

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 12/26/2024
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 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43062</p> <p>Based on record review, resident interview, and staff interview, the facility failed to provide emergency dental care for a resident. This affected one resident (#55) of three residents (#55, #75, and #98) reviewed for dental services. The facility census was 100.</p> <p>Findings include:</p> <p>Record review for Resident #55 revealed an admitted [DATE]. Diagnoses included gastro-esophageal reflux disease (GERD), major depressive disorder, anxiety disorder, obesity, osteoarthritis, dysphagia, essential primary hypertension, and diabetes mellitus.</p> <p>Review of Resident #55's Minimum Data Set (MDS) assessment, dated 10/25/24, revealed the resident was severely cognitively impaired. Further review of the MDS assessment confirmed Resident #55 required moderate assistance from staff with eating.</p> <p>Review of Resident #55's progress notes revealed on 08/23/24 Resident #55 requested to be seen by the dentist. Further review of the progress notes revealed on 08/28/24, the facility contacted Resident #55's responsible party and notified of the dentist recommendation for dental surgery. The facility stated they will have Resident #55's family sign the consent for dental surgery and the forms will be left at the front desk. Nothing else was documented related to the emergency dental surgery.</p> <p>Review of Resident #55's dental visit note, dated 08/27/24, revealed Resident #55 had an emergency dental consult on 08/27/24 at the facility. Further review of the dental note revealed Resident #55 requested lower dentures following the extraction of the broken teeth. The contracted facility dentist stated Resident #55 had a broken tooth recommended extraction of the broken tooth.</p> <p>Interview on 12/26/24 at 4:13 P.M. with the Director of Nursing (DON) confirmed Resident #55 had a recommendation from the dentist to have her broken tooth extracted. The visit and recommendation from the Dentist was written on 08/27/24. The DON confirmed the facility failed to document any follow up related to Resident #55's tooth extraction. The DON confirmed the facility failed to ensure the emergency visit extraction recommendation for Resident #55 was completed.</p> <p>Interview on 12/26/24 at 4:50 P.M. with Resident #55 confirmed she has a broken tooth that has not been removed. Resident #55 confirmed the broken tooth causes pain at times.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00159744.</p>

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

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