STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365309	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Trotwood LLC	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record, staff interview, and policy review, the facility failed to notify family of a resident's change of condition and/or regarding new physician orders. This affected one (#114) out of three residents reviewed for change of condition. The facility census was 102. Findings include: Record review for Resident #114 revealed this resident was admitted to the facility on [DATE] with the following diagnoses: anoxic brain damage, human immunodeficiency virus, end stage renal disease, dependence on renal dialysis, heart failure, tracheostomy, and sepsis. Resident #114 was Full Code. Review of Minimum Data Set (MDS) assessment dated [DATE] Medicare 5-day revealed this resident had impaired cognition evidenced by a Brief Interview for Mental Status (BIMS) score of 99. Unable to respond, Trach, pain regiment, feeding tube, pressure ulcer, continuous oxygen therapy, hemodialysis, anticoagulant, anticonvulsant. Review of progress notes for Resident for Resident #114 on 01/28/26 Licensed Practical Nurse (LPN) #123 noted at 8:26 A.M, Resident #114 had a bounding heart rate of 140, respirations 36, blood pressure, 95/62, temperature 98.9 degrees Fahrenheit, oxygen at 93% with trach in place, and using accessory muscles. The physician was contacted a verbal order given to administer Lopressor 50 milligrams (mg) and to repeat vital signs in thirty minutes. The physician was contacted of a heart rate of 112, respirations 24, and blood pressure 80/50. A new order to give midodrine 10 mg now and every six hours as needed, complete blood count and basic metabolic panel lab work complete now. Urinalyses with culture and sensitivity and chest radiograph to be completed now. No family was notified of change of condition or new orders. Interview on 01/28/25 at 8:41 A.M. with Director of Nursing verified no family was notified of Resident #114's change of condition or regarding the new orders. Review of facility policy Change in a Resident's Condition of Status, dated February 2001, revealed nurse will notify the resident's representative changes in medical care of nursing treatments and significant changes in mental or physical condition. This deficiency represents non-compliance investigated under Complaint Numbers 2740073 and 2725566.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 medical record reviews, staff and resident interviews, and policy review, the facility failed to ensure baths/showers were offered or completed as scheduled. This affected two (#85 and #112) out of three residents reviewed for activities of daily living (ADLs). The facility census was 102. Findings include: 1. Review of the medical record for Resident #85 revealed an admission date of 03/28/25 with medical diagnoses of cirrhosis of the liver, left above the knee amputation, diabetes mellitus (DM). Review of the medical record for Resident #85 revealed a quarterly Minimum Data Set (MDS) assessment, dated 01/01/26, which indicated Resident #85 was cognitively intact and required supervision for toilet hygiene, transfers, and set-up for eating and bed mobility. Review of the medical record for Resident #85 revealed shower documentation from 01/02/26 to 02/06/26 indicated the following: 01/02/26 refused, 01/09/26 completed, 01/16/26 completed, 01/20/26 refused, 01/23/26 completed, 01/27/26 completed and 02/06/26 completed. Further review revealed no documentation to support staff offered or provided a bath/shower after 01/02/26 until 01/09/26 and after 01/27/26 until 02/06/26. 2. Review of the medical record for Resident #112 revealed an admission date of 12/09/24 with medical diagnoses of chronic obstructive pulmonary disease, morbid obesity, diabetes mellitus, and chronic respiratory failure. Review of the medical record for Resident #112 revealed an annual Minimum Data Set (MDS) assessment, dated 12/11/25, indicated Resident #112 was cognitively intact and was independent with eating, bed mobility, toileting hygiene, and set-up assistance with showers and transfers. Review of medical record for Resident #112 revealed shower documentation from 01/07/26 to 02/07/26 indicated the following: 01/07/26 resident not available, 01/14/26 refused, 01/17/26 completed, 01/21/26 resident not room, 01/28/26 completed, 01/31/26 completed, 02/04/26 refused, and 02/07/26 completed. Further review revealed no documentation to support staff offered or provided a bath/shower after 01/07/26 until 01/14/26 and after 01/14/26 until 01/28/26. Interview on 02/09/26 at 2:03 P.M. with Resident #112 stated staff do not provide assistance with showers as scheduled. Interview on 02/11/26 at 9:21 A.M. with Director of Nursing (DON) stated if a resident was not available at the time of scheduled bath/shower then staff were to offer the opportunity to bath/shower the next day and staff were to document any refusals. DON confirmed the medical records for Residents #85 and #112 did not have documentation to support bath/showers were provided or offered as scheduled. Review of the policy stated, Activities of Daily Living (ADLs), revised April 2025 stated residents who are unable to carry out ADLs independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The policy stated cares/services included hygiene (bathing, dressing, grooming, and oral care), mobility (transfers and ambulation), elimination (toileting), dining (eating, including meals and snacks), and communication. The policy stated if resident refuses care that the resident was offered alternative interventions to minimize further decline and the refusals and details of the interventions refused are documented in the resident's clinical record. This deficiency represents non-compliance investigated under Complaint Number 2692596, 2705548, and 2725566.

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Arc at Trotwood LLC	5790 Denlinger Road Dayton, OH 45426

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. Based on observation and staff interview, the facility failed to ensure an Automated External Defibrillator (AED) device had new pads available for use in the event of a medical emergency. This had the affect on 18 out 19 residents the facility identified as a full code on the Rehab Hall. The census was 102. Findings include: Observation on 01/29/26 at 12:01 P.M. with Assistant Director of Nursing (ADON) of crash cart on Rehab Hall revealed AED (a portable life-saving device) was lying on top of crash cart with no pads connected to the AED. Observations revealed no pads were in the compartments of the AED or in the crash cart. On top of the crash cart was an items listed for daily checks. All items were checked off daily. There were no check off box to check AED for working order or if pads were in place. Interview on 01/29/26 at time of finding with revealed ADON verified no pads for AED were ready available. The facility confirmed 18 out of the 19 residents on the Rehab Hall are Full Code and this is the crash cart/AED that would be used in the event of an emergency or code situation. This deficiecny represents non-compliance investigated under Complaint Number 2725566.

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F 0689 Level of Harm - Minimal harm or potential for 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 reviews, observation, staff and resident interviews, review of facility incident/accident log, and policy and procedure review, the facility failed to ensure smoking/vaping devices were properly secured and not at bedside. This affected one (#85) out of three residents reviewed for smoking. The facility also failed to ensure a resident's fall was investigated and interventions were implemented and failed to ensure neurological checks were completed after a unwitnessed falls. This affected one (#115) out of three residents reviewed for falls. The facility census was 102. Findings include:1.Review of the medical record for Resident #85 revealed an admission date of [DATE] with medical diagnoses of cirrhosis of the liver, left above the knee amputation, diabetes mellitus (DM). Review of the medical record for Resident #85 revealed a quarterly Minimum Data Set (MDS) assessment, dated [DATE], which indicated Resident #85 was cognitively intact and required supervision for toilet hygiene, transfers, and set-up for eating and bed mobility. Review of the medical record for Resident #85 revealed a Smoking Safety evaluation, dated [DATE], which indicated Resident #85 used tobacco and required staff supervision for smoking and was not able to store smoking materials. The smoking evaluation stated Resident #85 did not use electronic cigarettes/vaping devices. Review of the medical record for Resident #85 revealed a smoking care plan which stated Resident #85 was a smoker but did not indicate if Resident #85 was independent or required staff supervision with smoking. Observation with interview on [DATE] at 8:36 A.M. revealed Resident #85 lying in bed and a vaping device was noted to be lying on the bed near Resident #85's hand. Interview with Resident #85 confirmed that was his vape and that he used it sometimes in his room. Interview on [DATE] at 8:38 A.M. with MDS nurse #103 confirmed Resident #85 had a vaping device lying on his bed next to him. MDS nurse #103 stated she was not aware that Resident #85 used a vaping device and thought he only used tobacco products. MDS #103 also confirmed Resident #85's smoking evaluation had not been updated since [DATE]. 2.Review of the medical record for Resident #115 revealed an admission date of [DATE] with medical diagnoses of hypertensive heart and chronic kidney disease, end stage renal disease, and anemia. Review of the record revealed Resident #115 expired on [DATE]. Review of the medical record for Resident #115 revealed a quarterly MDS assessment, dated [DATE], which indicated Resident #115 was cognitively intact and required partial/moderate staff assistance with bathing, bed mobility, and transfers and supervision with toilet hygiene. Review of the medical record for Resident #115 revealed a Fall Risk assessment, dated [DATE], which indicated Resident #115 only had one to two falls in the past three months and was not at risk for falls. Review of the medication record for Resident #115 revealed nursing notes which stated Resident #115 had falls on 10//04/25, [DATE], [DATE], and [DATE]. Review of nurse's note on [DATE] stated Resident #115 sustained an unwitnessed fall. Further review of the medical record revealed no documentation to support the facility initiated neurological checks after the unwitnessed fall. Review of the medical record revealed a Change of Condition evaluation dated [DATE] which stated Resident #115 had an unwitnessed fall but did contain any nurse progress notes related to the fall. Further review revealed the facility had not initiated neurological checks after the unwitnessed fall on [DATE]. Review of the facility incident log revealed no documentation to support the facility completed an investigation into or implemented interventions for Resident #115's fall on [DATE]. Interview on [DATE] at 1:50 P.M. with Licensed Practical Nurse (LPN) #192 confirmed Resident #115's medication record did not contain documentation to support neurological checks were initiated after falls on [DATE] or [DATE]. LPN #192 stated the facility had not investigated or implemented any interventions for Resident #115's fall on [DATE]. Review of the facility policy (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Smoking- Residents, revised [DATE] stated smoking is only permitted in designated resident smoking areas, which are located outside of the building. The policy stated smoking is not allowed inside the facility under any circumstances. The policy continued to state electronic cigarettes and smokeless tobacco are permitted in designated areas only. Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc, except under direct supervision. The policy stated electronic cigarettes (e-cigarettes) are not considered smoking devices with respect to the risk of ignition, but they are considered a risk for residents related to potential health effects for the smoker, second-hand aerosol exposure, nicotine overdose by ingestion or contact with the skin, and explosion or fire caused by the battery. To prevent accidents associated with e-cigarettes and to respect the rights of residents who do not want to be exposed to second-hand aerosol, residents are permitted to use e-cigarettes with supervision and in designated smoking areas only. Review of the facility form titled, Procedure: Resident Fall Response and Documentation, stated the purpose was to ensure consistent, timely, and complete response to resident falls, including resident safety, family and physician communication, and documentation in Point Click Care (PCC). Stated nursing staff are to assess the resident immediately for injuries and vital signs, to notify the attending physician or on-call immediately, to notify family or responsible party of any falls or injuries, complete a fall risk event entry in PCC, to enter all required interventions into PCC and document narrative notes that include circumstances of the fall, resident's condition after the fall, interventions performed, and notifications completed. The procedure stated to initiate and document neurological checks per protocol for head injury/unwitnessed falls, reassess the resident's fall risk level and update care plan accordingly. This deficiency represents non-compliance investigated under Complaint Number 2692596.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and resident interviews, and policy review, the facility failed to administer medications as per physician orders. This affected one (#112) out of three residents reviewed for medication administration. The facility census was 102. Findings include: Review of the medical record for Resident #112 revealed an admission date of 12/09/24 with medical diagnoses of chronic obstructive pulmonary disease, morbid obesity, diabetes mellitus, and chronic respiratory failure. Review of the medical record for Resident #112 revealed an annual Minimum Data Set (MDS) assessment, dated 12/11/25, indicated Resident #112 was cognitively intact and was independent with eating, bed mobility, toileting hygiene, and set-up assistance with showers and transfers. Review of the medical record for Resident #112 revealed a physician order dated 12/09/24 for metformin 500 milligram (mg) one tablet by mouth two times per day, orders dated 12/10/24 for ferrous sulfate 325 mg one tablet by mouth daily, loratadine 10 mg one tablet by mouth daily, Theragran-M one tablet by mouth daily, and montelukast sodium 10 mg one tablet by mouth daily. Further review revealed physician orders dated 10/01/25 for ibuprofen 800 mg one tablet by mouth three times per day, 10/02/25 for methocarbamol 750 mg one tablet by mouth three times daily, and 01/16/25 for Os-Cal 500-150 mg one tablet by mouth daily. Review of the medical record for Resident #112 revealed the November 2025 Medication Administration Record (MAR) which had no documentation to support medications were administered as ordered on 11/12/15, 11/21/25, 11/25/25, 11/27/25, and 11/28/25. Review of the January 2026 MAR revealed no documentation to support Resident #112 received medications as ordered on 01/22/26 and 01/23/26. Interview on 02/09/26 at 2:03 P.M. with Resident #112 stated he does not get his medications at times. Interview on 02/11/26 at 9:50 A.M. with Administrator confirmed the medical record for Resident #112 did not have documentation to support medications were administered as ordered on 11/12/15, 11/21/25, 11/25/25, 11/27/25, 11/28/25, 01/22/26, and 01/23/26. Review of the facility policy titled, Administering Medications, revised April 2019 stated medication are administered in a safe and timely manner and as prescribed. The policy stated medications are administered in accordance with prescriber's orders, including any required time frame. This deficiency represents non-compliance investigated under Complaint Number 2705548.

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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 interviews, and policy review, the facility failed to administer insulin as ordered and to ensure blood pressure medications were administered per the ordered parameters resulting in significant medication errors. This affected one (#64) out of three residents reviewed for medications. The facility census was 102. Findings include: Review of the medical record for Resident #64 revealed an admission date of 10/18/25 with medical diagnoses of acute and chronic respiratory failure, dysphagia, chronic obstructive pulmonary disease (COPD), diabetes mellitus (DM), and end stage renal disease (ESRD). Review of the medical record for Resident #64 revealed an admission Minimum Data Set (MDS) assessment, dated 10/31/25, which indicated Resident #64 was cognitively intact and required substantial/maximum assistance with toilet hygiene and bathing, was dependent upon staff for transfers, and required supervision with bed mobility. Review of the medical record for Resident #64 revealed a physician order dated 10/20/25 for midodrine 10 mg one tablet via percutaneous endoscopic gastrostomy tube (peg-tube) three times per day for hypotension and to hold if systolic blood pressure (SBP) was greater than 110, an order dated 10/22/25 for insulin lispro solution pen-injector 100 units per milliliter (ml) to inject 8 units subcutaneously (SQ) before meals and at bedtime, an order dated 10/27/25 for allopurinol 100 milligram (mg) one tablet via peg-tube daily, and orders dated 10/28/25 for metoprolol 25 milligram (mg) one tablet via peg-tube two times per day for hypertension and to hold if SBP was less than 100 or diastolic blood pressure (DBP) was less than 60, apixaban 5 mg one tablet via peg-tube daily, rifaximin 550 mg one tablet via peg-tube two times per day for encephalopathy, acetaminophen 650 mg via peg-tube three times per day, and ipratropium-albuterol inhalation solution 3 mg per ml to inhale 3 ml orally every four hours. Further review of the physician orders revealed an order dated 10/30/25 for lansoprazole 3 mg per ml to give 10 ml via peg-tube daily, an order dated 11/02/25 for Lantus Solostar solution pen-injector 100 units per ml to inject 28 units SQ two times per day, and an order dated 11/10/25 for Advair discus inhalation aerosol powder breath activated 100-50 micrograms per activation one puff inhale two times per day for asthma. Review of the medical record for Resident #64 revealed the Medication Administration Record (MAR) for December 2025 revealed no documentation to support medications were administered as ordered on 12/10/25- 12/12/25, 12/15/25, 12/29/25, or 12/30/25. Review of the January 2026 MAR revealed documentation to support blood pressure medications (metoprolol and midodrine) were administered outside of blood pressure parameters on 01/03/26, 01/06/26, 01/07/26, 01/11/26, 01/13/26, 01/14/26, 01/15/26, and 01/16/26. Interview on 01/29/26 at 9:42 A.M. with Registered Nurse (RN) #275 confirmed the medical record for Resident #64 revealed no documentation to support Resident #64 received medications, including insulin, as ordered on 12/10/25-12/12/25, 12/15/25, 12/29/25, or 12/20/25. RN #275 confirmed Resident #64 was administered blood pressure medications outside of blood pressure parameters on 01/03/26, 01/06/26, 01/07/26, 01/11/26, 01/13/26, 01/14/26, 01/15/26, and 01/16/26. Review of the facility policy titled, Administering Medications, revised April 2019 stated medication are administered in a safe and timely manner and as prescribed. The policy stated medications are (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered in accordance with prescriber's orders, including any required time frame. This deficiency represents non-compliance investigated under Complaint Number 2727077 and 2705548.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interview, the facility failed to ensure kitchen was kept in a clean and sanitary manner. This had the potential to affect all the residents who received trays from the kitchen, the facility identified two residents (#108 and #125) who did not receive meal trays. The facility census was 102. Findings include:Observation on 02/10/26 at 7:40 A.M. of the kitchen revealed grease had run down the grill from the drip pan into a metal pan and onto some towels on the floor. The observation revealed the drip pan had overflowed and the grease along the grill and in the metal pan and towels had solidified.Interview on 02/10/26 at 7:45 A.M. with Dietary Manager (DM) #108 confirmed the drip pan for the grill had overflowed and the grease had run down the grill into a metal pan and towels on the floor. DM #108 stated the handle to the drip pan had been broken for about four months. DM #108 stated usually maintenance would come to the kitchen daily to open the drip pan for the kitchen staff so the drip pan could be emptied. DM #108 confirmed the drip pan had not been emptied for a few days. The facility confirmed all residents receive meals from the kitchen, except two residents (#108 and #125).This deficiency represents non-compliance investigated under Complaint Number 2692596.