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	04/09/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review the facility failed to ensure proper hand hygiene was maintained during medication administration for Resident #46 and Resident #61 and during incontinence care for Resident #59. This affected three residents (#46, #59, #61) out of six residents reviewed for hand hygiene practices. The facility census was 78.Findings include:1. Observation on 04/09/26 between 8:40 A.M. and 9:17 A.M. of medication administration revealed the following: Licensed Practical Nurse (LPN) #363 dispensed and administered medications to Resident #41 and did not utilize hand hygiene upon exiting the room; LPN #363 then immediately dispensed and administered medications to Resident #61 and did not utilize hand hygiene upon exiting the room; LPN #363 then went to the medication storage room before returning to the medication cart; LPN #363 did not utilize hand hygiene after returning to the mediation cart from the medication storage room and then immediately dispensed and administered medications to Resident #46; LPN #353 then assisted Resident #46 with inserting and adjusting her nasal cannula for oxygen administration, and then LPN #363 washed her hands.An interview on 04/09/26 at 9:15 A.M. with LPN #363 verified the above findings.Review of the facility policy titled Medication Administration-General Guidelines, dated 01/2028 revealed medications were to be administered in accordance with good nursing principles and practices, hand hygiene was to be done prior to handling medications and after direct resident contact.Review of the undated facility policy titled Hand Washing-Hygiene, revealed hand hygiene would aid in the prevention and transmission of disease, hand hygiene was to be performed before direct resident contact, hand hygiene was to be performed before handling medications, after contact with objects near the resident, and after removing gloves.2. Review of the medical record revealed Resident #59 was admitted to the facility on [DATE] with a re-entry date of 11/11/25 with diagnoses that included epilepsy, physical debility, Type 2 diabetes, muscle weakness, and major depressive disorder.Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #59 was cognitively intact, did not reject care, was dependent on staff for toileting hygiene, required maximal assistance to turn side to side, and was frequently incontinent of urine.Review of the care plan revealed Resident #59 was incontinent of urine with a goal dated 02/23/26 that the resident would not have skin breakdown, interventions included provide incontinence care as needed and assist with toileting.An observation on 04/09/26 at 11:12 A.M. of incontinence care for Resident #59 with Nurse Aid in Training (NAIT) #371 and LPN #328 revealed the following: NAIT #371 was providing perineal care to Resident #59 and after the resident was cleansed of the skin cleaner NAIT #371 removed her gloves and then immediately put on a new pair without utilizing hand hygiene; NAIT #371 then dried Resident #59 with a towel; Resident #59 was assisted to her left side by NAIT #371 and LPN #328; incontinence care continued when NAIT #371 asked LPN #328 to get an incontinence brief from the bathroom; LPN #328 went to the resident bathroom, removed her gloves, came back into the room, handed NAIT #371 the incontinence brief and then immediately put on new gloves without utilizing hand hygiene, and then continued assisting with Resident #59 positioning; and then incontinence care was completed and Resident #59 made comfortable and repositioned.An observation on 04/09/26 at 11:23 A.M. revealed a hand sanitizer dispenser was not located in (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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #59's bathroom.An interview on 04/09/26 at 11:25 A.M. with NAIT #371 verified her gloves were changed without utilizing hand hygiene.An interview on 04/09/26 at 11:35 A.M. with LPN #328 verified hand hygiene was not completed before new gloves were applied.Review of the facility policy titled Perineal Care, dated 05/01/25 revealed after gloves are removed hand hygiene was to be utilized before new gloves were applied.Review of the undated facility policy titled Hand Washing-Hygiene, revealed hand hygiene would aid in the prevention and transmission of disease, hand hygiene was to be performed before direct resident contact, hand hygiene was to be performed before handling medications, after contact with objects near the resident, before applying gloves, after removing gloves, after contact with intact resident skin, and after contact with contaminated objects.