

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Arc at Trotwood LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5790 Denlinger Road Dayton, OH 45426	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on medical record review, staff interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to develop a comprehensive person-centered care plan for a resident who developed pressure ulcers while residing in the facility. This affected one (#30) out of the three residents reviewed for pressure ulcer care and services. The facility census was 68.</p> <p>Findings include:</p> <p>Review of the medical record for the Resident #30 revealed an admitted [DATE] with medical diagnoses of metabolic encephalopathy, diabetes mellitus, history of cerebral infarction, dysphagia, hypertension, and hypothyroidism. Review of the medical record revealed a discharge date of [DATE].</p> <p>Review of the medical record for Resident #30 revealed an admission Minimum Data Set (MDS) assessment, dated 09/09/24, which indicated Resident #30 had moderate cognitive impairment. The MDS indicated Resident #30 required supervision/touching assistance with eating and was dependent upon staff for toilet hygiene and transfers and required substantial/maximum assistance for bathing and bed mobility. The MDS revealed Resident #30 was always incontinent of bladder and bowel, was at risk for skin breakdown, and did not have any skin breakdown present upon admission.</p> <p>Review of the medical record for Resident #30 revealed a skin assessment, dated 10/01/24, for an unstageable pressure ulcer to mid-sacrum which was first observed on 09/30/24. The measurements were 3 centimeters (cm) by 2.5 cm by 1 cm with 100% slough present and no tunneling noted. The assessment indicated a treatment was ordered, family was notified, and interventions in place included pressure relieving cushion to bed and chair, wound care, turn and reposition every two hours and as needed, daily skin checks by Certified Nursing Assistant (CNA) and off-loading.</p> <p>Review of the skin assessment, dated 10/15/24, revealed the unstageable pressure ulcer to mid-sacrum measured 13 cm by 5.5 cm prior to debridement and had 100% slough. The skin assessment noted the wound had worsened and had an odor and large amount of purulent drainage. The skin assessment also revealed a deep tissue injury (DTI) to right buttock which measured 5.5 cm by 2.0 cm with 100% necrotic tissue and a DTI to left buttock which measured 6 cm by 2 cm with 100% necrotic tissue.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record for Resident #30 revealed a physician order dated 09/30/24 for low air loss mattress, and an order dated 10/02/24 to cleanse mid-sacral wound with normal saline, apply Santyl, nickel thick layer, cover with moist gauze and cover with dry clean dressing daily and as needed which was discontinued on 10/08/24. Review of the orders revealed an order dated 10/08/24 to cleanse mid-sacral wound with normal saline, apply Santyl, nickel thick layer, cover with moist gauze and cover with dry clean dressing daily and as needed and to apply 20% zinc around the wound. The order was discontinued on 10/15/24. The medical record revealed an order dated 10/15/24 to cleanse mid-sacral wound with normal saline, apply Santyl nickel thick layer, cover with moist gauze and cover with dry clean dressing daily and as needed and orders to cleanse left and right buttocks with normal saline, apply xeroform to wound bed and cover with dry clean dressing every shift and as needed.</p> <p>Review of the medical record for Resident #30 revealed a baseline care plan dated 09/01/24 which indicated the resident was at risk for skin breakdown and the interventions included encourage good nutrition, keep skin clean and dry, provide pressure relieving or reducing devices, minimize pressure over boney prominence's, and record skin changes. Further review of the medical record for Resident #30 revealed no documentation to support the facility developed a comprehensive person-centered care plan for Resident #30's newly developed pressure ulcers.</p> <p>Interview on 10/22/24 at 1:55 P.M. with MDS Nurse #215 confirmed the medical record for Resident #30 did not have documentation to support the facility developed a comprehensive person-centered care plan for Resident #30's pressure ulcers. MDS Nurse #215 stated the facility utilized the RAI manual 3.0 for guidelines on care plan development.</p> <p>Review of the RAI 3.0 manual, dated October 2023, page 4-8, stated the comprehensive care plan is an interdisciplinary communication tool that must include measurable objectives and time frames. The comprehensive care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The RAI manual continued to state the care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00158988, OH00158969 and OH00158968.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46613</p> <p>Based on medical record review, observations and staff interview, the facility failed to follow infection control procedures while performing wound care. This affected one (#11) out of three residents reviewed for infection control. The facility census was 68.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #11 revealed an admitted [DATE] with medical diagnoses of end stage renal disease, diabetes mellitus, obesity, right sided hemiparesis, and atherosclerotic heart disease.</p> <p>Review of the medical record for Resident #11 revealed a quarterly Minimum Data Set (MDS), dated [DATE], which indicated Resident #11 had moderate cognitive impairment and required substantial/maximum staff assistance for toilet hygiene, bathing, and bed mobility and was dependent upon staff for transfers.</p> <p>Review of the medical record for Resident #11 revealed a skin assessment, dated 10/15/24, which indicated Resident #11 had a deep tissue injury (DTI) to left heel which measured 2 centimeters (cm) by 2 cm with 100% eschar. The assessment revealed the DTI was first observed 06/18/24.</p> <p>Review of the medical record for Resident #11 revealed a physician order dated 07/10/24 to apply barrier wipe/spray to left heel daily and as needed. Review of the physician orders revealed no documentation to support an order for Enhanced Barrier Precautions (EBP).</p> <p>Observation on 10/22/24 at 9:42 A.M. revealed Director of Nursing (DON) and Wound Physician #230 provided wound care for Resident #11 pressure ulcer to her left heel. The observation revealed DON wash hands, apply gloves and remove old dressing. Wound Physician #230 measured the wound and provided the description of the wound to Licensed Practical Nurse (LPN) #209. Wound Physician #230 stated the pressure ulcer to Resident #11's left heel was 2 cm by 2 cm with 80% eschar and wet granulation, with no infection noted. DON was observed to wash hands and apply new gloves and the treatment to Resident #11's left heel was completed as ordered. The observation revealed DON did not don a gown during wound care. The observation also revealed Resident #11's room did not have a sign posted for EBP or personal protective equipment (PPE) available near Resident #11's room.</p> <p>Interview on 10/22/24 at 1:30 P.M. with DON confirmed he had not donned a gown for Resident #11's wound care. DON stated the facility did not follow EBP for Resident #11 and the resident should have been in EBP.</p> <p>The deficiency is based on incidental findings discovered during the course of this complaint investigation.</p>		