

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 08/27/2025
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record and facility policy review, the facility failed to securely store medications. This affected one resident (#57) of five reviewed for medication administration. The facility census was 89. Findings include: Review of the medical record for Resident #57 revealed an admission date of 01/22/25 with diagnoses including but not limited to dysphagia following cerebral infarction, type two diabetes, hemiplegia and hemiparesis affected the non-dominant side. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #57 revealed an intact cognition. Resident #57 required set up assistance for eating. Resident #57 was totally dependent on staff for toileting, transfers and bed mobility. Review of the physician orders for Resident #57 revealed an order stating resident required assistance from staff to complete self-care and mobility due to hemiplegia dated 06/17/25 and an order for Fluticasone Propionate Nasal Suspension 50 micrograms two spray in both nostrils two times a day for allergies dated 05/16/25. The resident did not have an order to self-administer medications. Observation on 08/26/25 at 8:18 A.M. of medication administration with Licensed Practical Nurse (LPN) #281 revealed nurse prepared medication for Resident #57 including gathering the Fluticasone Propionate Nasal Suspension 50 micrograms nasal spray and entered the resident room. LPN #281 attempted to administer Fluticasone Propionate Nasal Suspension 50 micrograms to resident when he responded that he already did that pointing a bottle of nasal spray which was sitting on his bedside table. Resident #57 stated the night shift left the nasal spray in his room the night before. LPN #281 administered the other prescribed medications, removing the bottle of Fluticasone Propionate Nasal Suspension 50 micrograms off of the resident's bedside table when she left the room. Interview on 08/26/25 at 8:25 A.M. with LPN #281 verified the bottle of Fluticasone Propionate Nasal Suspension 50 micrograms should not have been in the room and verified the resident did not have a physician order for medication self-administration. Interview on 08/26/25 at 2:41 P.M. with Director of Nursing (DON) verified medications should not be left in the resident's room. Review of the facility policy titled Medication Labeling and Storage dated 02/2023 states that medications and biologicals are in locked in compartments and only authorized personnel have access to keys.</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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record and facility policy review, the facility failed to ensure the medical record was accurate. The facility documented medication as administered by facility staff when it was self-administered by the resident without nursing supervision. This affected one resident (#57) of five reviewed for medication administration. The facility census was 89. Findings Include: Review of the medical record for Resident #57 revealed an admission date of 01/22/25 with diagnoses including but not limited to dysphagia following cerebral infarction, type two diabetes, hemiplegia and hemiparesis affected the non-dominant side. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #57 revealed an intact cognition. Resident #57 required set up assistance for eating. Resident #57 was totally dependent on staff for toileting, transfers and bed mobility. Review of the physician orders for Resident #57 revealed an order stating resident required assistance from staff to complete self-care and mobility due to hemiplegia dated 06/17/25 and an order for Fluticasone Propionate Nasal Suspension 50 micrograms two spray in both nostrils two times a day for allergies dated 05/16/25. The resident did not have an order to self-administer medications. Observation on 08/26/25 at 8:18 A.M. of medication administration with Licensed Practical Nurse (LPN) #281 revealed nurse prepared medication for Resident #57 including gathering the Fluticasone Propionate Nasal Suspension 50 micrograms nasal spray and entered the resident room. LPN #281 attempted to administer Fluticasone Propionate Nasal Suspension 50 micrograms to resident when he responded that he already did that pointing a bottle of nasal spray which was sitting on his bedside table, Resident #57 stated the night shift left the nasal spray in his room the night before. Observation on 08/26/25 at 8:23 A.M. LPN #281 was observed to sign the medication administration record (MAR) for Resident #57 for Fluticasone Propionate Nasal Suspension 50 micrograms indicating it was administered by LPN #281. Interview on 08/26/25 at 2:41 P.M. with Director of Nursing (DON) verified the nurse should not have documented the Fluticasone Propionate Nasal Suspension 50 micrograms as administered in the MAR when it was not witnessed by the nurse as being administered. Review of the facility policy titled Administering Medications dated 04/2019 states the individual administering the medication initials the resident MAR on the appropriate line after giving each medication and before administering the next one. This violation represents non-compliance investigated under Complaint Number 2575242.</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** Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were administered in a way to avoid cross contamination. This affected one resident (#86) of five residents observed during medication administration. The Facility census was 89. Findings Include: Medical record review for Resident #86 revealed the resident was admitted to the facility on [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease, epilepsy, and nontraumatic intracerebral hemorrhage. Review of the quarterly Minimum Data Set (MDS) assessment for Resident #86 dated 08/12/25 revealed intact cognition. Resident #86 required set up assistance to moderate assistance for activities of daily living. Review of the physician orders for Resident #86 for the month of August 2025 revealed resident had an order for Aspirin enteric coated delayed release 81 milligram (mg) tablet, give one tablet one time a day dated 12/15/24. Observation of medication pass on 08/26/25 at 7:47 A.M. with Licensed Practical Nurse (LPN) #278 revealed hand hygiene was completed then the nurse was observed to retrieved medication cart keys, unlocked medication cart, pulled open cart drawer and touch multiple bottles before opening a stock bottle of aspirin. LPN #278 dispensed one tablet into the lid of the stock bottle and in the process dropped one tablet onto the medication cart. LPN #278 picked up the aspirin from the surface of the medication cart and put it back in the multiple dose bottle, securing the cap and was observed to place the bottle back in the medication cart. Interview on 08/26/25 at 7:57 A.M. with LPN #278 verified she picked up the tablet and put it back into the bottle with the other tablets. LPN #278 stated she probably should have thrown the tablet away. Interview on 08/26/25 at 2:41 P.M. with the Director of Nursing (DON) verified nurses are not to touch medications with bare hands. Review of the facility policy titled Administering Medication dated 04/2019 states staff follows established facility infection control procedures for the administration of medications. This violation represents non-compliance investigated under Complaint Number 1377238.</p>		