STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365427	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loveland Care Center	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)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENCE OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, review of outside provider office notes, review of hospital records, and staff interview, the facility failed to ensure wound care treatments were implemented for a resident. This resulted in Actual Harm on 08/08/25 when the facility failed to implement the orthopedic surgeon's orders for treatment to Resident #2's left ankle surgical wound. Subsequently, Resident #2 was admitted to the hospital for an infection to the left ankle surgical wound, which was treated with debridement, placement of a wound vac, and intravenous (IV) antibiotics. This affected one (Resident #2) of three residents reviewed for surgical wounds. The facility census was 75 residents. Findings include: Review of the medical record for Resident #2 revealed an admission date of 06/16/25 with diagnoses including open reduction and internal fixation of bimalleolar left ankle fracture, chronic kidney disease, and diastolic congestive heart failure. Resident #2 was discharged to the hospital from the orthopedic surgeon's office on 08/08/25 and did not return to the facility. Review of the Minimum Data Set (MDS) assessment for Resident #2 dated 06/20/25 revealed the resident was cognitively intact and required staff assistance with activities of daily living. (ADL.) Review of the orthopedic surgeon's progress notes revealed the resident was seen post operatively at the surgeon's office for follow-up to surgery to the left ankle on 06/27/25, 07/03/25, 07/11/25 and 07/25/25 with an appointment scheduled for 08/08/25. Review of the office visit report for Resident #2 dated 07/25/25 revealed a physician's order for the resident to be referred to for wound care and for the facility's wound care practitioner to evaluate and treat the surgical wound to the resident's left ankle. Review of the physician's orders for Resident #2 in the electronic medical record for July and August 2025 revealed there were no orders for a referral to wound care nor were there any treatment orders for the left ankle surgical wound. Review of the office visit report for Resident #2 dated 08/08/25 revealed the resident's left ankle surgical wound presented with signs of infection. The dressing to the wound had foul-smelling drainage and the wound itself had a large opening with a full-thickness skin defect directly over the ankle and redness around the perimeter of the wound. Resident #2 reported to the surgeon that despite the referral to wound care no one at the facility had changed the dressing to his ankle or evaluated the wound. Due to concern for surgical wound infection the orthopedic surgeon sent Resident #2 to the hospital for a direct admission to for the treatment of the infected surgical wound to include debridement, placement of wound vac, and IV antibiotics. Review of the hospital notes for Resident #2 dated 08/08/25 revealed the resident was admitted to the hospital from the orthopedic surgeon's office with an infection to the left ankle surgical wound. The dressing to the wound had not been changed, and Resident #2 underwent debridement of the wound, and a wound vac was placed. Resident #2 was also started Daptomycin, an IV antibiotic, for the wound infection. During an interview on 05/05/26 at 10:00 A.M., the Director of Nursing (DON) stated Resident #2 had an appointment on 07/25/25 at the orthopedic surgeon's office at which the surgeon gave an order for Resident #2 to be evaluated by the facility's wound care practitioner and to obtain treatment orders to the left ankle surgical wound. The DON confirmed the nurses failed to transcribe the order for wound care referral and the facility's wound care practitioner did not examine the resident nor did she (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Actual harm Residents Affected - Few	provide orders for treatment of the resident's left ankle surgical wound. The DON verified the facility nurses provided no treatment to Resident #2's wound during the time frame of 07/25/25 to 08/08/25. The DON stated Resident #2 was sent to the hospital directly from the orthopedic surgeon's office on 08/08/25, was admitted , and did not return to the facility. The deficiency was corrected on 02/16/26 when the facility implemented the following corrective action: On 02/16/26, nurses were in-serviced on the importance of transcribing and implementing orders from appointments with outside physicians. On 02/16/26, Unit Managers completed an audit of December 2025 and January 2026 physician orders to ensure no orders were missed on current in-house residents. Monthly audits of physician orders were completed in February 2026, March 2026 and April 2026, and will continue on an ongoing basis. This deficiency represents noncompliance investigated under Complaint Number 2748554.