STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365889	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lodge Nursing & Rehab Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the facility failed to store and prepare food in a sanitary manner to prevent spoliage and protect against a foodborne illness. This had the potential to affect all residents residing in the facility except for the three residents (#6, #13 and #15) with diet orders of nothing by mouth. The facility census was 117.Observation on 04/06/2026 at 9:05 A.M. revealed a red plastic bucket with a liquid inside being stored in the food preparation sink. Interview with Dietary Director (DD) # 446 revealed that the red bucket contained sanitizer and that it should not be stored in the food preparation sink. Observation on 04/06/2026 at 9:05 A.M. revealed two cracked eggs were stored in a small pastic bowl on ice in the kitchen. Further observation revealed that the ice was almost completely melted. Observation on 04/06/2026 9:07 A.M. revealed DD #446 taking a temperature of the eggs. DD #446 verified that the ice had melted and the eggs were at 46 degrees F. DD #446 verified that the eggs should be stored below 41 degrees F. Observation on 04/06/2026 at 9:09 A.M. revealed that the can opener blade was unclean with a build up of food debris. Interview with DD #446 verified that the can opener blade was unclean. Observation on 04/06/2026 at 9:14 A.M. revealed two plastic containers that were stacked while wet. Interview with DD #446 verified that the pans were wet and should have been completely air dried prior to stacking. Observation on 04/06/2026 at 9:15 A.M. revealed a cooler on the tray line that was holding a variety of items such as drinks and yogurts. Further observation revealed that the thermometer in the cooler was reading 45 degrees F. DD #446 verified the thermometer was reading 45 degrees F. Observation on 04/06/2026 at 9:17 A.M. revealed DD #446 taking the temperature of a yogurt that was in the cooler on the tray line. DD #446 verified that the yogurt was at 44 degrees F and that it should be below 41 degrees F. Observation on 04/06/2026 at 9:23 A.M. revealed opened bags of dry spaghetti noodles, egg noodles, zetti noodles, and penne noodles without an open date. Interview with DD #446 verified that the bags of pasta were not dated when they were opened. Observation on 04/08/2026 at 12:09 P.M. revealed Dietary Aide (DA) #394 obtain a grilled cheese sandwich from the walk in cooler, don gloves, and proceed to prepare the sandwich. Interview wit DA #394 verified that she did not wash her hands prior to donning gloves and preparing the sandwich. Review of the undated facility policy titled, Food Storage revealed foods should be dated as required by state regulations. Refridgerated food must maintain at or below 41 degrees F. Review of the undated facility policy titled, General Food Preparation revealed employees should wash their hands prior to putting on and after removing gloves. All food equipment should be cleaned, sanitized, air dried and reassembled after each use.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to treat residents with respect and dignity. This affected two (#8 and #11) of two residents reviewed for dignity. The facility census was 114. 1.Resident #11 admitted to the facility on [DATE] with diagnoses including malignant neoplasm of base of tongue, general anxiety disorder, and delusional disorders. Review of the minimum data set (MDS) dated [DATE] revealed Resident #11 had moderate cognitive impairment. Observation on 04/06/2026 at approxiamately 12:15 P.M. revealed Resident #11 was standing in her door way and visibly agitated. Resident #11 was being argumentative with staff while they were attempting to assist her. Interview on 04/09/2026 at the same time as the observation, Registered Nurse (RN) #418 made a comment to the surveyor stating that with the way Resident #11 is acting it appears the cancer has spread to her brain. 2.Review of the medical record revealed that Resident #8 was admitted to the facility on [DATE] with diagnoses including parkinson's disease without dyskinesia with fluctuations, psychotic disorder with hallucinations, and bipolar disorder. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #8 is cognitively intact. Resident #8's ability to hear is highly impaired. Review of the care plan revealed Resident #8 has a communication problem related to damage to the nerves in her ears causing her to be deaf. Interventions include being able to communicate by lip reading, writing, using communication board, gestures, sign language, and picture cards. Interview on 04/07/26 at 8:20 A.M. with Resident #8 revealed that she would like an American Sign Language interpreter for the interview. During an interview on 04/07/2026 at 8:38 A.M. RN #418 asked the surveyor how the interview with Resident #8 went. When the surveyor stated that Resident #8 had requested an interpreter, RN #418 stated that Resident #8 only requested an interpreter because she loves the attention. Interview on 04/09/2026 at 7:25 AM with Corporate Quality Assurance Nurse #309 verified that both comments made by RN #418 are not appropriate when speaking about a resident. Review of the facility policy titled, Dignity dated 02/28/20 revealed each resident will be cared for in a manner that promtes and enhances quality of life, dignity, respect and individuality. This deficiency represents non-compliance investigated under Complaint Number 1331410.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based medical record review, observation, resident interview, staff interview, and policy review, the facility failed to ensure residents who were dependent on staff received adequate activities of daily living (ADL) care. This affected three (#29, #65, and #115) of four residents reviewed ADL's. The facility census was 117. Findings include: 1. Review of the medical record of Resident #29 revealed an admission date of 02/26/26. Diagnoses included right femur fracture, type 2 diabetes mellitus, depression, and history of breast cancer. Review of the comprehensive minimum data set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident required setup/cleanup assistance with eating, substantial/maximal assistance with bed mobility and transfers, and was dependent for toileting and bathing. Observation on 04/06/26 at 3:00 P.M. revealed Resident #29 lying in bed. Resident #29 had several chin hairs, varying in length from 1 to 1.5 inches. Interview on 04/06/26 at 3:04 P.M., Resident #29 emphatically stated she absolutely did not prefer to have chin hairs. Resident #29 stated, when she lived in the community, she would go to the spa and get dermaplaned and was embarrassed at what her chin looked like. Resident #29 stated staff had not offered to shave her. Interview on 04/06/26 at 3:16 P.M., Licensed Practical Nurse (LPN) #305 verified Resident #29 had several long chin hairs. LPN #305 offered to have staff clean her up and Resident #29 stated, she would love that. 2. Review of the medical record of Resident #65 revealed an admission date of 01/22/26. Diagnoses included type 2 diabetes, effusion of right knee, and hyperlipidemia. Review of the comprehensive MDS assessment dated [DATE] revealed the resident had intact cognition. The resident required setup/cleanup assistance with eating, substantial/maximal assistance with bed mobility, transfers, and toileting and bathing. Observation on 04/08/26 at 3:24 P.M. revealed Resident #65 sitting in their chair. Resident #65 had long, grown out toenails. Resident #65's great big toe toenail curved into their index toenail on each foot. This caused irritation to the index toenail. Interview on 04/08/26 at 3:25 P.M., Resident #65 emphatically stated she was experiencing pain from her toenails rubbing against each other and getting caught on things. Resident #65 also confirmed they had requested the facility to cut them over a month ago. Interview on 04/08/26 at 3:30 P.M., Licensed Practical Nurse (LPN) #318 confirmed Resident #65 had long, grown out toenails. LPN #318 confirmed they would put in a consultation for the podiatrist and that the resident's toenails length was unacceptable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/08/26 at 10:05 A.M with Corporate Quality Assurance Nurse (CQAN) #309 confirmed staff should have addressed Resident #65's toenail length. 3. Review of the medical record revealed Resident #115 was admitted on [DATE] with diagnoses including displaced intertrochanteric fracture of left femur, muscle wekaness, dementia and intervertebral disc degeneration. Review of the MDS assessment dated [DATE] revealed Resident #115 was cognitively intact. Further review of the MDS revealed Resident #115 is dependent on staff for showering. Review of the care plan revealed Resident #115 has an activities of daily living (ADL) self care performance deficit. Interventions include Resident #115 requires total dependance with shower/bathing of self and assistance with ADLs as needed. Interview on 04/06/2026 at 12:10 P.M. with Resident #115 revealed that he has not been getting his showers regularly. Resident #115 stated that recently he went about two weeks without a shower. Review of the bathing task record revealed Resident #115 is offered bathing on Mondays and Thursdays. Review of the task for Feburay 2026 revealed eight days when bathing should have been offered and all eight days were marked as not attempted. Review of the task for March 2026 revealed bathing should have been offered on nine days. Further review of the task revealed Resident #115 recieved bathing assistance on 03/13/26, 03/17/26, 03/26/26, and 03/29/26. Review of the task for April 2026 revealed 04/02/26 was blank and 04/06/26 was marked not attempted. Interview on 04/09/26 at 7:20 A.M. with CQAN #309 verified that based on documentation, Resident #115 did not recieve a shower on the days marked not attempted or blank. Review of the facility policy titled, Activities of Daily Living (ADL) Care, dated 01/2024, revealed nursing staff would assist residents with ADL needs, including basic care tasks, such as bathing, based on individual needs. This deficiency represents non-compliance investigated under Complaint Number 1331411, 2797726, 1331409, 2611291, and 2961234.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and policy review, the facility failed to ensure residents receive psychiatric services in a timely manner. This affected one (#11) of one resident reviewed for behavioral health services. The facility census was 117. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm of base of tongue, generalized anxiety disorder, depression, and delusional disorders. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #11 has moderate cognitive impairment. Review of the care plan revealed Resident #11 has impaired cognitive function/dementia or impaired thought process. Interventions include keeping family and care giver informed of Resident #11's capabilities and needs. Monitor, document and report to the physpician any changes is Resident #11's cognitive function. Observation 04/06/2026 at 12:15 P.M. revealed Resident #11 standing in the doorway of her room. Resident #11 appeared to be agitated and was untrusting of staff attempting to encourage her to use her walker to prevent a fall. Interview on 04/07/2026 at 9:04 A.M. with Resident #11 revealed that the facility has not offered her psychiatric services and that she would like someone to talk to if those services were offered. Review of the medical record revealed that a services request form for mental health services was signed by Resident #11 on 03/10/26.Review of the progress note dated 03/22/26 at 3:36 P.M. revealed Resident #11's family is concerned about her mental health and requested her to be seen by psychiatry. Review of the progress note dated 03/23/26 at 8:25 P.M. revealed Resident #11 was anxious and the family was requesting for her to be evaluated for a medication change. Review of the physician order note dated 03/25/26 at 4:56 P.M. revealed Resident #11 recieved a new order to be seen by Eventus WholeHealth for psychological/psychiatric services. Review of the progress note dated 03/26/26 at 8:59 P.M. revealed that the nurse spoke with psychiatric services about a change in medication management. The request was denied and stated that it would be reevaluated next week. Review of the care conference notes from 03/30/26 revealed Resident #11's family discussed Residents #11's frequent refusals of care and requested for her to have a psychiatric evaluation. Review of the progress note dated 03/31/26 at 2:26 P.M. revealed Resident #11's sister had recently taken her to an infusion appointment where Resident #11 refused lab draws, urine collection, hydration and medication infusion. The sister stated that Resident #11 has delusions and doesn't recognize familiar people in her life, and doesn't trust them. Review of the progress note dated 04/07/26 at 10:02 A.M. revealed Resident #11 was obsevered in bed wearing a coat and her lower extremeties uncovered with a brief in place. The writer offered to adjust room temperature, close door, and pull the privacy curtain to promote confort and safety which was declined by Resident #11. The writer stated the refusal of care may be influenced by underlying medical conditions and psychiatric conditions. Interview on 04/09/2026 at 8:34 A.M. with Corporate Quality Assurance Nurse (QCAN) #309 revealed that Resident #11 was seen by psych services on 04/08/26. QCAN #309 verified that services usually start within a week of being requested and that Resident #11 had not been seen prior to 04/08/26.Review of the facility policy titled, Behavior Management dated 01/27/21 revealed the facility will identify behaviors, implement interventions, monitor and adress changes.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:24Number of residents cited:2 Based on observation, interviews, medical record review, and policy review, the facility failed to ensure medication carts were appropriately locked while nurses administered medications. The facility identified one (Resident #31) resident residing on the Central Unit who was cognitively impaired with mobility. Additionally the facility failed to ensure eye drops were stored according to manufacturer's recommendations. This affected one (Resident #17) of one residents receiving eye drops from the Shelter-Even medication cart. The facility census was 114. Findings include: 1.Review of the medical record revealed Resident #31 was admitted to the facility on [DATE]. Diagnoses included unspecified cerebral infarction, unspecified vascular dementia with mood disturbance, unspecified protein calorie malnutrition, and malignant neoplasm of the colon with colostomy status. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 had severely impaired cognition, had no behaviors, did not wander, and occasionally rejected care. She used a walker for ambulation and required touch assistance at times. Observation on [DATE] at 9:48 A.M. revealed Registered Nurse (RN) #376 prepared medications for Resident #94, and left the medication cart unlocked before entering the room. RN #376 administered the medications in four spoonful's and gave the resident sips of water with Miralax between bites. She assessed Resident #94's pulse and blood oxygen levels using a pulse oximeter, adjusted the head of bed to the resident's comfort, and washed her hands before returning to the unlocked medication cart. During and interview on [DATE] at 9:50 A.M. RN #376 acknowledged the medication cart was unlocked and was not in sight when the nurse administered medications to Resident #94 and apologized. Review of policy titled Medication Administration dated [DATE] revealed the medication cart is locked at all times unless in use and under direct supervision of the medication nurse. 2.Review of the medical record revealed Resident #17 was admitted to the facility on [DATE]. Diagnoses included late-onset Alzheimer's disease, unspecified protein calorie malnutrition, chronic obstructive pulmonary disease, and macular degeneration. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 had moderately impaired cognition, had no behaviors, did not wander, and did not refuse care. Review of the medical record revealed Resident #17 had physician orders dated [DATE] for Cosopt PF Ophthalmic Solution 22.3-6.8 MG/ML (Dorzolamide HCl-Timolol Maleate) to instill one drop into both eyes twice daily related to non-exudative age-related macular degeneration. Observation on [DATE] at 2:58 P.M. revealed the top drawer of the Shelter - Even med cart, contained a box of Cosopt PF Ophthalmic Solution 22.3-6.8 MG/ML (Dorzolamide HCl-Timolol Maleate) single-use ampules packed in silver light-resistant packages of 15 ampules each. Instructions on package stated After pouch is opened, store in the single use pouch to protect from light, and throw away any unused single-use containers 15 days after opening the first pouch. Two pouches of ampules were opened. One pouch containing twelve ampules had a handwritten expiration date labeled [DATE]. The second opened pouch contained nine ampules and was not labeled or dated. During an interview on [DATE] at 3:03 P.M. Licensed Practical Nurse (LPN) #303 verified the twelve Cosopt ampules in the package labeled Expires [DATE] were outdated, and stated she did not know when the unlabeled package had been opened. LPN #303 stated nurses usually dated multi-use packages or bottles on the day they were opened. She stated she was unaware that the Cosopt ampules expired within fifteen days of opening the foil pack. Review of policy titled Medication Storage dated [DATE] revealed Medications were stored safely and securely according to manufacturer's recommendations.