

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365889	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2024
NAME OF PROVIDER OR SUPPLIER Lodge Care Center Inc The		STREET ADDRESS, CITY, STATE, ZIP CODE 9370 Union Cemetery Road 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 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** 43062</p> <p>Based on record review, interview, review of a facility Self-Reported Incident (SRI) and facility policy review, the facility failed to thoroughly investigate a resident's fall and failed to implement new fall interventions to prevent future falls. This affected one (#42) out of three Residents reviewed. The facility census was 102.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #42 revealed the resident was admitted to the facility on [DATE]. Diagnoses included dementia, anxiety, diabetes mellitus, atrial fibrillation, and hypotension.</p> <p>Review of the fall care plan for Resident #42 dated 02/10/24, revealed the resident was at risk for falls related to dementia, impaired safety awareness, resistance to care at times, fear of falling, and fluctuations of assistance with transfers and toileting assistance. The fall care plan revealed no new interventions to prevent additional falls after the resident's fall on 08/29/24.</p> <p>Review of the facility's incident log from 07/01/24 through 09/24/24 revealed Resident #42 had no documented incidents related to a fall on 08/29/24 during a staff transfer.</p> <p>Review of a nurse's progress note for Resident #42 dated 08/29/24 at 10:29 A.M., authored by Licensed Practical Nurse (LPN) #201 revealed the resident had large skin tears to right wrist, forearm, and a small tear on her right elbow and bruising. Per the night shift State tested Nurse Aide (STNA), the resident was combative with care. The night STNA stated she and the resident fell to the ground during a transfer. No other bruises or abrasions were found besides the skin tears. The resident was assessed and complained of back pain. A new treatment order was put in place for skin tears and the supervisor, the Director of Nursing (DON) and the Assistant DON (ADON) were made aware.</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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's SRI created 08/29/24 at 11:43 A.M., revealed Resident #42 had an injury of unknown source. Resident #42 was noted to have three skin tears to her left upper extremity. The resident was unable to recall or verbalize what happened. Resident #42 remained at baseline and had no recollection as to how she obtained the skin tears to her left upper extremity due to cognition. Resident #42 was assessed by a nurse and had no further injuries and denied pain. The summary indicated Resident #42 had three skin tears to the left upper extremity. The resident as assessed by a nurse and bandages were removed and a treatment order was put in place. The physician and families were notified, and calls were placed to the staff working the previous shift. On 09/03/24 at 8:42 A.M., the facility completed the SRI and indicated abuse, and neglect was not suspected due to evidence being inconclusive. The investigation determined Resident #42 had fallen during a transfer earlier that morning with a STNA in the room and the incident was reported to the nurse on duty. Education was provided to the staff on abuse and areas of unknown origin and reporting of falls.</p> <p>Review of a Wound Nurse Practitioner (WNP) note for Resident #42 dated 09/03/24 revealed the resident presented with multiple abrasions on her left forearm. A treatment plan included Xeroform gauze with abdominal (ABD) pad and Kerlix applied to the abrasions of the left forearm daily. The note revealed no documentation related to a fall the resident sustained on 08/29/24.</p> <p>Review of the witness statement by STNA #326 dated 08/29/24 and narrated by the DON, revealed STNA #326 was caring for Resident #42 on 08/29/24 around 11:00 A.M. and reported everything to the agency nurse assigned to Resident #42. STNA #326 indicated the agency nurse assessed the resident and bandaged the skin tears. STNA #326 stated during her morning care, Resident #42 began to struggle against her and knocked her and the resident off balance, causing them to fall and the resident fell on top of her. STNA #326 stated Resident #42 hit her arm on the frame of the closet door which caused several skin tears. STNA #326 yelled for help and the nurse came to assist her and assess the resident.</p> <p>Review of the witness statement by LPN #325 dated 08/29/24 and narrated by the DON, revealed she was notified by an STNA that another STNA and the resident had fallen and needed assistance. LPN #325 stated she assessed Resident #42 and dressed her skin tears. When DON questioned LPN #325 about why an incident was not reported and why she didn't create a nurse's note, LPN #325 stated she did not know she needed to do these things.</p> <p>Review of Resident #42's most recent Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively impaired. The resident was dependent on staff for transfers.</p> <p>Interview with Agency LPN # 325 on 09/20/24 at 8:13 A.M., revealed she was the nurse on duty on 08/29/24. LPN #325 stated STNA # 326 reported to her that she lowered Resident #42 to the ground and Resident #42 came down on top of STNA #326's stomach. LPN #325 stated she never considered the incident a fall because she was informed that Resident #42 never hit the floor. LPN #325 verified Resident #42 had skin tears and she bandaged the skin tears. LPN #325 stated she told the nurse supervisor who signed her timecard as she was leaving the facility. LPN #325 verified she did not notify the physician or the family because she was not aware she needed to.</p> <p>(continued on next page)</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>Interview with Assistant Director of Nursing (ADON) #200 on 09/24/24 at 4:46 P.M., verified Resident #42 had a fall during a staff transfer on 08/29/24. ADON #200 verified the facility failed to thoroughly investigate Resident #42's fall because the facility was not immediately aware of a fall until after they started the injury of unknown origin investigation. ADON #200 stated he was completing morning rounds on 08/29/24 and noticed Resident #42's had skin tears on her arm. ADON #200 stated he questioned the information that agency STNA #326 provided to him about Resident #42 being combative due to the information not being correct because Resident #42 never had a history of being combative and never displayed that type of behavior. ADON #200 stated he could not provide any related information about why the fall was not investigated. ADON #200 stated that after a resident falls, the facility will meet as a team to discuss care plans, complete a risk management report, and discuss new interventions. ADON #200 verified the facility failed to meet as a team and discuss Resident #42's fall and failed to implement any new interventions to prevent future falls for Resident #42. ADON #200 stated the investigation was more focused on an unknown injury.</p> <p>Review of a facility document titled, Fall Prevention and Training for Elderly Residents, undated, revealed keeping the resident safe and sound was the top priority. The facility utilizes risk assessment tools, environmental factors, medication management and assistive devices for elements to prevent falls. The facility will identify fall risk, implement and evaluate interventions utilized to aid the prevention of falls, and revise them as necessary.</p> <p>Review of the facility policy titled, Fall Management, dated 01/2001, revealed each resident's risk factors and environmental hazards will be evaluated with a resident's comprehensive plan of care developed along with interventions monitored for effectiveness. The facility will follow and complete the following steps: assess the resident, complete a post-fall assessment, notify physician and family, review the residents plan of care and update, document all assessments and actions, and obtain witness statements in the case of injury.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157672.</p>		