

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Loveland Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 501 North Second Street Loveland, OH 45140	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492</p> <p>Based on observation, interview, record review, and policy review, the facility failed to ensure staff treated residents with dignity and respect when providing feeding assistance. This affected one (Resident #20) of four residents sampled for feeding assistance. The facility census was 74.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #20 was admitted to the facility on [DATE]. Diagnoses included unspecified cerebral infarction, chronic obstructive pulmonary disease, schizoaffective disorder-bipolar type, unspecified anxiety disorder, and unspecified protein calorie malnutrition.</p> <p>Review of the most recent minimum data set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 had moderately impaired cognition, had verbal behaviors, did not wander, and did not reject care. Resident #20 was impaired on one side and required partial, moderate assistance with eating.</p> <p>Review of the care plan dated 01/21/20 revealed Resident #20 had and activities of daily living (ADL) self-care deficit. Interventions included one-staff extensive assistance with meals to be spoon-fed and drinks in sippy cups.</p> <p>Observation on 11/07/24 at 11:58 A.M. revealed Licensed Practical Nurse (LPN) #117 was seated at a table in the main dining room with Resident #20. LPN #117 fed a spoonful of food to Resident #20, seated in a wheelchair to her right, then turned back to the table and began scrolling through her cell phone on the table.</p> <p>During an interview on 11/07/2024 at 12:06 P.M. LPN #117 verified she was scrolling through her cell phone while feeding Resident #20. LPN #117 stated she had texted the Nurse Practitioner earlier and was checking to see if she had responded. LPN #117 stated she was unaware of any rules restricting cell phone use while feeding patients.</p> <p>Review of policy titled Policy and Procedure for Resident Rights, Advance Directives, and Advance Care Planning dated 11/2023 revealed residents had the right to a dignified existence and the right to be treated in a manner and environment that promoted maintenance or enhancement of his or her quality of life.</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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This deficiency represents noncompliance investigated under Complaint number OH00159395 and OH00158863.		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492</p> <p>Based on observations, interview, medical record review, and policy review, the facility failed to ensure residents were bathed according to personal preference. This affected one (Resident #10) of five residents sampled for bathing. The facility census was 74.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included unspecified hepatic failure, unspecified staphylococcus disease, type II diabetes, unspecified protein calorie malnutrition, unspecified depression, acute on chronic diastolic congestive heart failure, unspecified psoriasis, unspecified chronic kidney disease, alcoholic cirrhosis of the liver with ascites, and unspecified homelessness.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander. Resident #10 required set up assistance with oral hygiene, and substantial/maximum assistance with bathing.</p> <p>Review of care plan dated 10/16/24 revealed Resident #10 had a self-care deficit related to balance deficit, disease process, and weakness. Interventions included assistance with activities of daily living (ADL)s as needed, encourage participation in ADLs, and showers twice weekly on Monday and Thursday nights.</p> <p>Review of progress note dated 10/30/24 at 3:33 P.M. LPN #164 documented Resident #10 was demanding a bed bath. LPN #164 explained to (the) resident he only will be getting shower/bed bath on Monday/Thursday nights. Resident was vocal about not getting the care he deserves at nighttime and was cursing about the night workers.</p> <p>Review of the medical record revealed Resident #10 was hospitalized and was not present in the facility on 10/18/24, 10/19/24, 10/20/24, and 10/29/24.</p> <p>Review of shower sheets revealed Resident #10 received bed baths on 10/25/24, 10/31/24, 11/04/24, and 11/06/24.</p> <p>During an interview on 11/06/24 at 9:33 A.M. Resident #10 stated he was itchy because he had not had a shower or bed bath in a while. He was supposed to get baths at night and for the previous two nights staff had refused to bathe him.</p> <p>During an observation on 11/06/24 at 9:43 A.M. Resident #10 stated to LPN #164 the night shift nurse had refused to give him a bed bath or change his bed linens. LPN #164 stated to Resident #10 residents only received two baths per week and his were scheduled on Mondays and Thursdays during the night shift.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/06/24 at 9:45 A.M. LPN #164 verified she had stated to Resident #10 residents only received two baths per week. LPN #164 stated residents could not be bathed every day. Residents were bathed on scheduled shower days and as needed if they looked dirty, and they tried to accommodate preferences for bathing times.</p> <p>Review of policy titled Policy and Procedure for Resident Rights, Advance Directives, and Advance Care Planning dated 11/2023 revealed residents had the right to self-determination and choices for care were incorporated into the plan of care.</p> <p>Review of policy titled ADL Care dated 11/2023 revealed ADL assistance was provided on a schedule that was in accordance with the preferences of the resident.</p> <p>This deficiency represents noncompliance investigated under Complaint number OH00159395.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492</p> <p>Based on record review, interview, and policy review, the facility failed to ensure resident care plans were comprehensive and reflected all resident care needs. This affected one (Resident #10) of nine residents sampled for care plans. The facility census was 74.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included unspecified hepatic failure, unspecified staphylococcus disease, type II diabetes, unspecified protein calorie malnutrition, unspecified depression, acute on chronic diastolic congestive heart failure, unspecified psoriasis, unspecified chronic kidney disease, alcoholic cirrhosis of the liver with ascites, and unspecified homelessness.</p> <p>Review of care plan dated 10/16/24 revealed Resident #10 had no care plan for psoriasis or discomfort related to itching.</p> <p>During an interview on 11/06/24 at 9:47 A.M. Resident #10 stated he felt like he needed help with his psoriasis. It was all over his body. The resident stated he had an order for Triamcinolone (corticosteroid) topical cream and took Hydroxyzine (antihistamine) for itching. The resident stated staff were applying non-medicated lotions, too, that were helpful but not as effective as the Triamcinolone cream. The patient stated he wanted to see a dermatologist.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander. Resident #10 required set up assistance with oral hygiene, and substantial/maximum assistance with bathing.</p> <p>Review of care plan dated 10/16/24 revealed Resident #10 had no care plan for psoriasis or discomfort related to itching.</p> <p>During an interview on 11/07/2024 at 12:17 P.M. LPN Unit Manager #132 verified Resident #10 had no care plan for psoriasis or itching.</p> <p>Review of policy titled Care Planning/Interdisciplinary Team dated 11/2023 revealed the Interdisciplinary Team was responsible for the development of an individualized comprehensive care plan for each resident.</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492</p> <p>Based on interview, record review, and policy review, the facility failed to ensure residents were given assistance with or access to daily oral care. This affected one (Resident #10) of five residents sampled for activities of daily living (ADL) assistance. The facility census was 74.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #10 was admitted to the facility on [DATE]. Diagnoses included unspecified hepatic failure, unspecified staphylococcus disease, type II diabetes, unspecified protein calorie malnutrition, unspecified depression, acute on chronic diastolic congestive heart failure, unspecified psoriasis, unspecified chronic kidney disease, alcoholic cirrhosis of the liver with ascites, and unspecified homelessness.</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact, had no behaviors, did not reject care, and did not wander. Resident #10 required set up assistance with oral hygiene, and substantial/maximum assistance with bathing.</p> <p>Review of care plan dated 10/16/24 revealed Resident #10 had altered dental status and required assistance with dental hygiene. Interventions included assistance with oral care as needed, brushing and flossing teeth daily.</p> <p>Review of the medical record revealed Resident #10 had no documentation related to daily assistance with oral care.</p> <p>During an interview on 11/06/24 at 9:47 A.M. Resident #10 stated he had only brushed his teeth once during his stay and staff were not offering assistance with oral care.</p> <p>During an interview on 11/06/24 at 10:01 A.M. Certified Nursing Assistant (CNA) #173 stated she completed rounds for morning care after breakfast each day and did not offer oral care unless the resident specifically asked for assistance. CNA #173 stated she did not have time for oral care. CNA #173 stated when resident #10 first admitted , she set him up for oral care when he asked for assistance. CNA #173 stated she had not provided setup assistance for oral care in a few weeks because Resident #10 did not ask for it. CNA #173 stated there was no place in the medical record for aides to document oral care, so there was no documentation of oral care being offered, provide, or refused in the record.</p> <p>During an interview on 11/07/24 at 2:02 P.M. Licensed Practical Nurse (LPN) Unit Supervisor #132 verified there was no documentation available for oral care, but it should be offered daily.</p> <p>Review of policy titled ADL Care dated 11/2023 revealed all residents received necessary services to maintain good nutrition, grooming, and personal and oral care.</p> <p>This deficiency represents noncompliance identified under Complaint number OH00159395.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492</p> <p>Based on observations, interview, record review, and policy review, the facility failed to ensure residents assessed for fall risk had fall preventions interventions in place according to the care plan. This affected one (Resident #62) of six residents sampled for falls. The facility census was 74.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #62 revealed the resident was admitted to the facility on [DATE]. Diagnoses included unspecified anxiety disorder, major depressive disorder, and unspecified malignant neoplasm.</p> <p>Review of the most recent Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had moderately impaired cognition, had no behaviors, did not reject care, and did not wander.</p> <p>Review of the care plan dated 10/22/21 revealed Resident #62 had potential for injuries related to falls. Interventions included anti-rollback to wheelchair, assist in positioning for comfort as needed, Dycem to wheelchair when in use, encourage non-skid footwear, instruct on use of adaptive equipment, observe/report unsafe conditions, therapy evaluations as needed, toileting every two to three hours, and a raised toilet seat.</p> <p>Observations made on 11/07/24 at 9:19 A.M. revealed Resident #62 did not have the anti-rollback device installed on her wheelchair as indicated in her care plan.</p> <p>During an interview on 11/07/24 at 9:53 A.M. Assistant Director of Nursing (ADON) #113 verified Resident #62's wheelchair located in her bathroom did not have an anti-rollback device installed on it and verified her care plan stated the wheelchair would have anti-rollback. Resident #62 was present during this interview and stated to ADON #113 about one week prior, maintenance had taken the wheelchair she had been using prior to the fall, which had the anti-roll back device, with the current, smaller wheelchair that did not have the anti-rollback device because she had trouble maneuvering the former, wider wheelchair through the narrow bathroom doorway.</p> <p>Review of policy titled Fall Prevention Policy and Procedure dated 02/2024 revealed the facility identified residents who were at risk for falls and implemented a plan of care to address risk factors and protect from injury.</p> <p>This deficiency represents noncompliance identified under complaint number OH00159423 and OH00158863.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42492</p> <p>Based on observation, interview, and policy review, the facility failed to ensure staff sanitized hands when providing feeding assistance to multiple residents. This affected two Residents #65 and #72 of four residents sampled for feeding assistance. The facility census was 74.</p> <p>Findings include:</p> <p>1. Review of most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 was cognitively intact, had no behaviors, did not wander, and did not reject care. Resident #72 required set-up assistance for eating.</p> <p>Review of care plan dated 04/30/22 revealed Resident #72 had an activities of daily living (ADL) self-care deficit. Interventions included supervision assistance with eating with set up help only in the Geri-chair. If the resident was eating in bed, then staff must assist.</p> <p>2. Review of the medical record revealed Resident #65 was admitted to the facility on [DATE]. Diagnoses included unspecified Alzheimer's disease, unspecified protein calorie malnutrition, and major depressive disorder.</p> <p>Review of the most recent MDS assessment dated [DATE] revealed Resident #65 had severely impaired cognition, had no behaviors, did not wander, and did not reject care. Resident #65 was dependent for eating.</p> <p>Review of care plan dated 02/01/22 revealed Resident #65 had and ADL self-care deficit. Interventions included total assistance per one staff member with eating.</p> <p>Observation on 11/07/24 at 12:02 P.M. revealed Certified Nursing Assistant (CNA) #156 was seated between Residents #65 and #72 and was using both hands interchangeably to feed residents at the same time without sanitizing hands between residents. CNA#156 used the fork in her right hand to feed Resident #72 a bite of salad. CNA #156 switched the fork to her left hand, loaded the fork with salad, switched the fork from the left to the right hand, and fed Resident #72 another bite of salad. Next CNA #156 took Resident #65's spoon in her left hand, scooped a spoonful of pureed strawberry angel food cake and fed Resident #65 with the spoon in her left hand. CNA #156 set the placed the spoon in the dish containing Resident #65's dessert, placed the fork in Resident #72's salad bowl, used both hands to remove the cover from Resident #72's container of apple juice, and placed the juice container on the table. Then CNA #156 loaded Resident #65's spoon with pureed cake using her left hand and fed the resident a bite of cake. CNA#156 used the fork in her right hand to feed Resident #72 a bite of salad. CNA #156 switched the fork to her left hand, held the salad bowl in her right hand, Scraped the sides of the bowl, loaded the fork with salad, switched the fork from the left to the right hand, and fed Resident #72 another bite of salad. Next, CNA #156 picked up Resident #65's milk carton with her right hand and assisted Resident #65 to take a sip of milk through the straw. CNA #156 did not sanitize her hands at any point during the observation.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/07/2024 at 12:08 P.M. CNA #156 stated she had been trained to use only one hand per resident when feeding multiple residents at the same time and verified she had been using her hands interchangeably when feeding Residents #65 and #72 and did not sanitize her hands between feeding residents.</p> <p>Review of policy titled General Infection Control dated 11/2023 revealed all staff followed proper infection control measures to prevent the spread of infection.</p>		