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	07/24/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and review of facility policy, the facility failed to ensure a physician order was obtained for Resident #7's right lower arm skin tear. This affected one resident (#7) of one resident reviewed for general skin conditions. The facility census was 77.Findings include: Review of Resident #7’s medical record revealed the resident was admitted on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia, aphasia and chronic systolic congestive heart failure. Review of Resident #7’s care plan for skin care revealed an intervention dated 04/15/25 to perform treatments as per the physician orders. Review of Resident #7’s Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited moderate cognitive impairment. Review of Resident #7’s Wound Information form dated 07/07/25 revealed the resident had a right lower arm skin tear which measured one centimeter (cm) length by 0.8 cm width. Review of Resident #7’s Wound Information form dated 07/21/25 at 7:33 P.M. revealed the resident had a right lower arm skin tear first identified on 07/02/25 at 10:28 P.M. which measured 1.2 cm length by 1. 2 cm width. Review of Resident #7’s physician orders for July 2025 revealed no treatment orders for the resident’s right lower arm skin tear. Observation on 07/21/25 at 9:07 A.M. revealed Resident #7 was lying in bed and had a dressing on the right arm. The dressing was dated 07/19/25. An interview on 07/21/25 at 9:18 A.M. with Certified Nursing Assistant (CNA) #223 verified Resident #7 had a dressing on the right arm dated 07/19/25. An interview on 07/22/25 at 2:59 P.M. with the Director of Nursing (DON) revealed Resident #7 did not have an active physician order for treatment to the skin tear on the right arm. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview on 07/22/25 at 4:30 P.M. with the DON revealed a treatment plan was obtained on 07/02/25 for Resident #7 to receive treatment to the right lower arm skin tear including cleanse the right forearm with normal saline, pat dry, and cover with a clean dressing every other day. The DON verified it had not been written as a physician order. Review of the Clean Technique Wound Care policy updated 05/01/25 revealed it was the facility policy to provide wound care to residents using professional standards of practice.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and review of facility policy, the facility failed to ensure Resident #5's left lower leg/foot dressing was administered as ordered. This affected one resident (Resident #5) of three residents reviewed for pressure ulcers/injury. The facility census was 77.Findings include:Review of Resident #5's medical record revealed the resident was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease, cellulitis of the right and left lower limbs and chronic pain. Review of Resident #5's Pressure Ulcer Care Plan revealed an intervention dated 01/29/25 to perform current treatment as ordered and observe treatment for effectiveness.Review of Resident #5's Quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #5's physician orders revealed an order dated 07/17/25 to flush the left medial ankle and posterior Achilles with normal saline, pat dry, pack with iodoform and cover with a dry dressing daily; an order dated 07/17/25 to apply betadine wet to dry to bilateral heels once a day; an order dated 07/22/25 to cleanse the left heel and right heel with normal saline, pat dry, apply xeroform gauze into the wound, cover with an abdominal dressing, wrap with kerlix and secure with tape once a day.Review of Resident #5's medication administration record (MAR) and treatment administration record (TAR) from 07/01/25 to 07/22/25 revealed on 07/20/25 Licensed Practical Nurse (LPN) #213 documented the wound care was on hold and wound rounds were the next day and on 07/21/25 the betadine was unavailable to be administered to the resident's right and left heel per the physician's order.Review of Resident #5's progress notes from 07/01/25 to 07/22/25 did not reveal evidence that the resident's left medial ankle and posterior Achilles wound care were on hold by the physician.An observation including interview was conducted on 07/21/25 at 2:56 P.M. with Physical Therapist (PT) #293 of Resident #5's left foot and ankle's dressing that was observed with a date mark of 07/19/25. PT #293 verified Resident #5's left foot and ankle dressing was dated 07/19/25. An observation on 07/22/25 at 3:45 P.M. with the Director of Nursing (DON) of wound care treatment for Resident #5 revealed the nurse removed the dressing to Resident #5's right heel, removed her gloves, washed her hands, put on gloves, cleaned the right heel with normal saline, removed gloves, washed hands, put on gloves, applied xeroform non-stick dressing, an abdominal dressing and kerlix to the right heel. Betadine was not applied to the right heel.An observation on 07/22/25 at 4:00 P.M. with the DON of wound care treatment for Resident #5 revealed the nurse removed the dressing to Resident #5's left heel, removed her gloves, washed her hands, put on gloves, cleansed the left heel with normal saline, removed her gloves, washed her hands, put on gloves, placed a xeroform non-stick dressing, an abdominal dressing and kerlix to the left foot. Betadine was not applied to the left heel.An observation on 07/23/25 from 10:35 A.M. to 10:42 A.M. with the DON of the treatment administration cart and treatment storage rooms did not reveal evidence of betadine in the facility.An interview on 07/23/25 at 10:42 A.M. with the DON revealed she had called the Nurse Practitioner (NP) to change the order for Resident #5 to have betadine applied to bilateral heels once a day because the facility ran out of betadine. The DON confirmed Resident #5 had not received wound care treatment as ordered. Review of the Pressure Injuries: Assessment, Prevention and Treatment policy updated 05/01/25 revealed the facility should identify the residents at risk for developing pressure injuries, implement interventions to prevent the development of pressure injuries and provide care for existing pressure injuries. This deficiency represents non-compliance investigated under Complaint Number OH00167333 (1373385).

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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** Based on record review and interview, the facility did not ensure Resident #81 was administered medication according to physician orders. The affected one resident (#81) of five residents reviewed for medication administration. The facility census was 77.Findings include: Review of the medical record revealed Resident #81 was admitted to the facility on [DATE]. Diagnoses included type two diabetes mellitus. Resident #81 discharged from the facility on 04/09/25.Review of the admission Minimum Data Set 3.0 assessment dated [DATE] revealed Resident #81 had intact cognition, had lower extremity impairment on one side, required substantial assistance with turning in bed, urinary continence was not rated, and he was frequently incontinent of bowels. Resident #81 was at risk of developing pressure injuries however he was not admitted with any unhealed pressure injuries. Review of the physician orders revealed Resident #81 had an order for Mounjaro (diabetic medication)15 milligrams subcutaneous one a week on Monday dated 02/26/25 and discontinued on 03/24/25 (changed to Tuesday on 03/24/25 so they could give him the injection after it came in from the pharmacy)Review of the March 2025 Medication Administration Record (MAR) revealed Resident #81 was not administered his once weekly Mounjaro on 03/03/25, 03/17/25, and 03/24/25. The comment section of the MAR indicated on 03/03/35 the medication was discontinued, on 03/17/25 it was on hold, and on 03/24/25 it was on hold. Resident #81 was administered the medication on 03/10/25. Review of the pharmacy delivery sheet dated 02/27/25 revealed Resident #81 received one 15 milligram injection of Mounjaro.Review of the pharmacy delivery sheet dated 03/25/25 revealed Resident #81 received four-15 milligram injections of Mounjaro.An interview on 07/23/25 at 10:45 A.M with Regional Nurse #292 revealed on 03/03/25 the nurse working had inadvertently put in the comment section of the MAR that the Mounjaro for Resident #81 was discontinued because she had discontinued his Lantus insulin and she wrote that in error for his Mounjaro. RN #292 verified the nurse never administered the Mounjaro on 03/03/25. RN #292 stated Resident #81 was given one dose of the Mounjaro on 03/10/25 which had been delivered on 02/26/25 however, the pharmacy had not sent any more doses and no one in management was aware the facility had not received any more doses from the pharmacy and Resident #81 had missed several doses until 03/24/25 when they reached out to the pharmacy and had them deliver the medication and it was administered the next day. RN #292 stated the facility had not realized pharmacy had not sent it. RN #292 stated Resident #81 had not received the 03/17/25 and 03/24/25 dose because it was not available from the pharmacy and it was then given on 03/25/25.