

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Arlington Pointe		STREET ADDRESS, CITY, STATE, ZIP CODE 4900 Hendrickson Road Middletown, OH 45044	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570</p> <p>Based on record review, interviews and policy review, the facility failed to notify a resident's family of a change in condition requiring a resident to go to the hospital. This affected one (Resident #8) of four residents reviewed for change in condition. The facility census was 95.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #8 admitted to the facility on [DATE] with diagnoses of elevated white blood cell count, other specified abnormal findings of blood chemistry, cerebral infarction, and post hemorrhagic anemia.</p> <p>Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 was cognitively intact.</p> <p>Review of lab results collected on 04/22/24 at 4:50 A.M. and received on 04/22/24 at 9:32 A.M. revealed Resident #8 had a hemoglobin of 6.9 grams per deciliter (G/DL) Reference range is 11.2-15.7.</p> <p>Review of physician orders dated 04/22/24 at 12:09 P.M. revealed an order for Resident #8 to get a Blood Transfusion at 8:30 A.M. on 04/23/24.</p> <p>Review of Resident #8's nurse's progress notes revealed no documentation on new physician order received for the blood transfusion. There was no documentation the family was notified of the resident being sent out for a blood transfusion.</p> <p>Interview on 05/06/24 at 10:20 A.M. with Licensed Practical Nurse (LPN) #733 confirmed there was a recent incident where Resident #8 was sent out to have a blood transfusion on 04/23/22 and the family was not notified.</p> <p>Interview on 05/06/24 at 2:16 P.M. with Director of Nursing (DON) confirmed Resident #8 was sent out for a blood transfusion on 04/23/24, but she thought family had been notified.</p> <p>Review of the policy for Change in Condition dated 11/23 revealed the facility will promptly notify the resident, his/her attending physician, and the resident's sponsor/responsible party in an event of a change in condition or status.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 366437	If continuation sheet Page 1 of 4

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents non-compliance investigated under Complaint Number OH00153318		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48570</p> <p>Based on record review and staff interviews the facility failed notify the ordering physician of lab results on a urinalysis with culture that fell outside of the clinical reference range. This affected one (Resident #101) of four residents reviewed for lab services. The facility census was 95.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #101 admitted to the facility on [DATE] and discharged from the facility on 04/13/24 with diagnoses of spinal stenosis, lumbar region without neurogenic claudication, and interstitial cystitis (chronic) with hematuria.</p> <p>Review of the Minimum Data Set (MDS) assessment completed on 04/13/24 revealed Resident #101 was cognitively intact.</p> <p>Review of Resident #10's care plan revealed the residnet was at risk for for infection due to immobility, incontinence and surgical site with intervention to monitor lab work.</p> <p>Review of physician orders for Resident #101 revealed an order for a urinalysis with culture dated 03/20/24.</p> <p>Review of laboratory results dated [DATE] revealed Resident #101's urine culture was positive for a Urinary Tract Infection (UTI). The organism identified was enterococcus faecium (VRE) was susceptible to the antibiotics Linezolid and Nitrofurantoin.</p> <p>Review of physician orders revealed an order dated 04/13/24 for Macrobid oral capsule 100 milligrams (mg) (Nitrofurantoin Monohyd Macro) Give 100 mg by mouth two times a day for UTI Vancomycin-resistant Enterococcus VRE for 7 Days.</p> <p>Review of Resident #101 nurse's progress notes revealed on 04/13/24 at 9:43 A.M. the physician was notified Resident #101 had a change in mental status and increased weakness with moderate confusion and was notified urinalysis sensitivity results.</p> <p>Interview on 05/06/24 at 11:56 A.M. with Registered Nurse (RN) #732 confirmed Resident #101 recently had a UTI and she failed to notify the physician of the results of the urinalysis and culture when they came back. Interview confirmed it was approximately 10 days after the results the physician was notified and an antibiotic was initiated on 04/13/24. Interview confirmed the process was to notify the physician immediately if critical or by the end of the day if lab results are out of range.</p> <p>Interview on 05/06/24 at 12:55 P.M. with Licensed Practical Nurse (LPN) #776 confirmed the physician was not notified of the urinalysis until almost 10 days later on 04/13/24 when an antibiotic was initiated. Interview confirmed the physician should be contacted on the day lab results are received if out of range.</p> <p>(continued on next page)</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/06/24 at 2:16 P.M. with the Director of Nursing (DON) confirmed Resident #101 was not started on an antibiotic until 04/13/24 and confirmed there was no documentation showing the physician was aware of the results of the urinalysis until 04/13/24 when the resident had a change in mental status.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00153318.</p>		