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	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Trotwood LLC	5790 Denlinger Road Dayton, OH 45426

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on interview and record review, the facility failed to notify residents that the amount of funds in their accounts was 200 dollars less than the Medicaid resource limit and that the residents may lose eligibility for Medicaid. This affected six (#10, #43, #5, #29, #27 and #11) out of seven residents reviewed for personal funds. The facility census was 97. Findings include: On 05/21/25 at 12:11 PM, during review of the list of resident funds documentation provided by the facility during the survey it was noted that Resident #10, #43, #5, #29, #27 and #11 were all Medicaid recipients and all had balances over $2,000 dollars in their funds accounts. Interview with Business Office Manager (BOM) #4 confirmed Resident #10, #43, #5, #29, #27 and #11 were Medicaid recipients and their balances were over the maximum amount allowed by Medicaid. BOM #4 was asked to provide spend down notification letters that were sent to the residents. BOM #4 stated that there were no spend down notification letters sent to the residents. BOM #4 stated that letters were on her desk but have not been sent.

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, record review, facility document review, and facility policy review, the facility failed to resolve a concern in a timely manner for 1 (Resident #66) of 2 residents reviewed for grievances. In addition, the facility failed to document concerns, ensure resolution, and provide feedback for 1 (Resident #57) of 2 residents reviewed for grievances. Findings included: A facility policy titled, Grievances, effective 03/2024, revealed, Purpose: To ensure prompt resolution of all grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their stay at this campus. The Grievances policy specified, Grievances may be filed orally (meaning spoken), in writing, or anonymously. The policy revealed, Every effort shall be made to resolve grievances in a timely manner, usually within 5 business days (excludes weekends and holidays). 1. An admission Record revealed the facility admitted Resident #66 on 03/07/2025. According to the admission Record, the resident had a medical history that included diagnoses of left non-dominant side hemiplegia (paralysis) and hemiparesis (muscle weakness) and cerebral infarction (stroke). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/14/2025, revealed Resident #66 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed Resident #66 had functional limitations in range of motion, impairment on one side of their upper and lower extremities and utilized a wheelchair for a mobility device. Resident #66's Care Plan Report, included a focus area initiated 03/08/2025, that revealed the resident had an activities of daily living (ADL) self-care performance deficit. Interventions directed staff to offer to assist the resident out of bed into a wheelchair daily (initiated 04/11/2025). A Concern/Compliment Form, dated 04/16/2025, revealed Resident #66 and their family member reported a concern via phone. The form specified, Nature of Concern/Compliment: Wheelchair 'Hydraulics' system is Broken. The Concern/Compliment Form revealed the facility's findings were that the wheelchair was the resident's personal wheelchair, and the facility's maintenance staff could not do anything with it. The form indicated a representative of the wheelchair manufacturer would be called. The Concern/Compliment Form revealed the facility followed up with Resident #66 on 04/21/2025, but the document was incomplete as it did not indicate whether the resident was satisfied with the outcome and actions taken. The form was signed by the notifying staff, the Administrator/Assistant Administrator, and the Grievance Official. During an interview on 05/12/2025 at 10:48 AM, Resident #66 stated they and their family member spoke to facility staff regarding their wheelchair not working properly. Resident #66 stated that the wheelchair's hydraulic system did not work. During an interview on 05/16/2025 at 9:16 AM, Resident #66 stated that the functions on the wheelchair control panel did not always work. Resident #66 stated they were told the therapy department would assist with their wheelchair. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/19/2025 at 9:43 AM, Family Member (FM) #40 stated the hydraulic system of Resident #66's wheelchair had not worked properly for a couple of months. FM #40 said they contacted the wheelchair company at the telephone numbers that were listed on the sticker on the wheelchair, and they were told the facility would have to make contact to get the wheelchair repaired. FM #40 confirmed they spoke to the Social Services Director (SSD) regarding the resident's wheelchair and the SSD stated she was not aware of the concern but would look into getting the wheelchair repaired. FM #40 stated they spoke to maintenance staff who stated they could not fix the wheelchair, and did not know what to tell the resident. FM #40 stated they told the Administrator that nothing was being done about the resident's wheelchair, and he stated he would look into it, but had not provided any response. During an interview on 05/16/2025 at 9:29 AM, the SSD confirmed Resident #66 filed a concern form regarding their wheelchair not working properly. The SSD stated the concern form was completed on 04/16/2025, but she had not contacted the wheelchair manufacturer's representative to come out and service the wheelchair. During an interview on 05/16/2025 at 9:49 AM, the Maintenance Director stated the facility did not complete repairs on residents' personal wheelchairs, but facility staff would contact the wheelchair manufacturer's representative to complete service and repairs. The Maintenance Director stated that the therapy department was responsible for contacting the representative. During an interview on 05/16/2025 at 10:14 AM, the Rehabilitation Director stated the facility would reach out to the durable medical equipment supplier for repair of a resident's personal wheelchair. The Rehabilitation Director stated she was not aware of a concern form regarding Resident #66's wheelchair needing repairs. She said maintenance staff could have notified the supplier's representative as there was a sticker (on the wheelchair) with the supplier's name and contact information. During an interview on 05/17/2025 at 10:34 AM, the Maintenance Director stated he would normally inform the therapy department about a broken wheelchair. The Maintenance Director stated he had not contacted a wheelchair company representative to have Resident #66's wheelchair repaired. The Maintenance Director stated the resident's concern was discussed in the morning meeting on 04/21/2025, but he did not know if there was any follow-up to ensure the wheelchair was repaired. During an interview on 05/17/2025 at 1:50 PM, the Director of Nursing (DON) stated he was not aware of any unresolved grievances for Resident #66 and was not aware that the resident's wheelchair needed to be repaired. During an interview on 05/18/2025 at 8:15 AM, the Administrator stated he was not aware of a concern regarding Resident #66's wheelchair. 2. An admission Record indicated the facility admitted Resident #57 on 07/02/2023. According to the admission Record, the resident had a medical history that included diagnoses of cerebral palsy, heart failure, and chronic obstructive pulmonary disease (COPD). (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/23/2025, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #57 required substantial to maximal assistance with showers and bathing themselves and was dependent on staff for personal hygiene and chair/bed-to-chair transfers. Resident #57's Progress Notes, dated 03/13/2025, revealed a Behavior note that indicated the resident stated she had not received any medication since the prior afternoon. The note indicated the resident accused the nurse of stealing their albuterol inhaler that the day shift nurse left on their table. Resident #57's Progress Notes, dated 03/26/2025, revealed a Behavior note that indicated the resident was angry that a state tested nurse aide (STNA) would not change them every 45 minutes as indicated by the wound physician, per the resident. The note revealed Resident #57 stated Licensed Practical Nurse (LPN) #21 broke their nebulizer on purpose and their oxygen tubing had a hole. The note indicated the supply room was locked, but nurses retrieved oxygen tubing from the resident's drawer, replaced the tubing, and attempted to redirect them. The note revealed the resident stated they had issues on the day shift as all STNA's in the facility were lazy. The note indicated the Director of Nursing (DON) was notified of the resident's behaviors. Resident #57's Progress Notes, dated 04/01/2025 at 6:16 PM, revealed a Behavior note that indicated the resident was at the nurses' station and complained they had not received a breathing treatment or pain medication, and had been waiting to be changed since 4:00 PM. The note indicated LPN #21 placed the medication in the nebulizer and the resident yelled that the machine did not work, and that the nurse broke it. The note indicated that during change of shift report, the day shift nurse informed LPN #21 that Resident #57 had continuous behaviors on the day shift, and LPN #21 notified the Assistant Director of Nursing (ADON) of continued behaviors. During an interview on 05/19/2025 at 8:32 AM, Resident #57 stated they spoke with the Assistant Director of Nursing (ADON) in March (2025) about concerns. Resident #57 stated staff did not listen to them when they needed to be changed, and they were upset about how staff hung their clothes. During an interview on 05/19/2025 at 9:14 AM, STNA #16 stated if a resident had complaints or concerns, she would inform nurses, but she did not file grievances on behalf of residents. According to STNA #16, Resident #57 had a lot of complaints and complained to everyone. She stated the resident had concerns about not getting their medications if they were given five minutes after they were due, getting out of bed, and not being changed fast enough. STNA #16 said the nurses and the DON were aware of the resident's concerns. STNA #16 stated she did not have the time to write down all the resident's concerns and did not always communicate the concerns to nursing staff. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/19/2025 at 8:48 AM, the Social Services Director (SSD) revealed that any concerns shared with nursing staff, whether from a resident or a family member, must be reported. The SSD stated complaints could be verbal or written, and if the concern was filed verbally, it would be placed on a concern form. The SSD stated she expected STNA's to handle issues, but if an issue were ongoing, it would go to the next level and the concern should be reported to the nurse in charge. According to the SSD, she was only aware of Resident #57's concern regarding hearing aids, which the facility already addressed. The SSD stated she was not aware of Resident #57's concerns related to oxygen tubing not being available, not receiving timely incontinence care, not receiving timely response to their call light, or that staff were not getting them out of bed. During an interview on 05/19/2025 at 11:19 AM, LPN #15 revealed Resident #57 always had complaints about something, and staff did not always document the resident's concerns. LPN #15 stated she did not know why she did not document or report the concerns, but the resident was always speaking with the DON and management staff, so she assumed the concerns were shared. LPN #15 stated Resident #57's concerns included not having supplies available, staff not getting them up quickly enough, not getting their medications on time, activities, and not having things to do at the facility. LPN #15 confirmed she had not documented the concerns in progress notes or on a complaint form. During an interview on 05/19/2025 at 12:58 PM, the ADON stated a grievance form would be completed if the residents' concerns could not be rectified immediately. The ADON stated residents' concerns should be reported to the charge nurse, the DON, or the Administrator. He stated the facility addressed residents' concerns in the morning meetings; department heads worked on the concerns and returned the form within five days. According to the ADON, he was not informed of any concern for Resident #57 regarding supplies, timely incontinent care, STNA's, staff not getting the resident out of bed, not getting medications or treatments, and activities. He stated he would have expected staff to document or provide details about the resident's concerns. During an interview on 05/19/2025 at 1:28 PM, the DON stated residents' concerns must be reported to the nursing staff and they would write them on concern forms, or residents could express their concerns verbally. The DON stated he was not aware of any of Resident #57's concerns and would have expected staff to inform him of the concerns. The DON confirmed the facility did not have documentation of Resident #57's concerns. He stated accountability in the facility was lacking. During an interview on 05/19/2025 at 1:49 PM, the Administrator stated that when a resident shared concerns with the nursing staff, the concerns needed to get to the managers. He stated if staff could fix the issues right away, then no concern form should be completed, but if the concern could not be immediately resolved, then a concern form would be completed. The Administrator stated he was not aware of any concerns regarding Resident #57, and he would have expected the concerns to be documented on the concern form. This deficiency represents non-compliance investigated under Complaint Number OH00164128.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. Based on interview, record review, facility policy review, and review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 92 days of the prior MDS assessment for 1 (Resident #49) of 9 residents reviewed for the resident assessment task. In addition, the facility failed to ensure quarterly MDS assessments were signed as complete within 14 days of the Assessment Reference Date (ARD) for 3 (Residents #4, #34, and #46) of 9 residents reviewed for the resident assessment task. Findings included: A facility policy titled, MDS Completion and Submission Timeframes, revised 10/2023, revealed, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy specified, 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. The CMS Long-Term Care Facility RAI 3.0 User's Manual, Version 1.19.1, dated 10/2024, revealed, Chapter 2: Assessments for the RAI, section 05. Quarterly Assessments, specified The Quarterly assessment is an OBRA [Omnibus Budget Reconciliation Act] non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. The manual specified, The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). 1. An admission Record revealed the facility admitted Resident #49 on 05/20/2020. According to the admission Record, the resident had a medical history that included diagnoses of acute on chronic diastolic (congestive) heart failure and type two diabetes mellitus without complications. Resident #49's MDS history contained within their electronic health record (EHR) revealed their most recently completed MDS was a quarterly MDS, with an ARD of 01/02/2025. The MDS history indicated the resident's next quarterly MDS was 27 days overdue. According to the MDS history, a quarterly MDS, with an ARD of 04/02/2025, had a status of, In Progress. During an interview on 05/17/2025 at 2:00 PM, the Director of Nursing (DON) stated quarterly MDS assessments were due every 92 days. During an interview on 05/18/2025 at 8:15 AM, the Administrator stated he was aware the facility was behind on some MDS assessments. He said this was due to staff transitions, and the MDS Coordinator had only been in the role for about two weeks. During an interview on 05/18/2025 at 2:42 PM, the Administrator stated he expected the MDS assessments to be completed timely, according to the RAI manual. 2. An admission Record indicated the facility admitted Resident #4 on 02/02/2018. According to the admission Record, the resident had a medical history that included diagnoses of unspecified dementia and type two diabetes mellitus without complications. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4's quarterly MDS, with an ARD of 04/03/2025, revealed the assessment was not signed as complete until 05/16/2025. During an interview on 05/17/2025 at 2:00 PM, the Director of Nursing (DON) stated MDS assessments should be completed within 14 days of the ARD. During an interview on 05/18/2025 at 8:15 AM, the Administrator stated he was aware the facility was behind on some MDS assessments. He said this was due to staff transitions, and the MDS Coordinator had only been in the role for about two weeks. During an interview on 05/18/2025 at 2:42 PM, the Administrator stated he expected the MDS assessments to be completed timely, according to the RAI manual. 3. An admission Record indicated the facility admitted Resident #34 on 01/18/2016. According to the admission Record, the resident had a medical history that included diagnoses of unspecified cerebral infarction and essential (primary) hypertension. Resident #34's quarterly MDS, with an ARD of 04/01/2025, revealed the assessment was not signed as complete until 05/16/2025. During an interview on 05/17/2025 at 2:00 PM, the Director of Nursing (DON) stated MDS assessments should be completed within 14 days of the ARD. During an interview on 05/18/2025 at 8:15 AM, the Administrator stated he was aware the facility was behind on some MDS assessments. He said this was due to staff transitions, and the MDS Coordinator had only been in the role for about two weeks. During an interview on 05/18/2025 at 2:42 PM, the Administrator stated he expected the MDS assessments to be completed timely, according to the RAI manual. 4. An admission Record indicated the facility admitted Resident #46 on 11/01/2024. According to the admission Record, the resident had a medical history that included diagnoses of unspecified stage three chronic kidney disease and cerebrovascular disease. Resident #46's quarterly MDS, with an ARD of 04/03/2025, revealed the assessment was not signed as complete until 05/16/2025. During an interview on 05/17/2025 at 2:00 PM, the Director of Nursing (DON) stated MDS assessments should be completed within 14 days of the ARD. During an interview on 05/18/2025 at 8:15 AM, the Administrator stated he was aware the facility was behind on some MDS assessments. He said this was due to staff transitions, and the MDS Coordinator had only been in the role for about two weeks. During an interview on 05/18/2025 at 2:42 PM, the Administrator stated he expected the MDS assessments to be completed timely, according to the RAI manual.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview, record review, and facility policy review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately coded related to the use of a non-invasive mechanical ventilator for 1 (Resident #57) of 2 residents reviewed for respiratory services. Findings included: A facility policy titled, Certifying Accuracy of the Resident Assessment, revised 11/2019, indicated, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. The policy revealed, 3. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. An admission Record indicated the facility admitted Resident #57 on 07/02/2023. According to the admission Record, the resident had a medical history that included diagnoses of heart failure, chronic obstructive pulmonary disease (COPD), sleep apnea, lobar pneumonia, and dependence on supplemental oxygen. A quarterly Minimum Data Set (MDS), with an Assessment Reference date (ARD) of 04/23/2025, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received oxygen therapy and did not use a non-invasive mechanical ventilator. Resident #57's Care Plan Report, included a focus area initiated 06/25/2024, that indicated the resident had altered respiratory status/difficulty breathing related to respiratory failure, shortness of breath, sleep apnea, and COPD. Resident #57's April 2025 Treatment Administration Record [TAR], revealed a transcription of an order with a start date of 07/21/2024 and a discontinue date of 04/17/2025, for Treatment CPAP [continuous positive airway pressure, a non-invasive mechanical ventilator] at night at setting of 8. at bedtime. The TAR revealed staff documented that the CPAP was administered on 04/09/2025, 04/10/2025, 04/11/2025, 04/12/2025, and 04/16/2025 which was during the 14-day look-back period for the quarterly MDS with an ARD of 04/23/2025. During an interview on 05/18/2025 at 12:33 PM, the Director of Nursing (DON) stated it was important for MDS assessments to accurately reflect residents' conditions. He stated the information (for the MDS assessments) came from documentation and interviews. The DON stated observations of the resident should also be done. The DON confirmed the use of CPAP machines should be included in MDS assessments and MDS staff should see the machines when they did their observations of residents. During an interview on 05/18/2025 at 1:48 PM, the Administrator stated that the accuracy of MDS assessments was important because it provided a snapshot of the resident. He stated that the information for the MDS came from assessments, documents, interviews, and observations by different departments. The Administrator confirmed that the use of non-invasive mechanical ventilators should be captured on MDS assessments.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview, record review, and facility policy review, the facility failed to ensure a Level I Preadmission Screening and Resident Review (PASARR) accurately reflected all diagnosed mental disorders and prescribed psychotropic medications for 2 (Resident #16 and Resident #92) of 4 residents reviewed for PASARR requirements. Findings included: A facility policy titled, Preadmission Screening and Annual [sic] Resident Review (PASARR), effective 03/2024, indicated, It is the policy to screen all potential admissions on an individualized basis. As part of the preadmission process, the facility participates in the Preadmission Screening and Resident Review (PASARR) screening process (Level I) for all new and readmissions per requirement to determine if the individual meets the criterion for mental disorder (SMI/SMD) [serious mental illness/serious mental disorder], intellectual disability (ID) or related condition. 1. An admission Record revealed the facility originally admitted Resident #16 on 02/21/2025 and most recently admitted the resident on 04/19/2025. According to the admission Record, the resident had a medical history that included diagnoses of post-traumatic stress disorder; major depressive disorder, recurrent severe without psychotic features; and a history of a suicide attempt. The admission Record indicated each of these diagnoses were classified as, Present on Admission. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/06/2025, revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had active diagnoses at the time of the assessment that included depression, post-traumatic stress disorder, and suicide attempt. The MDS indicated Resident #16 received antipsychotic, antianxiety, and antidepressant medications during the seven-day assessment look-back period. Resident #16's 02/2025 Medication Administration Record (MAR) revealed the transcription of the following orders: - an order started on 02/22/2025 and discontinued on 03/14/2025 for aripiprazole (an atypical antipsychotic medication) 5 milligrams (mg) once daily for depression; - an order started on 02/22/2025 and discontinued on 03/06/2025 for duloxetine hydrochloride delayed release (an antidepressant medication) 60 mg, two capsules in the morning for depression; - an order started on 02/22/2025 and discontinued on 03/14/2025 for escitalopram oxalate (an antidepressant medication) 20 mg in the morning for depression; - an order started on 02/22/2025 and discontinued on 03/14/2025 for amitriptyline hydrochloride (an antidepressant medication) 50 mg twice daily for depression; and - an order started on 02/22/2025 and discontinued on 03/06/2025 for buspirone hydrochloride (an anti-anxiety medication) 15 mg three times daily for anxiety. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #16's Level I PASARR, signed by the Social Services Director on 03/18/2025, revealed a Resident Review was completed due to an expiring hospital exemption. The Level I PASARR indicated Resident #16 had not received psychotropic medications including antipsychotic, antidepressant, and antianxiety medications in the past six months. During an interview on 05/17/2025 at 2:44 PM, the Social Service Director (SSD) stated she completed Resident #16's PASARR form and she confirmed it did not reflect the psychotropic medications the resident received. The SSD stated she did not know who currently reviewed PASARR forms for accuracy. During an interview on 05/18/2025 at 7:43 AM, the Director of Nursing (DON) stated admissions staff and the social worker were responsible for the PASARR process. The DON stated the PASARR process was to ensure residents' mental health issues were recognized and addressed. The DON stated he expected PASARR forms to be complete and accurate. The DON reviewed Resident #16's PASARR form and stated it was not accurate, because the resident received psychotropic medications. During an interview on 05/18/2025 at 12:09 PM, the Administrator stated he expected residents' PASARR forms to be accurate. The Administrator stated the purpose of the PASARR was to determine if residents needed a Level II review to determine if they needed more services. 2. An admission Record revealed the facility admitted Resident #92 on 12/10/2024. According to the admission Record, the resident had a medical history that included a diagnosis of schizophrenia, which was present at the time of admission. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/17/2024, revealed Resident #92 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had a diagnosis of schizophrenia and received antipsychotic, antidepressant, and anticonvulsant medications in the prior seven days. Resident #92's Order Summary Report, listing active orders as of 05/15/2025, included the following orders: - an order dated 12/10/2024 for divalproex sodium extended release (an anti-seizure medication sometimes used as a mood stabilizer) 250 milligrams (mg), one tablet once daily for behaviors; - an order dated 12/10/2024 for divalproex sodium extended release 250 mg, three tablets at bedtime for behaviors; - an order dated 12/15/202 for haloperidol (an antipsychotic medication) 5 mg three times daily for behaviors; - an order dated 12/10/2024 for sertraline hydrochloride (an antidepressant medication) 150 mg once daily for depression; and - an order dated 12/10/2024 for olanzapine (an antipsychotic medication) 20 mg at bedtime for behaviors. (continued on next page)

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Arc at Trotwood LLC	5790 Denlinger Road Dayton, OH 45426

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #92's Level I PASARR, dated 12/06/2024, indicated Resident #92 had none of the listed diagnoses of mental disorders, which included schizophrenia. The screening form indicated the resident had not received psychotropic medications including antipsychotic, antidepressant, and mood stabilizer medications in the past six months. During an interview on 05/17/2025 at 2:44 PM, the Social Services Director (SSD) stated admissions staff were responsible for ensuring the PASARR was correct before the resident got to the facility. During an interview on 05/18/2025 at 7:43 AM, the Director of Nursing (DON) stated admissions staff and the social worker were responsible for the PASARR process. The DON stated the PASARR process was to ensure residents' mental health issues were recognized and addressed. The DON stated he expected PASARR forms to be complete and accurate. The DON reviewed Resident #92's PASARR form and confirmed there were no mental health diagnoses checked, and the form indicated no psychotropic medications were prescribed for the resident. The DON stated that upon admission to the facility, Resident #92 had orders for Zyprexa (olanzapine) and Depakote (divalproex sodium) which should have been noted on the PASARR form. The DON said the resident's PASARR was wrong (on admission), and the facility should have submitted another Level I PASARR form. During an interview on 05/18/2025 at 12:09 PM, the Administrator stated he expected residents' PASARR forms to be accurate. The Administrator stated the purpose of the PASARR was to determine if residents needed a Level II review to determine if they needed more services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff documented the administration of medications in accordance with acceptable standards of practice. Specifically, staff documented the administration of medication prior to actually administering the medication for 1 (Resident #57) of 4 residents observed during medication administration. Findings included: A facility policy titled, Medication Administration Policy, revised 01/2015, revealed the section titled, I. Level of Responsibility, included, - Licensed nurse (RN [registered nurse], LPN [licensed practical nurse]) may; a) prepare, b) administer, and c) record the administration of medications. An admission Record indicated the facility admitted Resident #57 on 07/02/2023. According to the admission Record, the resident had a medical history that included diagnoses of cerebral palsy, heart failure, chronic obstructive pulmonary disease, and type 2 diabetes mellitus. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/23/2025, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of MDS 15, which indicated the resident had intact cognition. Resident #57's Order Summary Report, with active orders as of 05/14/2025, included an order dated 05/12/2025, for Lantus (insulin glargine) 100 unit/milliliter (ml), with instructions to inject 22 units subcutaneously every 12 hours for diabetes mellitus. An observation on 05/14/2025 at 9:05 PM revealed Registered Nurse (RN) #4 administered Resident #57's medications that included the resident's scheduled 8:00 PM dose of Lantus. Resident #57's Medication Administration Record [MAR], dated 05/2025, indicated that on 05/14/2025 the resident's 8:00 PM dose of Lantus was documented by RN #4 as administered at 7:32 PM. During an interview on 05/15/2025 at 8:10 AM, RN #4 stated that he signed the medication (Lantus) off (documented that it was administered) on the MAR before he had administered it and that it was a mistake, and he should not have done that. RN #4 stated the process was to check the MAR, check the medication, administer the medication, then sign off on the MAR. During an interview on 05/15/2025 at 12:05 PM, the Director of Nursing (DON) stated the process for administering medications was to observe the resident taking the medications then document the administration of the medications on the MAR. The DON stated the medications should be administered before the nurse documented on the MAR because the computer would not let adjustments be made if the resident did not accept or take the medication. The DON stated he expected the medication to be administered before it was signed off on the MAR. During an interview on 05/15/2025 at 12:27 PM, the Administrator stated he expected medications to be pulled, administered, and then signed for on the MAR.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff checked for incontinence every two hours and provided incontinence care when indicated for 1 (Resident #57) 1 sampled resident reviewed for urinary tract infections. Specifically, during the dayshift on 05/15/2025, Resident #57 was not checked for incontinence or provided incontinence care until 10:40 AM. Findings included: A facility policy titled, Incontinence Care, dated 10/2024, indicated, Purpose: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Guidelines: Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provided perineal and genital care after each episode. An admission Record indicated the facility admitted Resident #57 on 07/02/2023. According to the admission Record, the resident had a medical history that included diagnoses of type two diabetes mellitus, urinary tract infection, overactive bladder, and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/23/2025, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #57 was not on a toileting program and was always incontinence of urine and bowel. Resident #57's Care Plan Report, included a focus area, revised 03/04/2025, that indicated the resident had an activity of daily living (ADL) self-care performance deficit. This focus area indicated the resident was incontinent and wore briefs. Another focus area, initiated 5/08/2025, indicated the resident had bowel incontinence. Interventions dated 05/08/2025 directed staff to check Resident #57 every two hours (for incontinence), assist with toileting as needed, and provide perineal care after each incontinent episode. During an interview on 05/15/2025 at 9:40 AM, Resident #57 stated they had not yet been changed that morning, and their bed was soaking wet. Resident #57 stated they were waiting for staff to come in, clean them, and get them up. During a concurrent interview and observation of Resident #57's room on 05/15/2025 at 9:54 AM, two basins of water and towels were noted on the resident's over-the-bed table. Resident #57 stated that State Tested Nurse Aide (STNA) #1 told the resident they would be back to take care of them in about fifteen minutes. A concurrent observation and interview on 05/15/2025 at 10:40 AM revealed STNA #1 and STNA #37 entered Resident #57's room to provide care. The observation revealed STNA #1 pulled down the covers and removed Resident #57's gown. A folded-up bath blanket positioned under the resident and the mattress were saturated. STNA #1 stated she had not provided any personal care to Resident #57 yet that morning, because she had other residents she had to get to first due to physician appointments. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/16/2025 at 11:17 AM, Unit Manager (UM) #9 should be checked for incontinence and changed (if found to have had an incontinent episode) at least every two hours. During an interview on 05/16/2025 at 12:13 PM, the Assistant Director of Nursing (ADON) stated Resident #57 should be checked for incontinence and changed (if found to have had an incontinent episode) every two hours. During an interview on 05/16/2025 at 5:45 PM, Licensed Practical Nurse (LPN) #21 stated Resident #57 was supposed to be checked and changed (if found to have had an incontinent episode) every two hours. During an interview on 05/16/2025 at 7:06 PM, STNA #1 stated they normally conducted rounds (systematic, scheduled nursing staff visits to check on residents) immediately when coming on shift. STNA #1 stated that on 05/15/2025 several residents had appointments and she also had to deliver trays and provide feeding assistance, so she got done late. STNA #1 stated she usually changed Resident #57 before breakfast, but she was not able to do that on 05/15/2025. During an interview on 05/18/2025 at 12:33 PM, the Director of Nursing (DON) stated incontinence care should be provided every two hours and as needed. During an interview on 05/18/2025 at 1:48 PM, the Administrator stated incontinence care should be provided every two hours. This deficiency represents non-compliance investigated under Complaint Number OH00164128.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, record review, and facility policy review, the facility failed to provide residents with food at an appetizing temperature for 1 (Resident #5) of 20 sampled residents. Findings included: A facility policy titled, Food Temp [Temperature] Point of Service Guidelines, updated 11/2024, revealed, Food will be served at an appropriate and palatable temperature for hot food items equal to or greater than 115-120 degrees Fahrenheit per stated guidelines F483.60: Proper 'safe and appetizing temperature' means both appetizing to the resident and minimizing the risks for scalding and burns. An admission Record revealed the facility admitted Resident #5 on 06/04/2024. According to the admission Record, the resident had a medical history that included a diagnosis of end stage renal failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/07/20255, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed Resident #5 required setup or clean up assistance with eating. Resident #5's Care Plan Report, included a focus area revised 05/05/2025, that indicated Resident #5 was at risk for potential nutritional problems related to the diagnosis of congestive heart failure. Interventions directed staff to monitor, document, and report as needed any signs and symptoms of dysphagia (difficulty swallowing) which included the resident refusing to eat. The Care Plan Report included a focus area revised 02/17/2025 that indicated the resident needed dialysis related to renal failure. Interventions directed staff that the resident's dialysis treatments were three times a week at 9:45 AM on Mondays, Wednesdays, and Fridays. During an observation on 05/14/2025 at 12:29 PM, Resident #5's lunch meal tray sat on the bedside table, though the resident was not in the room. During an observation on 05/14/2025 at 12:47 PM, Resident #5's lunch meal tray remained on the bedside table. During an observation on 05/14/2025 at 1:24 PM and 1:57 PM, the same lunch tray for Resident #5 remained on the bedside table. During an observation on 05/14/2025 at 2:30 PM, Resident #5 had returned from the dialysis center, and the resident's lunch tray remained on the bedside table. During an interview on 05/14/2025 at 2:32 PM, Resident #5 stated a lunch tray was often on the bedside table after the resident returned from the dialysis center. Resident #5 stated the lunch meal tray was not warmed or reheated. Resident #5 stated they were not aware they could request a fresh tray from the kitchen. Resident #5 stated the food was cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/14/2025 at 2:42 PM, State Tested Nurse Aide (STNA) #11 stated she left Resident #5's lunch tray on the bedside table until the resident returned from the dialysis center. STNA #11 stated Resident #5 normally returned from the dialysis center around 2:30 PM to 3:00 PM. STNA #11 stated Resident #5's lunch meal tray was placed in the resident's room around 12:00 PM to 12:15 PM. STNA #11 stated she would place the lunch tray in the microwave if the resident requested. During an interview on 05/14/2025 at 2:50 PM, the Dietary Director stated he was not aware of Resident #5's lunch tray being on the bedside table for two hours or more. He stated he expected the nursing staff to inform him when Resident #5 returned to provide a freshly made lunch tray for the resident. He stated he had not received notification Resident #5 had returned and needed a new tray. The Dietary Director stated he was not aware of Resident #5's lunch tray being re-heated. The Dietary Director stated the food should be discarded after two hours of being left out without refrigeration. During an interview on 05/14/2025 at 3:08 PM, Licensed Practical Nurse (LPN) #12 revealed that when Resident #5 went to the dialysis center, the resident's lunch tray was left in the room on the bedside table. She stated Resident #5's lunch tray remained in the room for around two hours. She stated the meal trays were placed in the room around noon. During an interview on 05/17/2205 at 2:00 PM, the Director of Nursing (DON) stated he was not aware of the facility staff placing the resident's food trays in the room for over two hours while the resident was not in the room. He stated he expected the residents to get safe food; the residents should get cold food that was cold and hot foods that were hot. During an interview on 05/18/2025 at 8:15 AM, the Administrator stated he expected the lunch trays to be provided at a proper temperature. The Administrator stated the facility should provide the residents with an appetizing lunch.

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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 interview, record review, and facility policy review, the facility failed to ensure residents' medical records were accurate and complete for 2 (Resident #57 and Resident #204) of 22 sampled residents. Findings included: A facility policy titled, Medical Record Policy, revised 06/2022, revealed, It is the policy of this facility that an organized, accurate and complete written record will be maintained for each resident in accordance with applicable State and Federal guidelines and laws. The Standards section of the policy revealed, 1. The Director of Nursing/designee with the support of the Medical Records Technician shall assure that medical records are maintained in accordance with the facility/s [sic] policies and procedures, and applicable federal and state regulations. Further review revealed, 6. The resident record shall contain at least the following information: k. Record of Medications and Treatments. Medication and treatment records, including records of oxygen administration, alcoholic beverages, skin treatments, catheter/ostomy care, etc. [et cetera, and so forth] and supplements will be documented, indicating the time, name of medication or treatment, dosage (if applicable), the reason for the and results of PRN [pro re nata, as needed] medications and treatment, and name and initials of the person administering the drug or treatment. l. Treatment or Medication Refusal. Residents/responsible parties have a right to refuse any treatment or medication. Notations of any refusals will be documented in the medical record. 1. An admission Record revealed the facility admitted Resident #204 on 03/18/2025. According to the admission Record, the resident had a medical history that included diagnoses of paraplegia and a Stage 4 pressure ulcer of the sacral region. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/26/2025, revealed Resident #204 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had two Stage 3 pressure ulcers, one deep tissue injury, and one unstageable pressure ulcer that were present on admission. According to the MDS, the resident also had surgical wound(s). The MDS further revealed that the resident was receiving pressure ulcer/injury care, surgical wound care, and nonsurgical dressings. Resident #204's Care Plan Report, included an undated focus area that indicated the resident had skin impairment of the right lateral ankle, right heel, right lower lateral leg, right lateral thigh, medial right knee, right medial ankle, right hip, left great toe, scrotum, left hip, coccyx, right buttock, and from the left buttock to the posterior leg. Interventions directed staff to provide treatment as ordered. Resident #204's March 2025 Treatment Administration Record [TAR], revealed the transcription of the following orders and corresponding documentation of treatment administration: - An order dated 03/21/2025 to cleanse the area from left the buttock down to the posterior left leg with normal saline (NS), pat the area dry, and cover with a clean dry dressing every day shift. Per the TAR, there was no documented evidence staff provided the treatment on 03/24/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order dated 03/21/2025 to cleanse the coccyx and the right buttock with NS, pat the area dry, and cover with a dry dressing every day shift. The TAR revealed no documented evidence that treatment was provided on 03/24/2025. - An order dated 03/20/2025 to cleanse the right lateral ankle with NS, pat the area dry, apply silver alginate to the wound bed, and cover with clean dry dressing every day shift. Per the TAR, there was no documented evidence staff provided the treatment on 03/20/2025 and 03/24/2025. - An order dated 03/20/2025 to cleanse the right lateral thigh with NS, pat the area dry, apply silver alginate, and cover with a clean dry dressing every day shift. The TAR revealed that there was no documented evidence staff provided the treatments on 03/20/2025 and 03/24/2025. - An order dated 03/21/2025 to cleanse the scrotum and the superior area with saline, pat the area dry, and cover the area with a clean dry dressing every day shift. Per the TAR, there was no documented evidence staff provided the treatments on 03/24/2025. - An order dated 03/27/2025 to cleanse the area superior to the scrotum with NS, pat the area dry, pack the wound bed with silver alginate rope, and cover with a bordered foam dressing every shift. Per the TAR, there was no documented evidence staff provided the treatment on night shift on 03/27/2025. - An order dated 03/27/2025 to cleanse the coccyx and the right buttock with NS, pat the area dry, pack the area with silver alginate rope, and cover the area with a dry clean dressing every shift. The TAR revealed that there was no documented evidence staff provided the treatment on the night shift on 03/27/2025. - An order dated 03/20/2025 to cleanse the lateral lower right leg with NS every shift, pat the area dry, apply skin prep to the area, and leave the area open to air. Per the TAR, there was no documented evidence staff provided the treatments on day shift on 03/25/2025 and on night shift on 03/27/2025. - An order dated 03/20/2025 to cleanse the left hip with NS, pat the area dry, apply Triad to the area, and cover the area with an abdominal dressing every shift. Per the TAR, there was no documented evidence staff provided the treatments during the day shifts on 03/24/2025. - An order dated 03/20/2025 to cleanse the medial right knee with NS every shift, pat the area dry, apply skin prep to the area, and leave the area open to air. The TAR revealed no documented evidence staff provided the treatments during the day shift on 03/24/2025. - An order dated 03/20/2025 to cleanse the right heel with NS, pat the area dry, apply skin prep to the area, cover with a bordered foam dressing for padding, and heel boots as tolerated every shift. Per the TAR, there was no documented evidence staff provided the treatments on day shift on 03/24/2025 and on night shift on 03/27/2025. - An order dated 03/20/2025 to cleanse the right medial ankle with NS, pat the area dry, apply skin prep to the area. leave the area open to air and apply heel boots for offloading as tolerated. The TAR revealed no documented evidence that staff provided treatments on 03/20/2025 and 03/24/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order dated 03/26/2025 to cleanse the right medial ankle with NS, pat the area dry, apply Xeroform to the ankle, cover with a dry clean dressing, and apply heel boots for offloading as tolerated every shift. Per the TAR, there was no documented evidence staff provided the treatment on night shift on 03/27/2025. During an interview on 05/17/2025 at 10:58 AM, Licensed Practical Nurse (LPN) #19 (the nurse assigned to Resident #204's unit on 03/24/2025) revealed she completed wound care for Resident #204 but had not always documented on the TAR following the treatment. During an interview on 05/13/2025 at 1:42 PM, Unit Manager #9 revealed that Resident #204 had received wound care treatment; however, she stated that some of the nurses may not have signed the TAR after completing the treatment. During an interview on 05/19/2025 at 5:00 PM, the Wound Nurse Practitioner (NP) stated Resident #204's wound care was being provided and there were no concerns with wound care. The Wound NP stated the resident had extensive, chronic wounds that were healing. During an interview on 05/17/2025 at 2:00 PM, the Director of Nursing (DON) stated the nurses should document on the resident's TAR when a treatment was provided. An interview with the Administrator on 05/18/2025 at 8:15 AM revealed he expected the nursing staff to sign the TAR when completing wound care. 2. An admission Record indicated the facility admitted Resident #57 on 07/02/2023. According to the admission Record, the resident had a medical history that included diagnoses of cerebral palsy, heart failure, chronic obstructive pulmonary disease (COPD) with dependence on supplemental oxygen, type 2 diabetes mellitus, polyneuropathy, overactive bladder, urinary tract infection, pneumonia, unspecified chest pain, and pain in left and right shoulders. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/23/2025, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #57 received insulin injections daily, an opioid, and oxygen therapy while a resident during the assessment's look-back period. Resident #57's Order Recap [Recapitulation] Report, for the timeframe from 01/01/2025 through 05/14/2025 included the following orders: - An order with a start date of 03/18/2025 and end date of 04/17/2025, for DuoNeb Solution 0.5-2.5 milligrams (mg) /3 milliliter (ml), with instructions to inhale 3 ml orally every four hours for shortness of breath or wheezing. - An order with a start date of 04/18/2025, for Humalog KwikPen 100 units/ml, with instructions to inject 20 units subcutaneously with meals for diabetes. - An order with a start date of 04/17/2025 and end date of 05/12/2025, for Lantus SoloStar 100 unit/ml, with instructions to inject 20 units subcutaneously every 12 hours for elevated blood sugar. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order with a start date of 05/13/2025, for Lantus SoloStar 100 unit/ml, with instructions to inject 22 units subcutaneously every 12 hours for diabetes mellitus. - An order with a start date of 01/17/2025 and end date of 04/17/2025, for Percocet 7.5-325 mg, with instructions to give one tablet by mouth every six hours for pain. - An order with a start date of 04/17/2025, for Percocet 7.5-325 mg, with instructions to give one tablet by mouth every six hours for pain. Resident #57's March 2025 Medication Administration Record [MAR], revealed no staff documentation to indicate whether or not the resident's Percocet was administered on 03/12/2025 at 6:00 PM, 03/18/2025 at 12:00 PM and 6:00 PM, 03/20/2025 at 6:00 AM, 03/24/2025 at 6:00 PM, 03/25/2025 at 12:00 PM and 6:00 PM, and on 03/31/2025 at 6:00 PM. Further review revealed no staff documentation to indicate whether or not the resident's DuoNeb Solution was administered on 03/18/2025 at 2:00 PM and 6:00 PM, 03/24/2025 at 6:00 PM, 03/25/2025 at 2:00 PM and 6:00 PM and 03/31/2025 at 10:00 PM. Resident #57's April 2025 Medication Administration Record, revealed no staff documentation to indicate whether or not the resident's Percocet was administered on 04/01/2025 at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM, 04/07/2025 at 6:00 PM, 04/08/2025 at 6:00 PM, 04/10/2025 at 6:00 AM, 04/22/2025 at 12:00 PM and 6:00 PM, 04/23/2025 at 6:00 PM, 04/28/2025 at 12:00 PM, 04/29/2025 at 12:00 PM, and 04/30/2025 at 12:00 PM. The MAR revealed no staff documentation to indicate whether or not the resident's Humalog was administered on 04/22/2025 at 8:00 AM, 12:00 PM and 5:00 PM, 04/23/2025 at 12:00 PM and 5:00 PM, and 04/28/2025 through 04/30/2025 at 8:00 AM, 12:00 PM and 5:00 PM. Further review revealed no staff documentation to indicate whether or not the resident's 9:00 AM dose of Lantus was administered on 04/28/2025 through 04/30/2025. Resident #57's Medication Administration Record, for the timeframe from 05/01/2025 through 05/13/2025, revealed no staff documentation to indicate whether or not the resident's Lantus was administered on 05/06/2025 at 9:00 AM. The MAR revealed no staff documentation to indicate whether or not the resident's Humalog was administered on 05/06/2025 at 8:00 AM, 12:00 PM, and 5:00 PM. Further review revealed no staff documentation to indicate whether or not the resident's Percocet was administered on 05/05/2025 at 6:00 PM, 05/06/2025 at 12:00 PM and 6:00 PM, 05/07/2025 at 6:00 PM, and 05/13/2025 at 6:00 PM. During an interview on 05/16/2025 at 5:45 PM, Licensed Practical Nurse (LPN) #21 stated she worked nights at the facility as needed. LPN #21 stated she gave Resident #57 a 6:00 PM dose of Percocet but was not able to sign it out on the MAR because it was on the day shift MAR. LPN #21 stated they had internet and computer issues. During an interview on 05/16/2025 at 7:06 PM, State Tested Nursing Aide (STNA) #1 stated she documented as much as she could, but they had a lot of computer problems such as getting locked out or booted out while documenting. During an interview on 05/17/2025 at 1:30 PM, Registered Nurse (RN) #17 stated she had problems with the computer and the internet. RN #17 stated she got kicked out of the system all the time. RN #17 stated she would put in a nurses note and save it but then later it would not be there. RN #17 stated she told the Director of Nursing (DON) about the issues. RN #17 stated sometimes it would not even accept her login identification. (continued on next page)

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	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Trotwood LLC	5790 Denlinger Road Dayton, OH 45426

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/17/2025 at 1:50 PM, LPN #29 stated she had trouble with the computer not always saving her work after she was done, so it looked like the medications were not passed but they were. LPN #29 stated she could not remember specifically when it happened, but management was aware of it. During an interview on 05/18/2025 at 12:33 PM, the DON stated that he had one nurse tell him that they were not able to complete their documentation because of computer problems, he was able to fix it, and no one else had mentioned it to him. During an interview on 05/18/2025 at 1:48 PM, the Administrator stated he was not aware of any computer issues.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were administered in a way to avoid transmission of communicable diseases and infections. Specifically, facility staff touched resident medications with their bare hands when administering medication, which affected 2 (Resident #20 and Resident #57) of 4 residents observed during medication administration. Findings included: A facility policy titled, Infection Control Program, revised 11/2017, revealed, 1. The facility has established an Infection Control Program which addresses all phases of the organization's operation to reduce or prevent the risks of nosocomial infections in residents and healthcare workers. A facility policy titled, Medication Administration Policy, revised 01/2015, revealed it did not include a procedure of medication administration of oral medications. 1. An admission Record indicated the facility admitted Resident #20 on 04/14/2025. According to the admission Record, the resident had a medical history that included diagnoses of a history of pulmonary embolism, chronic systolic heart failure, hypertension (high blood pressure), low back pain, muscle weakness, morbid obesity, and intraspinal abscess and granuloma. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/21/2025, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #20's Order Summary Report, with active orders as of 05/15/2025, included the following orders: - An order dated 04/15/2025, for allopurinol (a xanthine oxidase inhibitor) 100 milligrams (mg), with instructions to give one tablet in the morning for elevated blood pressure. - An order dated 04/15/2025, for apixaban (an anticoagulant) 5 mg, with instructions to give one tablet two times a day for elevated blood pressure. - An order dated 04/15/2025, for gabapentin (a gamma-aminobutyric acid analog) 300 mg, with instructions to give one capsule three times a day for muscle spasms. - An order dated 04/15/2025, for sacubitril-valsartan (an angiotensin receptor blocker and neprilysin inhibitor) 49-51 mg, with instructions to give one half tablet two times a day for elevated blood pressure. - An order dated 04/15/2025, for vitamin D, with instructions to give one tablet in the morning for vitamin supplement. - An order dated 05/13/2025, for empagliflozin (a sodium-glucose co-transporter 2 [SGLT2] inhibitor) 10 mg, with instructions to give one tablet one time a day for hyperglycemia (high blood sugar). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order dated 05/13/2025, for metoprolol succinate (a cardio selective beta blocker) extended release 25 mg, with instructions to give one tablet one time a day for elevated blood pressure. During an observation on 05/14/2025 at 8:22 AM, Licensed Practical Nurse (LPN) #3 prepared Resident #20's medications. LPN #3 dispensed one tablet of allopurinol 100 mg and one tablet of apixaban 5 mg directly into her hand from medication blister cards then placed the medications in a calibrated medicine cup. During a concurrent interview, LPN #3 stated she should not dispense medications into her hands because hands were dirty. LPN #3 then continued to dispense one capsule of gabapentin 300 mg, one half tablet of sacubitril-valsartan 49-51 mg, one tablet of vitamin D, one tablet of empagliflozin 10 mg, and one tablet of metoprolol succinate extended release 25 mg into the cup with the allopurinol and apixaban. LPN #3 locked the medication cart, initiated the computer privacy screen, then picked up the medication cups when the surveyor stopped her. LPN #3 stated that she should dispense the medication into the cup, not her hand. LPN #3 stated the two medications were considered contaminated, so all the medications in the cup were contaminated at that point. LPN #3 disposed of the medications and started over. During an interview on 05/15/2025 at 11:44 AM, the Assistant Director of Nursing (ADON), who was also the Infection Preventionist, stated medications should be dispensed from the medication card directly into a medication cup to avoid cross-contamination. The ADON stated he expected nurses to not dispense medications into their bare hands. During an interview on 05/15/2025 at 12:05 PM, the Director of Nursing (DON) stated the medication administration process was to pull medication cards from the cart and compare them with the medication administration record (MAR) and dispense the medication into a cup, not a hand. The DON stated medication should be dispensed into the cup because dispensing into the hand was an infection control issue. The DON stated he expected medication to not be dispensed into a bare hand then placed into the medication cup for administration. During an interview on 05/15/2025 at 12:27 PM, the Administrator stated the nurses should not dispense medication into their bare hand because that was an infection control issue, and if they put the contaminated medication in a cup with other medications, they were all contaminated. The Administrator stated he expected medications to be dispensed directly into a cup for infection control purposes. The Administrator stated he was not aware of any other facility policy that would address dispensing medication into a bare hand. 2. An admission Record indicated the facility admitted Resident #57 on 07/02/2023. According to the admission Record, the resident had a medical history that included diagnoses of cerebral palsy, heart failure, chronic obstructive pulmonary disease, and type 2 diabetes mellitus. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/23/2025, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #57's Order Summary Report, with active orders as of 05/14/2025, included an order dated 04/17/2025, for atorvastatin calcium (a lipid-lowering agent) 20 milligrams (mg), with instructions to give one tablet at bedtime for hyperlipidemia (a condition of high levels of fats in the blood). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/14/2025 at 9:05 PM, Registered Nurse (RN) #4 prepared Resident #57's medications. RN #4 dispensed one atorvastatin calcium 20 mg tablet directly into his bare hand from a medication blister card. During a concurrent interview, RN #4 stated he should not have dispensed the medication into his hand because then it was contaminated. RN #4 discarded the medication and obtained a new tablet. During an interview on 05/15/2025 at 11:44 AM, the Assistant Director of Nursing (ADON), who was also the Infection Preventionist, stated medications should be dispensed from the medication card directly into a medication cup to avoid cross-contamination. The ADON stated he expected nurses to not dispense medications into their bare hands. During an interview on 05/15/2025 at 12:05 PM, the Director of Nursing (DON) stated the medication administration process was to pull medication cards from the cart and compare them with the medication administration record (MAR) and dispense the medication into a cup, not a hand. The DON stated medication should be dispensed into the cup because dispensing into the hand was an infection control issue. The DON stated he expected medication to not be dispensed into a bare hand then placed into the medication cup for administration. During an interview on 05/15/2025 at 12:27 PM, the Administrator stated the nurses should not dispense medication into their bare hand because that was an infection control issue. The Administrator stated he expected medications to be dispensed directly into a cup for infection control purposes. The Administrator stated he was not aware of any other facility policy that would address dispensing medication into a bare hand.