STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365993	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare of Louisville Ctr for Rehab & Nsg Care	7187 St Francis Street, NE Louisville, OH 44641

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42015 Based on medical record review, resident interview, and staff interview, the facility failed to ensure Resident #29's pain medication was reordered timely. This affected one resident (#29) out of three (Resident #18, Resident #29, and Resident #54) reviewed for medication administration. The facility census was 64. Findings include: Review of the medical record for Resident #29 revealed an admitted [DATE]. Diagnoses included malignant neoplasm of head, face and neck, malignant neoplasm of tongue, dysphagia, oropharyngeal phase, and gastrostomy status. Review of the Minimum Data Set assessment dated [DATE] revealed Resident #29 was mildly impaired with a Brief Interview for Mental Status (BIMS) of 12. Review of Resident #29's February 2025 physicians orders revealed an order for Gabapentin 12 milliliters (ml) to equal 600 milligrams (mg) to be administered orally twice daily. Review of Resident #29's Medication Administration Record revealed the resident did not receive his Gabapentin 600 mg on 02/10/25 for the scheduled dose from 1:00 P.M. to 2:30 P.M. or on 02/11/25 from 6:30 A.M. to 10:30 A.M. The reason/comment section for the missed medication dates showed the rational as not administered, on hold, awaiting pharmacy. Review of Resident #29's nurse progress notes from 02/10/25 through 02/11/25 revealed no evidence where the physician was made aware of the missed doses of pain medication. Interview on 02/26/25 at 3:25 P.M. the Director of Nursing verified Resident #29's Gabapentin was not reordered timely by the facility nurses resulting in the resident missing two doses of his pain medication. Interview on 02/27/25 at 9:07 A.M. with Resident #29 revealed the facility did not always order his pain medication timely. He reported he had to wait for the pharmacy to bring in his medication and had also missed doses because the facility had not ordered the medications timely. This deficiency represents non-compliance investigated under Complaint OH00162436.

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