Care Plan Report, included a focus area initiated 08/22/25, that indicated the resident was participating in IV Therapy Company #1's program to promote IV infusion as evidenced by paraplegia, major depression, and DM. Interventions directed staff to monitor for adverse reactions to IV therapy and if noted, notify the physician, monitor the IV access site for redness, swelling, hot to touch, etc., and report adverse findings to the physician, provide aroma therapy, provide IV therapy as ordered, provide music therapy, and provide a relaxing environment. Review of a provider progress note dated 06/20/25 indicated IV hydration was medically indicated for Resident #82 to support fluid balance and prevent dehydration-related complications in the context of limited oral intake and ongoing risk factors. The note indicated to see the Physician Order Form for IV Hydration Therapy. This form was requested but not provided by the facility for the month of June 2025. Review of Resident #82's June 2025, Documentation Survey Report, revealed the resident's average fluid intake with meals was 573 milliliters (mL) per day. This documentation did not include information as to what the resident received between meals or with medications. The report indicated Resident #82's June 2025 urinary catheter output revealed an average output of 1,258 mL per day. Review of Resident #82's laboratory reports revealed no laboratory testing completed during the month of June 2025. Resident #82's Order Recap Report revealed the following orders for June 2025: - May enter peripheral IV insertion during scheduled infusions one time only for IV infusions until 06/26/2025, enter site insertion in supplementary documentation, ordered 06/25/2025. - Hydration + [and] Skin Infusion - one time (500 milliliters) 0.9% normal saline at 500 milliliters (mL) an hour, (total additive volume 14.4 mL) Vitamin C 5 grams (gm), B Complex (B1-Thiamine 200 milligrams [mg], B2-Riboflavin 4 mg, B3-Niacin 200 mg, B5-Pantothenic Acid 4 mg, B6-Pyridoxine 4 mg), Biotin 10 mg, Zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational deficit one time only for micronutrient hydration therapy until 09/25/2025, one time only for hydration and nutritional wellness secondary to wounds, administration time may vary based on clinic, ordered 06/25/2025. - 72-hour post monitoring evaluation for scheduled infusion every shift for three days and enter a progress note for any signs and symptoms of infection or adverse reactions, ordered 06/26/2025. Review of Resident #82's progress notes revealed a nursing note dated 06/26/25 that indicated a peripheral IV was inserted to the right antecubital (front of the elbow) space using a 24-gauge needle. Pre-infusion vital signs were taken, and the registered nurse (RN) initiated the IV Therapy Company #1's IV therapy micronutrient (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infusion per provider order. The note indicated the infusion started at 8:10 AM and was completed at 9:15 A.M. Post-infusion vital signs were obtained. The IV was discontinued, and a pressure dressing was applied per protocol. Review of Resident #82's, IV Hydration Resident Risk Screening Tool, signed by the previous Director of Nursing (DON) on 07/20/25, indicated the resident had persistent low fluid intake despite efforts to support adequate oral hydration due to diagnoses of paraplegia, major depression, and diabetes. The standard interventions implemented were to ensure the availability and accessibility of fluids and identify and provide the resident's preferred beverage. Conditions present that reduced the resident's capacity to maintain adequate fluid balance included difficulty communicating needs, functional/activities of daily living (ADL) impairment, depression or anxiety, malnutrition or at risk for malnutrition, and medications such as diuretics and laxatives. Factors that could be caused by, contribute to, or be complicated by chronic fluid deficit included recent or recurrent urinary tract infection (UTI) or other infection, and new/existing pressure ulcer/chronic wounds. The tool indicated the resident had no special considerations for IV fluid administration. The Physician Order Form: IV Hydration Therapy section of the tool was signed by the physician on 07/21/2025 and included an order for IV hydration for prevention of dehydration as indicated in the assessment above. The orders indicated, Fluid type: Normal Saline 0.9%; Fluid Volume: 500 mL; Infusion rate: 500 mL/hr.; Start peripheral IV; Hydration + [and] B-complex: (B1) 200 mg, (B2) 4 mg, (B5) 4 mg, (B6) 4 mg, (B3) 200 mg; vitamin C 5,000 mg; methyl-cobalamin B12 2,000 mcg [microgram]; zinc 10 mg with skin support (biotin B7 10 mg). Review of Resident #82's July 2025, Documentation Survey Report, indicated the resident's average fluid intake with meals was 700 mL per day. The report did not reflect fluid taken between meals or with medications. The report indicated Resident #82's July 2025 urinary catheter output averaged 1,255 mL per day. Review of Resident #82's laboratory reports revealed no laboratory testing completed during the month of July 2025. Review of Resident #82's Order Recap Report revealed the following orders for July 2025: - (IV Therapy Company #1) - May enter peripheral IV insertion during scheduled infusions one time only for IV infusions until 07/24/25, enter site insertion in supplementary documentation, ordered 07/23/25. - Hydration + skin infusion - one time (500 milliliters) 0.9% normal saline at 500 milliliters (mL) an hour, (Total additive volume 14.4 mL) vitamin C 5 gm, B complex (B1-thiamine 200 milligrams, B2-riboflavin 4 mg, B3-niacin 200 mg, B5-pantothenic acid 4 mg, B6-pyridoxine 4 mg), biotin 10 mg, zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational deficit one time only for micronutrient hydration therapy until 09/25/25, one time only for difficulty communicating needs, functional ADL impairment, depression/anxiety, malnutrition, medications such as diuretics and laxatives, etc., ordered 07/23/25. - (IV Therapy Company #1) IV - 72-hour post monitoring evaluation every shift for three days and enter a progress note for any signs and symptoms of infection or adverse reactions, ordered 07/23/25. Review of Resident #82's progress notes revealed a nursing note dated 07/24/2025 that indicated a peripheral IV was inserted to the right hand using a 24-gauge needle. Pre-infusion vital signs were taken, and the RN initiated IV Therapy Company #1's IV therapy micronutrient infusion per provider order. The note indicated the infusion started at 8:10 A.M. and was complete at 9:10 A.M. Post-infusion vital signs were obtained. The IV was discontinued and a pressure dressing was applied per protocol. Review of Resident #82's, IV Hydration Resident Risk Screening Tool, indicated the resident had persistent low fluid intake despite efforts to support adequate oral hydration due to paraplegia, major depression, and diabetic diagnoses. Standard interventions were to ensure the availability and accessibility of fluids and identify and provide the resident's preferred beverage. Conditions present that reduced the resident's capacity to maintain adequate fluid balance included difficulty communicating needs, functional/ADL impairment, depression or anxiety, malnutrition or at risk for malnutrition and medications such as diuretics and laxatives. Factors that could be caused by, contribute to, or be complicated by chronic fluid deficit included recent or recurrent UTI or other infection, and new/existing pressure ulcer/chronic wounds. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The tool indicated the resident had no special considerations for IV fluid administration. This section was not signed or dated by facility nursing staff. The Physician Order Form: IV Hydration Therapy section of the tool was signed by the nurse practitioner on 08/27/25 and included an order for IV hydration for prevention of dehydration as indicated in the assessment above. The tool indicated the orders as follows: Fluid type: Normal Saline 0.9%; Fluid Volume: 500 mL; Infusion rate: 500 mL/hr.; Start peripheral IV; Hydration + B-complex: (B1) 200 mg, (B2) 4 mg, (B5) 4 mg, (B6) 4 mg, (B3) 200 mg; vitamin C 5,000 mg; methyl-cobalamin B12 2,000 mcg; zinc 10 mg; magnesium chloride 600 mg; calcium chloride 100 mg with skin support (biotin B7 10 mg). Review of Resident #82's August 2025, Documentation Survey Report, indicated the resident's average daily fluid intake with meals was 728 ml. The report did not indicate the resident's fluid intake between meals or with medications. The report indicated the resident's urinary catheter output averaged 1,241 mL per day. Review of Resident #82's laboratory reports revealed no laboratory testing completed during the month of August 2025. Review of Resident #82's Order Recap Report revealed the following orders for August 2025: - May enter peripheral IV insertion during scheduled infusions one time only for IV infusions until 08/28/2025, enter site insertion in supplementary documentation, ordered 08/28/25. - Hydration + skin infusion-one time (500 milliliters) 0.9% normal saline at 500 mL an hour, (total additive volume 14.4 mL) vitamin C 5 grams (gm), B complex (B1-thiamine 200 milligrams [mg], B2-riboflavin 4 mg, B3-niacin 200 mg, B5-pantothenic acid 4 mg, B6-pyridoxine 4 mg), biotin 10 mg, zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational deficit one time only for micronutrient hydration therapy until 09/25/2025, one time only for hydration and nutritional wellness secondary to wounds, administration time may vary based on clinic, ordered 08/27/25. - (IV Therapy Company #1) IV - 72-hour post monitoring evaluation every shift for three days and enter a progress note for any signs and symptoms of infection or adverse reactions, ordered 08/28/25. Review Resident #82's progress notes revealed a nursing note dated 08/28/25 that indicated a peripheral IV was inserted to the left hand using a 24-gauge needle. Pre-infusion vital signs were taken, and the RN initiated IV Therapy Company #1's IV therapy micronutrient infusion per provider order. The note indicated the infusion started at 9:00 A.M. and was completed at 10:00 A.M. Post-infusion vital signs were obtained. The IV was discontinued and a pressure dressing was applied per protocol. Review of Resident #82's IV Hydration Resident Risk Screening Tool indicated the resident had persistent low fluid intake despite efforts to support adequate oral hydration due to paraplegia, major depression, and diabetic diagnoses. Standard interventions were to ensure the availability and accessibility of fluids and identify and provide the resident's preferred beverage. Conditions present that reduced the resident's capacity to maintain adequate fluid balance included difficulty communicating needs, functional/ADL impairment, depression or anxiety, malnutrition or at risk for malnutrition, and medications such as diuretics and laxatives. Factors that could be caused by, contribute to, or be complicated by chronic fluid deficit included recent or recurrent UTI or other infection, and new/existing pressure ulcer/chronic wounds. The tool indicated the resident had no special considerations for IV fluid administration. This section of the assessment was not signed or dated by a nurse. The Physician Order Form: IV Hydration Therapy section of the tool was signed by the Nurse Practitioner on 09/22/2025 and included an order for IV hydration for prevention of dehydration as indicated in the assessment above. The orders indicated: Fluid type: Normal Saline 0.9%; Fluid Volume: 500 mL; Infusion rate: 500 mL/hr.; Start peripheral IV; Hydration + B-complex: (B1) 200 mg, (B2) 4 mg, (B5) 4 mg, (B6) 4 mg, (B3) 200 mg; vitamin C 5,000 mg; methyl-cobalamin B12 2,000 mcg; zinc 10 mg; magnesium chloride 600 mg; calcium chloride 100 mg with skin support (biotin B7 10 mg). Review of Resident #82's, Documentation Survey Report, for September 2025 indicated the resident's fluid intake with meals averaged 766 mL per day. This did not include fluids taken between meals or with medications. The report indicated the resident's urinary catheter output averaged 1,149 mL day. Review of Resident #82's laboratory reports revealed no laboratory testing completed during (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the month of September 2025. Review of Resident #82's Order Recap Report revealed the following orders for September 2025: - (IV Therapy Company #1) - May enter peripheral IV insertion during scheduled infusions one time only for IV infusions until 09/25/25, enter site insertion in supplementary documentation, ordered 09/24/25. - Hydration + skin Infusion-one time (500 milliliters) 0.9% normal saline at 500 milliliters (mL) an hour, (total additive volume 14.4 mL) vitamin C 5 grams (gm), B complex (B1-thiamine 200 milligrams [mg], B2-riboflavin 4 mg, B3-niacin 200 mg, B5-pantothenic acid 4 mg, B6-pyridoxine 4 mg), biotin 10 mg, zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational deficit one time only for micronutrient hydration therapy until 09/25/25, one time only for hydration and nutritional wellness secondary to wounds, administration time may vary based on clinic, ordered 09/24/25. - There was no order for 72-hour post monitoring evaluation after the infusion in September 2025. Review of Resident #82's progress notes revealed a nursing note dated 09/25/25 that indicated a peripheral IV was inserted to the left wrist using a 24-gauge needle. Pre-infusion vital signs were taken, and the RN initiated IV Therapy Company #1's IV therapy micronutrient infusion per provider order. The note indicated the infusion started at 9:48 AM and was completed at 11:48 AM. Post-infusion vital signs were obtained. The IV was discontinued and a pressure dressing was applied per protocol. During an interview on 12/19/25 at 5:12 PM, Nurse Practitioner (NP) #45 stated IV Therapy Company #1 had their own protocol, so she was not sure why they changed what Resident #82 was getting. She stated she was minimally involved and that she signed the orders monthly but that was all. 2. Review of the medical record indicated the facility readmitted Resident #39 on 04/10/25. According to the record, the resident had a medical history that included diagnoses of paraplegia (partial or total paralysis of the legs and lower body), chronic hepatitis C, and stage 4 pressure ulcer of the sacral region. Review of a quarterly MDS assessment, with an ARD of 07/01/25, revealed Resident #39 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS assessment indicated that the resident had IV access, received parenteral/IV feeding, and received an average fluid intake of 500 cubic centimeters (cc) or fluid or less per day via IV or tube feeding. Review of Resident #39's, Care Plan Report, did not include a focus area that indicated the resident participated in IV Therapy Company #1's program. Review of Resident #39's progress notes revealed a nurse practitioner's note dated 06/19/25 that indicated the resident would be receiving IV hydration with supplemental micronutrients due to a prior medical history of pressure ulcers, a wound to the lower back and pelvis, and neurogenic bladder with frequent UTIs, making the resident susceptible to dehydration. Review of Resident #39's June 2025, Documentation Survey Report, revealed the resident's fluid intake with meals averaged 700 mL per day. This did not include the fluids the resident received between meals or with medications. The report revealed Resident #39's urinary catheter output was not monitored and documented for the month of June 2025. Review of Resident #39 laboratory reports revealed no laboratory testing completed during the month of June 2025. Review of Resident #39's, Order Recap Report, revealed the following orders for June 2025: - May use existing peripherally inserted central catheter (PICC) line during scheduled infusions, one time only for IV infusions until 06/26/25 and enter site insertion in supplementary documentation, ordered 06/25/25. - Hydration + skin infusion-one time (500 milliliters) 0.9% normal saline at 500 mL an hour, (Total additive volume 14.4 mL) vitamin C 5 gm, B complex (B1-thiamine 200 mg, B2-riboflavin 4 mg, B3-niacin 200 mg, B5-pantothenic acid 4 mg, B6-pyridoxine 4 mg), biotin 10 mg, zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational deficit one time only for micronutrient hydration therapy until 06/26/25, one time only for hydration and nutritional wellness secondary to wounds, administration time may vary based on clinic, ordered 06/25/25. - 72-hour post monitoring evaluation for scheduled infusion every shift for three days and enter a progress note for any signs and symptoms of infection or adverse reactions, ordered 06/25/25. Review of Resident #39's (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	progress notes revealed a nursing note dated 06/26/25 that indicated the resident's right upper arm PICC line was accessed and that the RN initiated IV Therapy Company #1's IV therapy micronutrient infusion per provider order. The note indicated pre-infusion vital signs were obtained and the infusion started at 8:05 AM and was completed at 9:00 A.M. Post-infusion vital signs were obtained and the PICC line was de-accessed per protocol. Review of Resident #39's, IV Hydration Resident Risk Screening Tool, signed by the previous DON on 07/20/25, indicated the resident had persistent low fluid intake despite efforts to support adequate oral hydration due to paraplegia, hepatitis C, and a stage 4 wound. Standard interventions were to ensure the availability and accessibility of fluids and identify and provide the resident's preferred drink. Conditions present that reduced the resident's capacity to maintain adequate fluid balance included functional/ADL impairment. Factors that could be caused by, contribute to, or be complicated by chronic fluid deficit included headaches and new/existing pressure ulcer/chronic wounds. The tool indicated the resident had no special considerations for IV fluid administration. The Physician Order Form: IV Hydration Therapy section of the tool was signed by the physician on 07/21/2025 and included an order for IV hydration for prevention of dehydration, as indicated in the assessment above. The orders indicated: Fluid type: Normal Saline 0.9%; Fluid Volume: 500 mL; Infusion rate: 500 mL/hr.; Start peripheral IV; Hydration + B-complex: (B1) 200 mg, (B2) 4 mg, (B5) 4 mg, (B6) 4 mg, (B3) 200 mg; vitamin C 5,000 mg; methyl-cobalamin B12 2,000 mcg; zinc 10 mg with skin support (biotin B7 10 mg). Review of Resident #39's July 2025, Documentation Survey Report, revealed the resident's fluid intake with meals averaged 588 mL per day. This did not include the fluids the resident received between meals or with medications. The report revealed Resident #39's urinary catheter output was not monitored and documented for the month of July 2025. Review of Resident #39's laboratory results dated as completed on 07/21/25 revealed no comprehensive micronutrient panel to measure the resident's vitamin and mineral levels. Review Resident #39's Order Recap Report revealed the following orders for July 2025: - May enter peripheral IV insertion during scheduled infusions one time only for IV infusions until 07/24/2025, enter site insertion in supplementary documentation, ordered 07/23/25. - Hydration + Skin Infusion-one time (500 milliliters) 0.9% normal saline at 500 mL an hour, (Total additive volume 14.4 mL) vitamin C 5 gm, B complex (B1-thiamine 200 mg, B2-riboflavin 4 mg, B3-niacin 200 mg, B5-pantothenic acid 4 mg, B6-pyridoxine 4 mg), biotin 10 mg, zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational deficit one time only for micronutrient hydration therapy until 06/26/2025, one time only for functional and ADL impairment, ordered 07/2/325. - 72-hour post monitoring evaluation for scheduled infusion every shift for three days and enter a progress note for any signs and symptoms of infection or adverse reactions, ordered 07/23/25. Review of Resident #39's progress notes revealed an electronic Medication Administration Record (eMAR)-Medication Administration Note dated 07/24/25 that indicated the resident's vein was not able to be accessed for IV therapy. Review of Resident #39's progress notes revealed a Nursing Note dated 07/24/25 that indicated a peripheral IV was inserted to the right forearm using a 24-gauge needle. Pre-infusion vital signs were taken, and the RN initiated IV Therapy Company #1's IV therapy micronutrient infusion per provider order. The note indicated the infusion started at 10:10 A.M. and, at 10:25 A.M., the IV site was noted to be infiltrated. The note indicated a second attempt to place a peripheral IV line was unsuccessful and a warm compress and pressure dressing were applied. 3. Review of an admission Record indicated the facility admitted Resident #1 on 08/08/25. According to the admission Record, the resident had a medical history that included diagnoses of diabetes mellitus (DM), hemiplegia (paralysis on one side of the body), major depressive disorder, and epilepsy. Reviwe of an admission MDS assessment, with an ARD of 11/18/25, revealed Resident #1 had a BIMS score of 12, which indicated the resident had moderative cognitive impairment. Review of Resident #1's, Care Plan Report, included a focus area initiated 09/17/25, that indicated the resident was participating in IV Therapy Company #1's program to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	promote IV infusion as evidenced by recent sepsis, diabetes mellitus, depression, history of urinary tract infection (UTI), history of a stroke, hemiplegia, and epilepsy. Interventions directed staff to monitor adverse reactions to IV therapy and, if noted, notify the physician, monitor the IV access site for redness, swelling, hot to touch, etc., and report adverse findings to the physician, provide IV therapy as ordered, and provide a relaxing environment. Review of Resident #1's, IV Hydration Resident Risk Screening Tool, indicated the resident had persistent low fluid intake despite efforts to support adequate oral hydration due to recent sepsis, diabetes mellitus, depression, history of UTI, history of stroke, hemiplegia, and epilepsy. Standard interventions were to ensure the availability and accessibility of fluids and identify and provide the resident's preferred drink. Conditions present that reduced the resident's capacity to maintain adequate fluid balance included functional/ADL impairment, malnutrition or at risk for malnutrition and medications such as diuretics and laxatives, psychotropic medications, or polypharmacy (>5 medications). Factors that could be caused by, contribute to, or be complicated by chronic fluid deficit included recent falls or increased fall risk. The tool indicated the resident had no special considerations for IV fluid administration. This section of the assessment was not signed or dated by a nurse. The Physician Order Form: IV Hydration Therapy section of the tool was signed by the Nurse Practitioner on 09/22/2025 and included an order for IV hydration for prevention of dehydration as indicated in the assessment above. The orders indicated: Fluid type: Normal Saline 0.9%; Fluid Volume: 1,000 mL; Infusion rate: 500 mL/hr.; Start peripheral IV; Hydration + B-complex: (B1) 200 mg, (B2) 4 mg, (B5) 4 mg, (B6) 4 mg, (B3) 200 mg; vitamin C 5,000 mg; methyl-cobalamin B12 2,000 mcg; zinc 10 mg. Review of Resident #1's September 2025, Documentation Survey Report, revealed the resident's fluid intake with meals averaged 676 mL per day. This did not include the fluids the resident received between meals or with medications. The resident's urinary catheter output was not monitored or documented on the form. Review of Resident #1's laboratory report dated as completed 09/24/25 did not include a comprehensive micronutrient panel to measure the resident's vitamin and mineral levels. Review of Resident #1's Order Recap Report revealed the following orders for September 2025: - (IV Therapy Company #1) - May enter peripheral IV insertion during scheduled infusions one time only for IV infusions until 09/25/25, enter site insertion in supplementary documentation, ordered 09/24/25. - Hydration + Skin Infusion-one time (1,000 mL) 0.9% normal saline at 500 mL an hour, (total additive volume 13.4 mL) vitamin C 5 grams (gm), B complex (B1-thiamine 200 milligrams [mg], B2-riboflavin 4 mg, B3-niacin 200 mg, B5-pantothenic acid 4 mg, B6-pyridoxine 4 mg), biotin 10 mg, zinc 10 mg, B-12 methyl-cobalamin 2 mg intravenous hydration at next scheduled clinic - medically necessary given standard interventions being insufficient to address clinical indications of hydrational deficit one time only for micronutrient hydration therapy until 09/25/25, one time only for hydration, ordered 09/24/25. - There was no order for 72-hour post monitoring evaluation after the infusion in September 2025. Review of Resident #1's progress notes revealed a nursing note dated 09/25/25 that indicated a peripheral IV was inserted to the left wrist using a 24-gauge needle. Pre-infusion vital signs were taken, and the RN initiated IV Therapy Company #1's IV therapy micronutrient infusion per provider order. The note indicated the infusion started at 8:30 AM and was completed at 10:30 AM. Post-infusion vital signs were obtained. The IV was discontinued and a pressure dressing was applied per protocol. Review of the, IV Therapy Services Agreement, signed by IV Therapy Company #1's Chief Operating Officer (#71) and the facility's corporate Chief Reimbursement Officer (#70) on 04/28/25, revealed IV Therapy Company #1 had not yet filed with the Ohio Secretary of State at the time the contract was signed. During an interview on 12/22/25 at 11:03 A.M., Chief Reimbursement Officer (CRO) #70, who signed the contract with IV Therapy Company #1, stated she did not have any information to provide regarding the contract and suggested the surveyor speak to Corporate Nurse Consultant (CNC) #71 in Ohio to get more information. She stated she could not say whether IV Therapy Company #1 was licensed to work in the state of Ohio. During an interview on 12/22/25 at 3:58 P.M., CNC #71 stated IV Therapy Company #1 informed them that they had an IV therapy service they wanted the facilities to start (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	using, so they had the regional consultant go through the charts to determine who would benefit from the services. She stated they were no longer providing the services because they were told it was considered experimental treatment in Ohio. She stated she was not aware of any issues with the contract. During an interview on 12/23/25 at 8:20 A.M., Nurse Practitioner (NP) #45 stated that she had minimal involvement with IV Therapy Company #1's program. She stated she never got to see the staff or talk to them about it and never saw any policies or procedures. She stated the assessments and orders were already filled out when she received them, and she signed the orders, but that was the extent of her involvement. During an interview on 12/23/25 at 9:24 A.M., the Director of Nursing (DON) stated she did not have any information about IV Therapy Company #1's program. She stated she did help with obtaining consents for the treatments in September, but she did not fill out the screening or the orders. She stated she was not sure who completed those. She stated she did not know the criteria for determining the necessity for the treatments but did know that there were different standards for different diagnoses, such as a resident with wounds would get different nutrients. During an interview on 12/23/25 at 10:44 A.M., the Administrator stated the facility used IV Therapy Company #1's services to help residents who had wounds and other issues because, depending on what the resident had going on, it could help their healing. She stated she was not familiar with all the details of the program. She stated she was not aware of any issues with the contract and was not aware of the issues with the company's failure to provide the appropriate certification documentation. Review of the State of Ohio Terminal Distributor Licensure of Prescriber Practices document located at https://www.pharmacy.ohio.gov/ and dated 08/24/2023, indicated, A Terminal Distributor of Dangerous Drugs (TDDD) license allows a business entity to purchase, possess, and/or distribute dangerous drugs at a specific location. Terminal distributors of dangerous drugs include, but are not limited to, hospitals, pharmacies, EMS [Emergency Medical Services] organizations, laboratories, nursing homes, and prescriber practices. Distribution includes the administration of drugs on-site to patients as well as providing medications to patients to take away from the facility for later use. The document also specified, Dangerous drugs are defined in the Ohio Revised Code [ORC] as any drug that meets any of the following: 1. Requires a prescription; 2. Bears on the label a Federal Legend (Rx [prescription] Only or Caution: Federal law prohibits dispensing without a prescription); 3. Is intended for injection into the human body; or 4. Any drug that is a biological product as defined in section 3715.01 of the Revised Code. The document indicated, ORC 4729.51 states that no licensed manufacturer, outsourcing facility, third-party logistics provider, repackager, or wholesale distributor shall sell dangerous drugs to anyone other than the following: (1) a licensed terminal distributor of dangerous drugs; (2) Any person exempt from licensure as a terminal distributor of dangerous drugs under section 4729.541 of the Revised Code; (3) a licensed manufacturer, outsourcing facility, third-party logistics provider, repackager, or wholesale distributor; or (4) A terminal distributor, manufacturer, outsourcing facility, third-party logistics provider, repackager, or wholesale distributor that is located in another state, is not engaged in the sale of dangerous drugs within this state, and is actively licensed to engage in the sale of dangerous drugs by the state in which the distributor conducts business. The document listed several scenarios

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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. 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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 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 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 Nurse (LPN) #02 stated nebulizer equipment should be stored in a plastic bag when not in use. She said there was not a plastic bag in the room, and she meant to get one to put the resident's nebulizer equipment in but got busy with something else and forgot. During an interview on 12/23/25 at 9:24 A.M., the DON stated respiratory equipment should be covered when not in use. She stated the nurses should have covered the nebulizer equipment and not set it on the table for infection control reasons. During an interview on 12/23/25 at 10:44 A.M., the Administrator stated respiratory equipment should be stored in a bag when not in use, and she expected Resident #06's nebulizer equipment to be stored properly. 3. Review of the medical record revealed the facility admitted Resident #37 on 06/19/23. Diagnoses included chronic obstructive pulmonary disease (COPD), obstructive sleep apnea, and moderate persistent asthma. Review of a quarterly MDS, with an ARD of 11/10/2025 revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of seven, which indicated the resident had severe cognitive impairment. Review of Resident #37's Care Plan Report included a focus area initiated 07/05/24, indicating the resident had a history of altered respiratory status related to COPD, asthma, congestive heart failure (CHF), history of smoking, and obstructive sleep apnea, and use of a continuous positive airway pressureˆ(CPAP) machine. An observation on 12/15/25 at 12:01 P.M. , revealed Resident #37's CPAP mask was not stored in a plastic bag. An observation on 12/20/25 at 1:30 P.M. revealed Resident #37's CPAP mask was lying on the resident's dresser. The mask was not stored in a plastic bag. An observation on 12/21/25 at 1:22 P.M. revealed Resident #37's CPAP mask was lying on the resident's dresser and the mask was not stored in a plastic bag. During an interview on 12/21/25 at 1:30 P.M., CNA #29 verified he just placed CPAP masks on top of the dresser when they were not in use. During an interview on 12/22/25 at 1:55 P.M. CNA #31 verified CPAP masks were to be stored in a plastic bag when not in use. During an interview on 12/21/2025 at 1:39 P.M., LPN # 10 stated CPAP masks should be stored inside a plastic bag when not in use. During an interview on 12/22/25 at 6:10 P.M., the DON stated the facility did not have a policy for storage of CPAP masks. The DON stated she expected staff to store CPAP masks in a plastic bag and not on top of a dresser or in a drawer. During an interview on 12/21/25 at 2:54 P.M., the Administrator stated she expected staff to store CPAP masks in a bag when not in use.

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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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on medical record review, resident responsible party interview, staff interview, and facility policy review, the facility failed to ensure a resident's responsible party was notified and approved of a change in treatment, specifically a change in the tube feeding rate for one (#6) of two residents reviewed for a change of condition/treatment. The census was 92.Findings include: Review of the medical record revealed the facility admitted Resident #6 on 10/28/22 and readmitted the resident on 04/11/23. Diagnoses included persistent vegetative state, unspecified severe protein-calorie malnutrition, and gastrostomy status. Review of a quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 10/15/25, indicated Resident #6 was in a persistent vegetative state with no discernible consciousness. The MDS assessment indicated the resident had a feeding tube and received 51 percent (%) or more of their total calories through a feeding tube and 501 cubic centimeters (CC) or more of fluid per day through the tube. Review of Resident #6's care plan included a focus area initiated 11/10/25 which indicated the resident required tube feeding related to chewing and swallowing problems. Interventions directed staff to have the Registered Dietitian (RD) evaluate the resident quarterly and as needed, monitor caloric intake, estimate needs, and make recommendations for changes to the tube feeding as needed. Review of Resident #6's progress notes revealed a dietary note dated 12/17/25 which indicated the resident took nothing by mouth and was tube-feeding dependent. The note indicated the current tube feeding order was for Fibersource high nitrogen (HN) at 60 milliliters per hour (mL/hr) for 18 hours per day, to be turned on at 12:00 P.M. and turned off at 6:00 A.M. daily. The note indicated recommendations were made to switch to a continuous feeding over 24 hours for ease of administration and to continue to provide the flushes and Prostat (protein supplement) as ordered, and change the tube feeding regimen to Fibersource HN at 45 mL/hr continuous feedings over 24 hours, which would provide the same nutrition as the current regimen. There was no documentation that the resident's responsible party was notified of the change in the resident's tube feeding regimen. Review of Resident #6's order summary report revealed an order dated 06/13/25 to start Fibersource HN at 65 ml/hr for 18 hours per day, to be turned on at 12:00 P.M. and off at 6:00 A.M. The report indicated the order was discontinued on 12/17/25 and changed to Fibersource HN at 45 mL/hr over 24 hours continuously. During an interview on 12/19/25 at 1:17 P.M., Resident #6's responsible party stated the resident was not supposed to receive continuous tube feeding and the tube feeding was only supposed to run from 12:00 P.M. until 6:00 A.M. the next day because the resident could not tolerate a continuous feeding. The responsible party stated they were not aware of any changes. During an interview on 12/20/25 at 2:58 P.M., Resident #6's responsible party stated they were not notified of the change in the tube feeding rate and would not have approved it because the resident was not able to tolerate continuous feedings, and the facility should know that. Resident #6's responsible party indicated the Director of Nursing (DON) stated she was going to investigate to see why the feeding order was changed. During an interview on 12/23/25 at 9:24 A.M., the DON stated the facility's regular dietitian was not present and the facility had an alternate dietitian come in who thought it made more sense to change Resident #6's tube feeding to continuous. The DON stated the dietitian did not communicate this with the Resident #6's responsible party but should have. During an interview on 12/23/25 at 10:44 A.M., the Administrator stated any time there were changes to the resident's orders, notifications should be made, either by the dietitian, the nurse, or the supervisor. Review of a facility policy titled, Change in a Resident's Condition or Status, revised 02/2021, revealed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g. [for example], changes in level of care, billing/payments, resident rights, etc. [et cetera]).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, resident and staff interview, medical record review, and facility policy review, the facility failed to provide activities of daily living (ADL) assistance for dependent residents. This affected one (#56) of four residents reviewed for ADLs. The census was 92.Findings include:Review of the medical record revealed the facility admitted Resident #56 on 10/13/23. Diagnoses included legal blindness and multiple sclerosis. Review of a quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/03/25, revealed Resident #56 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS assessment indicated the resident required substantial/maximal assistance for personal hygiene. Review of Resident #56's care plan included a focus area, revised 12/11/24, which indicated the resident had an activities of daily living (ADL) self-care deficit related to needing extensive to dependent assistance with ADLs and mobility. Interventions directed staff to assist the resident with personal hygiene. An observation on 12/17/25 at 3:45 P.M. revealed Resident #56 was observed to have long, dirty fingernails. During an interview on 12/18/25 at 10:55 A.M., Resident #56 stated he had a bed bath and staff had not offered to trim or clean his fingernails or to shave his facial hair. Resident #56 stated he wanted his fingernails to be cleaned, trimmed, and wanted his facial hair to be trimmed. During an interview on 12/18/25 at 11:00 A.M., Certified Nurse Aide (CNA) #12 stated when a resident received their shower/bath, the staff should have offered to trim and clean the resident's fingernails and shave the resident. CNA #12 stated Resident #56 received a bed bath that day, and the resident was dependent on staff for cleaning and trimming their fingernails and shaving. During an observation on 12/18/25 at 11:08 A.M., CNA #12 and Licensed Practical Nurse (LPN) #7 went to Resident #56's room and with the resident's permission, observed the fingernails and face of the resident. During a concurrent interview, CNA #12 and LPN #7 both confirmed the resident's nails were dirty, jagged, long, and needed to be trimmed and confirmed the resident needed to be shaved. During an interview on 12/18/25 at 11:10 A.M., CNA #12 stated Resident #56 had long dirty fingernails and untrimmed facial hair. CNA #12 stated she should have cleaned and trimmed the resident's fingernails and should have trimmed the resident's facial hair or shaved the resident depending on what the resident wanted her to do. CNA #12 stated she should have asked the resident if he wanted to be shaved or have his nails trimmed, but she did not ask the resident; she just gave the resident a bed bath. During an interview on 12/18/25 at 11:15 A.M., LPN #7 stated on the resident's shower days and as needed, the CNAs should offer to trim the non-diabetic resident's fingernails and facial hair. She stated CNAs could clean all residents' fingernails, but the nurses trimmed the diabetic residents' fingernails. During an interview on 12/18/25 at 11:45 A.M., Resident #56 stated he was dependent on staff to clean and trim his fingernails and to shave them. During an interview on 12/22/25 at 6:10 P.M., the Director of Nursing (DON) stated she expected the staff to clean and trim the resident's fingernails and to shave them on their shower/bath days or as needed. During an interview on 12/21/25 at 2:54 P.M., the Administrator stated she expected the staff to offer to clean and trim the resident's fingernails and to shave the residents. Review of a facility policy titled, Activities of Daily Living (ADL), Supporting, revised 04/2025, revealed residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on medical record review, observation, staff interview, resident representative interview, and policy review, the facility failed to ensure a residents tube feeding was administered according to physician orders. This affected one (Resident #06) of one resident reviewed for tube feedings. The facility census was 92.Findings Included:Review of the medical record revealed the facility admitted Resident #06 on 10/28/22 and readmitted the resident on 04/11/23. Diagnoses included persistent vegetative state, unspecified severe protein-calorie malnutrition, and gastrostomy 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 had a feeding tube and received 51 percent or more of their total calories via tube feedings and 501 cubic centimeters (cc) or more of fluid per day via the tube. Review of Resident #06's Care Plan included a focus area initiated 11/10/25, indicating the resident required tube feeding related to chewing and swallowing problems. Interventions directed staff to have the Registered Dietitian (RD) evaluate the resident quarterly and as needed, monitor caloric intake, estimate needs, and make recommendations for changes to the tube feeding as needed. Review of Resident #06's Physician Order Recap Report revealed an order dated 12/17/25 for enteral feedings via enteral tube of Fibersource HN (high nitrogen) at 45 milliliters per hour (mL/hr) continuously over 24 hours. Observations on 12/18/25 at 8:45 A.M. revealed Resident #06 was sitting in a Geri-chair and there was no tube feeding hanging in the room or infusing. At 12:36 P.M., Resident #06 was lying in bed, and there was no tube feeding hanging in the room or infusing. During an interview on 12/18/25 at 12:57 P.M., Registered Nurse (RN) #04 stated he forgot that he was supposed to hang the tube feeding for Resident #06 at 12:00 P.M. He stated he had not read the orders and did not know the rate had changed. He stated he was not aware that the feeding should have been running all morning. He stated it was usually hung at 12:00 P.M., until the next morning at a rate of 60 mL/hr. He stated he should have been told about the rate change during report but should have also checked the orders himself. Observations on 12/19/25 at 11:35 A.M. revealed Resident #06 lying in bed with no feeding hanging or infusing. At 1:17 P.M., Resident #06 was lying in bed, and the tube feeding was hanging and infusing at 60 mL/hr instead of 45 mL/hr as ordered. Resident #06's responsible party was in the room and stated the resident was not supposed to be on continuous tube feedings and the reason it was not hanging yesterday morning was because it was supposed to run from 12:00 PM to 6:00 AM at 60 mL/hr. The responsible party stated the resident could not tolerate continuous feeding, and they were not aware of any changes to the orders. During an interview on 12/19/25 at 1:26 P.M., Licensed Practical Nurse (LPN) #02 stated she hung Resident #06's feeding at noon, since it ran from 12:00 P.M. until 6:00 A.M. the next day at 60 mL/hr. She stated she was not aware of any changes or that it was supposed to be administered continuously. She stated she had not had a chance to read all the orders or treatments yet. She stated she should have checked the orders when she hung the bag to verify them but then said she should have been told in report that the rate was different. During an interview on 12/23/25 at 9:24 A.M., the Director of Nursing (DON) stated it was her expectation that the nurses follow the current and active orders for tube feedings. During an interview on 12/23/25 at 10:44 A.M., the Administrator stated tube feedings should be administered according to the orders. A facility policy titled Enteral Nutrition, dated 11/2018, indicated Adequate nutritional support through enteral nutrition is provided to residents as ordered. The policy also indicated, 11. The nurse confirms that orders for enteral nutrition are complete. Complete orders include: a. the enteral nutrition product; b. delivery site (tip placement); c. the specific enteral access device (nasogastric, jejunostomy tube, etc. [et cetera]); d. administration method (continuous, bolus, intermittent); e. volume and rate of administration; f. the volume/rate goals and recommendations for advancement toward these; and g. instructions for flushing (solution, volume, frequency, time and 24-hour volume).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, resident interview, staff interview, and policy review, the facility failed to provide respiratory care in accordance with physician's orders for one (Resident #35) of four residents reviewed for respiratory care. The facility census was 92. Review of the medical record for Resident #35 revealed an admission date of 12/20/2020. Diagnoses inlcuded chronic respiratory failure with hypercapnia (abnormally elevated carbon dioxide levels in the blood); chronic diastolic (congestive) heart failure; chronic obstructive pulmonary disease (COPD), unspecified; shortness of breath; and morbid (severe) obesity with alveolar hypoventilation. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/18/2025, revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Review of Resident #35's care plan, initiated 10/15/2025, indicated the resident had shortness of breath related to COPD, asthma, chronic respiratory failure, and history of hypoxia. An intervention dated 10/15/2025 directed nursing staff to provide supplemental oxygen as ordered. Review of Resident #35's order summary contained a physician ' s order, started on 07/07/2025 and discontinued on 12/16/25, for supplemental oxygen with humidification at 2-3 liters per minute (LPM) via nasal cannula as resident tolerates. A new order was obtained on 12/16/25 for supplemental oxygen with humidification at 2 LPM via nasal cannula. The order dated 12/16/2025 specified staff could titrate up to 3 LPM as the resident tolerated. An observation on 12/16/2025 at 9:11 A.M. revealed Resident #35 was receiving supplemental oxygen at 3 LPM via nasal cannula; however, the humidifier bottle attached to the oxygen concentrator was dated 11/25 and was empty. Resident #35 reported dryness in their nose. An observation on 12/17/2025 at 8:39 P.M. revealed Resident #35 was receiving supplemental oxygen at 3 LPM via nasal cannula; however, the humidifier bottle attached to the oxygen concentrator was still dated 11/25 and empty. An observation on 12/18/2025 at 11:51 A.M. revealed Resident #35 was receiving supplemental oxygen at 3 LPM via nasal cannula; however, the humidifier bottle attached to the oxygen concentrator was still dated 11/25 and empty. Interview with Resident #35 at the time of the observation revealed Resident #35 reported dryness inside their nostrils. A concurrent observation and interview on 12/19/2025 at 9:00 A.M. revealed Resident #35 was receiving supplemental oxygen at 3 LPM via nasal cannula; however, the humidifier bottle attached to the oxygen concentrator was still dated 11/25 and empty. Resident #35 reported dryness inside their nostrils. Resident #35 stated she was angry because it had been weeks since their humidifier bottle was changed. During an interview on 12/20/2025 at 12:45 P.M., Licensed Practical Nurse (LPN) #9 stated humidifier bottles should be changed when empty. During an interview on 12/20/2025 at 1:11 P.M., LPN #3 stated humidifier bottles should be changed when empty. During an interview on 12/21/2025 at 11:05 A.M., LPN #10 stated humidifier bottles should be changed once a week and when the humidifier bottle was empty to promote cleanliness and to prevent dryness in a resident ' s nose. During an interview on 12/22/2025 at 3:23 P.M., the Director of Nursing (DON) stated the nurses should be checking and changing the humidifiers appropriately. During an interview on 12/22/2025 at 3:59 P.M., the Administrator stated humidifiers should be changed when empty. A facility policy titled, Oxygen Administration, revised 10/2010, indicated, the purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure, review the physician's orders or facility protocol for oxygen administration. The section of the policy titled, Steps in the Procedure, specified, for staff to check the mask, tank, and humidifying jar, to be sure they are in good working order and are securely fastened, to be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through and to periodically re-check water level in humidifying jar.

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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. **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 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 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 (continued on next page)

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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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#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. LPN #2 stated the medication was initially given during the day but was changed so the resident received the medication at night. LPN #2 stated Resident #101 had not complained about the medication being given at the wrong time. LPN #2 stated she was unable to remember why the time of the quetiapine was changed. LPN #2 stated when a resident was admitted , medication orders were listed on the hospital's continuity of care form. The LPN reviewed Resident #101's form and stated it indicated the quetiapine was to be given at night. LPN #2 reviewed the admission assessment and stated she admitted Resident #101 and must have missed seeing the medication was supposed to be given at night. LPN #2 stated she had no memory of Resident #101 being groggy or hard to awaken after receiving the quetiapine during the morning. The DON was interviewed on 12/21/25 at 10:28 A.M. and stated she met with Resident #101 several times. The DON stated sometimes the conversations were about the resident's medication and sometimes the resident had other questions. The DON stated there was a meeting with Resident #101 and a family member, at which time Resident #101 had stated they had missed a dose of Suboxone (a medication to treat opioid dependence) but had not mentioned anything about the quetiapine being given at the wrong time. The DON stated her expectations were for medications to be given as the physician ordered. The Administrator was interviewed on 12/21/25 at 3:46 P.M. and stated she expected medication to be given as ordered. 3. Review of the medical record revealed the facility admitted Resident #100 on 03/10/25. Diagnoses included acute respiratory failure, ventricular tachycardia, and atherosclerotic heart disease. Review of an admission MDS assessment, with an ARD of 04/05/25, indicated Resident #100 had a BIMS score of 14, which indicated the resident had intact cognition. Review of Resident #100's care plan included a focus area, revised on 08/22/25, that indicated the resident was at risk for a nutritional problem or potential nutritional problem related to a past medical history of dementia, atherosclerotic heart disease, congestive heart failure, hypertension, anemia, and peripheral vascular disease. Interventions directed staff to administer medications as ordered and obtain weights per order. Review of Resident #100's order summary report contained a physician's order dated 03/30/25 for the anitplatlet medication clopidogrel bisulfate (Plavix) 75 mg, one tablet by mouth once daily for ventricular tachycardia. Review of Resident #100's April 2025 MAR contained no documentation to indicate the clopidogrel bisulfate was administered as ordered on 04/20/25. Review of Resident #100's May 2025 MAR contained no documentation to indicate the clopidogrel bisulfate was administered as ordered on 05/10/25, 05/18/25, and 05/27/25. During an interview on 12/19/25 at 7:47 A.M., Registered Nurse (RN) #14 stated he would not administer Plavix to a resident if they had significant bruising or an order to hold the medication. RN #14 stated if any medications were refused, it should be documented, and the physician should be notified. During an interview on 12/19/25 at 12:32 P.M., the DON stated residents' Plavix orders included monitoring, which would include monitoring for bleeding, bruising, tarry stools, et cetera. Outside of that order set, Plavix would be held for a procedure, active bleeding, or per doctor's orders. The DON stated staff were expected to administer Plavix per physician orders; after review of Resident #100's MAR, the DON stated the medication should not have been held for Resident #100 in April and May 2025. During an interview on 12/22/25 at 2:36 P.M., LPN #2 stated clopidogrel bisulfate was probably held because of the parameters of the medication. Review of a facility policy titled, Administering Medications, revised 04/2019, revealed medications are administered in a safe and timely manner and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).This deficiency represents non-compliance investigated under Complaint Number 2650678 and 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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, record review, and interview, the facility failed to provide routine dental services for one (Resident #45) of one resident reviewed for dental services. The facility census was 92.Review of the admission record revealed that the facility admitted Resident #45 on 07/30/2024. According to the admission record, Resident #45 had a medical history that included traumatic subdural hemorrhage with loss of consciousness, cerebral infarction (stroke) due to unspecified occlusion or stenosis of an unspecified cerebral artery, and aphasia (a language disorder from brain damage that impairs speaking understanding, reading, or writing). Review of the annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/06/2025 revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated Resident #45 had moderate cognitive impairment. The MDS indicated Resident #45 had difficulty communicating some words or finishing thoughts but was able to be understood if given time. The MDS revealed the resident may miss some parts or the intent of a message but was able to comprehend most conversation. According to the MDS, Resident #45 had a limitation in functional range of motion on one side of the upper extremities. Resident #45 experienced no weight loss during the assessment ' s lookback period and had obvious or likely cavities and broken natural teeth. The MDS indicated Resident #45 required supervision or touching assistance from staff for completion of oral hygiene. Review of Resident #45's care plan report included a focus area revised on 03/23/2025, that revealed the resident had broken carious natural teeth. Interventions directed the nursing staff and the social worker to coordinate arrangements for dental care, transportation as needed/as ordered (revised 08/12/2024) and to provide oral evaluations per facility protocol (revised 08/12/2024). Review of Resident #45's Kardex (a plan of care used by the certified nursing assistants (CNAs) to provide care for the resident), active as of 12/16/2025, indicated the resident was dependent on staff for personal hygiene and oral care. Review of Resident #45's order summary report with active orders as of 12/16/2025, revealed an order dated 02/10/2025, for the resident to receive a regular diet with a regular texture. Further review revealed no orders for a dental consultation. Review of Resident #45's electronic medical record revealed no documentation that indicated the resident had a dental appointment since their 07/30/2024 admission. During an observation on 12/15/2025 at 10:25 A.M., Resident #45 was unable to answer questions and was observed to be missing teeth. During an observation on 12/15/2025 at 12:41 P.M., Resident #45 was observed eating without problem and consumed approximately 75% of the meal. During an interview on 12/20/2025 at 11:55 A.M., the Medical Records Director (MRD) #63 stated if a resident requested to be seen by a dentist, their name went on a form that was submitted to the dental company. MRD #63 stated that if the resident was unable to request to be seen, then the nursing department could make the request. MRD #63 stated the resident ' s representative had to consent for the resident to be seen, or they were unable to have a dental consultation. MRD #63 stated after a dentist visit, the dental consultation report was uploaded into the electronic medical record. MRD #63 stated that if Resident #45 had no consultation report in their electronic medical record, that meant the resident had not been seen by the dentist. MRD #63 was unable to give a reason why Resident #45 had not had a dental appointment and stated that since the resident was unable to give consent, she was responsible for contacting the resident ' s representative. MRD #63 stated it had been a while since she had spoken with the resident ' s representative and added there was no documentation that she had contacted Resident #45 ' s representative regarding dental care. MRD #63 stated reasonable dental care visits were at least yearly. During an interview on 12/20/2025 at 2:02 P.M., CNA #18 stated that Resident #45 had no problem eating and did not seem to be in pain although the resident was missing teeth. During an interview on 12/21/2025 at 9:48 A.M., the Director of Nursing (DON) stated residents should be seen by a dentist at least twice a year. The DON stated that if staff had approached a resident representative for consent and consent for dental services was declined, there should be (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation in the electronic medical record. The DON stated the social services department usually assisted with making appointments, but the facility had gaps in having a social worker. The Administrator was interviewed on 12/21/2025 at 3:20 P.M. and stated that dental services should be provided to residents once or twice a year. The Administrator stated that if the staff contacted the resident ' s representative and they declined services, documentation should be found in the electronic medical record.

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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. 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 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on record review, interview, and facility policy review, the facility failed to maintain a current hospice plan of care for one (Resident #03) of one resident reviewed for hospice services. The facility census was 92. Review of the admission Record indicated the facility admitted Resident #03 on 01/20/2022. According to the admission Record, the resident had a medical history that included metabolic encephalopathy, type II diabetes mellitus, emphysema, and non-pressure chronic ulcer of the right lower leg. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/21/2025, indicated Resident #03 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #03 received hospice services. Review of Resident #03's Care Plan Report, included a focus area initiated 04/01/2025, that indicated the resident had a terminal condition and received hospice services that began 03/31/2025. The care plan included the name of the hospice company, address, and phone number. Interventions directed staff that good communication with hospice should be maintained (initiated 04/01/2025). Further review revealed there were no staff assigned to lead this intervention. Review of Hospice documentation found in the resident's hospice binder, kept at the nurse's station, indicated a Registered Nurse (RN) had made a routine visit on 04/02/2025, 04/09/2025, 04/22/2025, 04/29/2025, 05/07/2025, 05/15/2025, 05/21/2025, 11/12/2025, 11/14/2025, 11/18/2025, 11/24/2025, 12/02/2025, 12/05/2025, 12/12/2025, and 12/19/2025. Review of the Hospice and Facility Coordinated Plan of Care, found in Resident #03's hospice binder was blank. Review of the hospice Comprehensive Assessment and Plan of Care Update Report, dated 07/24/2025 at 9:01 A.M. was the most recent plan of care in Resident #03's hospice binder. The report indicated that the last hospice visit had been 07/22/2025. The report revealed that the benefit period dates were 06/29/2025 to 09/26/2025. During an interview on 12/19/2025 at 9:00 A.M., Licensed Practical Nurse (LPN) #10 stated she did not usually work on the unit where Resident #03 lived and was unaware of where a hospice binder was kept or even if there was a hospice binder for Resident #03. LPN #10 stated she did not know which hospice company provided services for the resident. LPN #10 stated if something happened to Resident #03 and she needed to call the hospice provider she would notify the Director of Nursing (DON). During an interview on 12/19/2025 at 4:00 P.M., Registered Nurse (RN) #4 stated he was unaware Resident #03 received hospice services. RN #4 stated he would be able to find the information about Resident #03's hospice services in the electronic medical record but was unable to find any information. RN #4 stated when hospice staff came into the building to visit residents, they spoke with facility staff. RN #4 looked for the hospice plan of care in the hospice binder and confirmed the end date for the plan of care was 07/2025 and there was no current plan of care in Resident #03's hospice binder. During an interview on 12/20/2025 at 4:16 P.M., the DON stated a current hospice plan of care should always be in the resident ' s chart. The DON stated she had recently assumed her position and realized there was an issue with receiving information from the hospice company. During an interview on 12/21/2025 at 9:40 A.M., the DON stated she had not expected the hospice plan of care to be outdated. The Administrator was interviewed on 12/21/2025 at 3:14 P.M. The Administrator stated she expected an updated care plan to be given to the facility for each resident. During a follow-up interview with the Administrator on 12/22/2025 at 8:36 A.M. and stated that there had been no staff training on hospice. A facility policy titled, Hospice Program, revised 07/2017, indicated, Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident ' s highest practicable physical, metal, and psychosocial well-being.