| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365309 | A. Building<br>B. Wing | 05/21/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Arc at Trotwood LLC | 5790 Denlinger Road<br>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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>Based on medical record review, staff interview, and review of the facility policy, the facility failed to notify resident guardians of new physician's orders. The affected one (Resident #59) of three residents reviewed for participation in care planning. The facility census was 99 residents. Findings include: Review of the medical record for Resident #59 revealed an admission date of 12/10/24 with diagnoses including schizophrenia, depression, and diabetes mellitus type two. Resident #59 had a court-appointed guardian of person since 2022 Review of the Minimum Data Set (MDS) assessment for Resident #59 dated 04/01/26 revealed the resident was moderately cognitively impaired and independently mobile. Resident had court appointed guardian of person since 2022. Review of the physician's orders for Resident #59 revealed an order dated 04/03/26 transcribed by Licensed Practical Nurse (LPN) #374 indicating the resident may leave the facility leave of absence (LOA). Interview on 05/18/26 at 1:46 P.M. with LPN #374 confirmed he transcribed a physician's order on 04/03/26 for Resident #59 to go on LOA but did not notify the guardian of the newly written order. LPN #374 stated when a resident receives a new order, the guardian of the resident should be notified. Interview on 05/18/26 at 2:24 P.M. with Regional Nurse (RN) #704 confirmed a guardian should be notified if a resident receives a new order. Regional Nurse #704 confirmed the facility had no documentation to demonstrate a previous guardian gave permission for Resident #59 to leave the facility. Interview on 05/18/26 at 2:28 P.M. with the Director of Nursing (DON) confirmed the facility nurse did notify Resident #59's guardian of the LOA order written on 04/03/26. Review of facility policy titled Therapeutic Leave of Absence revised April 2007 revealed residents leaving should be signed out on leave of absence. This deficiency represents noncompliance investigated under Complaint Number 2973107. |

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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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facility investigation, review of the Self-Reported Incident (SRI), staff interview, and policy review, the facility failed to timely report an allegation of neglect to the state agency. This affected one (Resident #59) of three residents reviewed for elopement. The facility census was 99 residents. Findings include: Review of the medical record for Resident #59 revealed an admission date of 12/10/24 with diagnoses including schizophrenia, type two diabetes mellitus, and depression.Review of the Minimum Data Set (MDS) assessment for Resident #59 dated 04/01/26 revealed the resident was moderately cognitively impaired and independently mobile. Review of the facility's investigation dated 05/01/26 revealed on 05/01/26 at 7:50 P.M. staff were unable to locate Resident #59. Staff initiated a search and implemented their missing resident protocol, which included contacting the local police department.Review of the SRI for Resident #59 dated 05/04/26 revealed the resident left the faciity on [DATE] and had not returned. The SRI indicated the facility initiated a search of the facility as well as the surrounding area and contacted the local police department for assistance, but were unable to locate the resident.Interview on 05/19/26 at 9:41 A.M. with Regional Nurse (RN) #704 confirmed the facility did not file the SRI for Resident #59 who went missing on 05/01/26 until 05/04/26. Review of the facility policy titled Emergency Procedure - Missing Resident revised August 2018 revealed incident of possible abuse and neglect should be reported to the state agency in the appropriate time frame. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on medical record review, staff interview, physician interview, and policy review, the facility failed to transcribe and implement physician orders in a timely manner. This affected one (Resident #102) of three residents reviewed for change in condition. The facility census was 99 residents. Findings include: Review of the medical record for Resident #102 revealed an admission date of 04/10/26 with diagnoses including acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, malignant neoplasm of the lung, and a discharge date of 04/20/26. Review of the Minimum Data Set (MDS) assessment for Resident #102 dated 04/14/26 revealed the resident was cognitively intact and required staff assistance with activities of daily living (ADLs.) Review of the physician's progress note for Resident #102 dated 04/16/26 per Physician #702 revealed the doctor gave telephone orders to Assistant Director of Nursing (ADON) #429 for the resident to have a chest x-ray, urinalysis, and complete blood count to be completed in two days.Review of the physician's orders for Resident #102 dated 04/16/26 to 04/20/26 revealed there were no orders transcribed for the resident to have a chest x-ray, urinalysis, and complete blood count. Interview on 05/20/26 at 3:21 P.M. via telephone with Physician #702 confirmed she provided orders on 04/16/26 at 8:04 A.M. to ADON #429 for Resident #102 for a chest x-ray and urinalysis to be completed on 04/16/26 and then another complete blood count two days later. Physician #702 stated she did not believe the orders were entered, because she had followed up with ADON #429. Physician #702 reported ADON #429 told the physician she had not entered the orders written on 04/16/26 because the nurse ran out of time. Interview on 05/20/26 at 4:34 P.M. with ADON #429 verified she had not transcribed any orders from Physician #702 for Resident #102 on 04/16/26. Review of the facility policy titled Telephone Orders revised February 2014 revealed verbal telephone orders must be transcribed in writing by the person receiving the order and recorded in the medical record.This deficiency represents noncompliance investigated under Complaint Number 2991724. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, staff interview, and facility policy review, the facility failed to ensure residents received adequate supervision and failed to ensure failed to provide the appropriate level of assistance during resident transfers . This affected two (Residents #59 and #103) of three residents reviewed for accidents and hazards. The facility census was 99 residents. Findings include: Review of the medical record for Resident #59 revealed admission date of 12/10/24 with diagnoses including schizophrenia, depression, and diabetes mellitus type two. Resident #59 had a court appointed guardian of person since 2022. Review of the Minimum Data Set (MDS) assessment for Resident #59 dated 04/01/26 revealed the resident was moderately cognitively impaired and independently mobile. Resident had court appointed guardian of person since 2022. Review of the physician's order for Resident #59 revealed an order dated 04/03/26 transcribed by Licensed Practical Nurse (LPN) #374 for resident may leave the facility on leave of absence (LOA.) Review of the care plan for Resident #59 dated 04/07/26 revealed the resident had a diagnosis and history of severe mental illness. Interventions included staff should monitor resident for aggressive behavior, noise levels, friendship patterns, common rehabilitative goals or services, sleep patterns, interests, recreational pursuits, and vulnerability as needed. Review of the medical record for Resident #59 revealed it did not include an assessment of the resident's appropriateness to leave the facility on an independent LOA. Review of facility investigation for Resident #59 dated 05/01/26 revealed the resident was discovered to be missing from the facility on 05/01/26 for the evening med pass. The facility initiated a search and implemented the missing resident protocol which included contacting local police department. Interview on 05/18/26 at 1:46 P.M. with Unit Manager (UM) #374 confirmed the facility did not conduct an assessment to determine if Resident #59 was safe to leave the facility on an independent LOA. UM #374 stated the facility conducted Brief Interview of Mental Status (BIMS) assessments on all of the residents on or around 04/03/26 and the decision to implement the order for the resident go on an independent LOA was based solely on the resident BIMS score and did not include other safety factors. Interview on 05/18/26 at 2:24 P.M. with Regional Nurse (RN) #704 confirmed the facility could not provide any evidence that Resident #59's former guardian gave the facility permission for resident to leave the facility independently. Interview on 05/18/26 at 2:28 P.M. with the Director of Nursing (DON) verified the facility did not contact Resident #59's guardian regarding the LOA order written on 04/03/26. The DON confirmed Resident #59 did not sign out the day he left the faciity on [DATE]. Interview on 5/19/26 at 9:37 A.M. with RN #704 confirmed resident returned to facility on 5/18/26 after leaving on 05/01/26. Regional Nurse #704 reported the resident did not disclose to facility staff where he has been staying while he was out of the facility for the past eighteen days. Interview on 5/19/26 at 11:13 A.M. with the Assistant Director of Nursing (ADON) verified LPN #348 notified her on 05/01/26 that Resident #59 was missing from the facility and had not signed himself out. The ADON confirmed Resident #59 was gone from facility from 05/01/26 and did not return until the evening of 05/18/26 and the resident did not disclose to the facility did not know where he had been while on LOA. Review of facility policy titled Therapeutic Leave of Absence revised April 2007 revealed residents could go out on therapeutic leave of absence when appropriate. 2.Review of medical record for Resident #103 revealed an admission date of 01/27/26 with diagnoses including traumatic subdural hemorrhage, hemiplegia and hemiparesis, and encounter for orthopedic aftercare. Review of the MDS assessment for Resident #103 dated 05/05/26 revealed the resident was dependent for shower/bathing, toileting hygiene, personal hygiene, and chair-to-bed-chair transfers. Review of care plan for Resident #103 dated 01/28/26 revealed the resident was at an increased risk for falls due to hemiplegia and hemiparesis and was to be transferred using via mechanical lift with two people. Interview on 05/21/26 at 9:12 A.M. with Certified Nurse Assistant (CNA) #409 confirmed<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | she had provided care to Resident #103 in April 2026. CNA #409 confirmed she had transferred Resident #103 by herself without use of mechanical lift several times from bed to chair and chair to bed. CNA #409 confirmed that sometimes when she used mechanical lift, the second person assisting her would leave the room while the mechanical lift was still being used to transfer a resident. CNA #409 confirmed she was not aware Resident #103 was care planned to be transferred by two people via mechanical lift. Review of facility policy titled Using a Mechanical Lift dated 2001 revealed at least two nursing assistants are needed to safely move a resident with mechanical lift when transferring a resident from bed to chair. This deficiency represents noncompliance investigated under Complaint Number 3000603. |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of the facility investigation, review of the Self-Reported Incident (SRI), staff interview, and policy review, the facility failed to ensure medical records were accurate and complete. This affected one (Resident #59) of three residents reviewed for documentation. The facility census was 99 residents. Findings include:Review of the medical record for Resident #59 revealed an admission date of 12/10/24 with diagnoses including schizophrenia, type two diabetes mellitus, and depression.Review of the Minimum Data Set (MDS) assessment for Resident #59 dated 04/01/26 revealed the resident #59 had moderately impaired cognition and was independently mobile. Review of the progress notes for Resident #59 dated 04/30/26 to 05/18/26 revealed there was no documentation that indicated the resident had left the facility without staff knowledge and without signing himself out and that his whereabouts from 05/01/26 to 05/18/26 were unknown.Review of the facility's investigation dated 05/01/26 revealed Resident #59 was unable to be located on 05/01/26 at around 7:50 P.M. which prompted staff to initiate a search and implement their missing resident protocol which included contacting the local police department.Review of the SRI dated 05/04/26 revealed Resident #59 left the faciity on [DATE] and had not returned. The SRI indicated the facility initiated a search of the facility as well as the surrounding area and contacted the local police department for assistance.Interview on 05/19/26 at 9:41 A.M. with Regional Nurse (RN) #704 verified there were no progress notes detailing the incident in Resident #59's medical record.Interview on 05/19/26 at 11:13 A.M. with Assistant Director of Nursing (ADON) #429 confirmed there should be a detailed progress note in the medical record regarding any leaves of absence from the facility.Review of the facility policy titled Charting and Documentation revised July 2017 revealed events or incidents involving residents were to be documented in the medical record. |