STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366141	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Louisville Gardens Care Center	4466 Lynnhaven Avenue NE Louisville, OH 44641

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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 record review, observation and interview, the facility failed to ensure staff administered Resident #32's wound treatment as ordered by the physician. This affected one resident (#32) out of three residents reviewed for wounds. The facility census was 66.Findings include:A review of Resident #32's clinical record revealed an admission date of 10/12/25 with diagnoses including morbid obesity, cognitive communication deficit, obstructive and reflux uropathy, pneumonia, type two diabetes mellitus, congestive heart failure, atrial fibrillation (irregular heart rhythm), high blood pressure, chronic kidney disease, depression, anxiety, disorientation and rotator cuff tear of the right shoulder.A review of Resident #32's wound assessment dated [DATE] indicated the presence of a deep tissue injury (A purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.) to the right lateral heel.A review of Resident #32's physician orders dated 12/01/25 revealed an order to cleanse the right lateral heel with normal saline, pat dry, apply betadine (antiseptic), cover with abdominal (ABD) pad and wrap with gauze daily and as needed during the night shift.A review of Resident #32's Treatment Administration Record (TAR) dated 12/01/25 to 12/31/25 revealed documentation the wound treatment was performed on 12/09/25.An observation on 12/10/25 at 12:00 P.M. of Resident #32's right lateral heel revealed the dressing was dry and intact and the date of the dressing was documented as 12/08/25 and initialed by the nurse.An interview on 12/10/25 at 12:00 P.M. with Certified Nursing Assistant (CNA) #75 and CNA #78 verified the above findings and agreed the wound treatment was not changed on 12/09/25.This deficiency represents non-compliance investigated under Complaint Number 2640234 and Complaint Number 2680110.

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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(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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure medications were available to administer to Resident #21 and Resident #39 in a timely manner. This affected two residents (#21 and #39) out of five residents reviewed for medication administration. The facility census was 66.Findings include:1. A review of Resident #21's clinical record revealed an admission date of 10/23/25 with diagnoses including pleural effusion, hemiplegia and hemiparesis following a stroke, atelectasis, trouble swallowing, cognitive communication deficit, tracheostomy, epilepsy, malnutrition, type two diabetes mellitus, chronic pancreatitis, depression, anxiety, high cholesterol and blood pressure, and acute/chronic respiratory failure requiring ventilator support.A review of Resident #21's clinical record revealed an admission to the facility on [DATE] following a hospitalization for acute respiratory failure.A review of Resident #21's physician orders dated 10/23/25 revealed an order to administer lacosamide (medication used to control seizures) 150 milligrams (mg) via percutaneous endoscopic gastrostomy (PEG) tube two times a day.A review of Resident #21's Medication Administration Record (MAR) dated 10/01/25 to 10/31/25 indicated the lacosamide medication was not administered on 10/23/25 and 10/24/25.A review of Resident #21's nursing progress notes dated 10/24/25 indicated the lacosamide medication was not administered because the pharmacy needed a prescription for the medication.An interview with Licensed Practical Nurse (LPN) #79 on 12/10/25 at 8:58 A. M. revealed Resident #21's lacosamide medication was not available in the facility to administer to Resident #21. LPN #79 stated she notified Certified Nurse Practitioner (CNP) #80 who was in the facility at the time. CNP #80 called the pharmacy to inform them of the need for Resident #21's lacosamide medication. LPN #79 stated this occurred at the end of her shift and the oncoming nurse (unnamed) would need to administer the lacosamide medication when it arrived from the pharmacy.Three attempts to speak to the oncoming nurse (LPN #81) were unsuccessful from 12/09/25 to 12/11/25 and an interview with CNP #80 on 12/09/25 at 2:32 P.M. verified she had called the pharmacy on 10/24/25 to obtain the lacosamide medication for staff to administer to Resident #21. CNP #80 stated she was unaware the staff did not receive the lacosamide medication prior to Resident #21's readmission to the hospital on [DATE].An interview with the Director of Nursing (DON) on 12/10/25 at 10:43 A.M. verified the above findings and agreed the documentation revealed Resident #21 did not receive the lacosamide medication on 10/23/25 and 10/25/25.2. A review of Resident #39's clinical record revealed an admission date of 08/20/18 with diagnoses including cerebral palsy, epilepsy, profound intellectual disability, hypothyroidism, depression, high cholesterol, anxiety and senile degeneration of the brain.A review of Resident #39's clinical record revealed a physician order dated 02/10/25 to administer phenobarbital 32.4 mg (anticonvulsant) rectally three times a day.A review of Resident #39's MAR dated 12/01/25 to 12/31/25 indicated the phenobarbital medication was not administered from 10:00 P.M. on 12/02/25 to 2:00 P.M. on 12/06/25.A review of Resident #39's nursing progress notes dated 12/02/25 indicated an attempt to pull the phenobarbital medication from the facility's stocked medications was unsuccessful due to the pharmacy needed an updated prescription. The note indicated CNP #82 was notified. Multiple nursing progress notes dated 12/02/25 to 12/06/25 revealed several attempts were made to have the pharmacy deliver the phenobarbital rectal suppository medication, and the physician was notified as well.An interview with LPN #74 on 12/10/25 at 9:45 A.M. verified Resident #39's phenobarbital medication was not available in the facility to administer to Resident #39. LPN #74 stated she contacted the pharmacy and spoke to the pharmacy staff who informed her they were unable to provide the phenobarbital medication until a prescription was provided to the pharmacy. LPN #74 stated she emailed and sent two prescriptions for the phenobarbital medication to the pharmacy which the pharmacy denied receiving at least seven times. LPN #74 stated Resident #39 had seizures and was worried she would have a seizure due to not receiving her seizure medication. LPN #74 stated on 12/06/25 CNP #82 sent the prescription via electronic scripts, and the pharmacy finally delivered the phenobarbital medication. LPN #74 verified Resident #39 did not receive the phenobarbital medication from 12/02/25 to 12/06/25. LPN #74 stated Resident #39 received the phenobarbital medication on 12/06/25 at 5:40 P.M.An interview with the DON on 12/10/25 at 10:43 A.M. revealed she reviewed the nursing progress notes daily on all the residents in the facility and verified she was aware there were several doses of the phenobarbital medication missed from 12/02/25 to 12/06/25 due to the pharmacy did not deliver the medication. The DON stated she called the pharmacy herself to ensure after they received the electronic script on 12/06/25 that a drop shipment was

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, review of the facility admission Agreement, interview and facility policy review, the facility failed to ensure Resident #7's admission paperwork was completed in a timely manner and Resident #44's medication administration documentation was accurate. This affected one resident (#7) out of three residents reviewed for admission paperwork and one resident (#44) out of three residents observed during medication administration. The facility census was 66.Findings include:Based on record review, review of the facility admission Agreement, interview and facility policy review, the facility failed to ensure Resident #7's admission paperwork was completed in a timely manner and Resident #44's medication administration documentation was accurate. This affected one resident (#7) out of three residents reviewed for admission paperwork and one resident (#44) out of three residents observed during medication administration. The facility census was 66.Findings include:1. A review of Resident #7's clinical record revealed an admission date of 03/31/25 and readmission date of 05/11/25 with diagnoses including chronic obstructive pulmonary disease, pulmonary embolism, mild dementia with agitation, deep vein thrombosis of lower extremity, asthma, depression, diabetes mellitus, type two, gastroesophageal reflux disease, heart failure, high blood pressure and cholesterol, and iron deficiency anemia.Review of the cognitive care plan note dated 09/22/25 and signed by the physician on 09/29/25 revealed a diagnosis of Dementia: Moderate in severity based on the recent local score, this patient does not have a diagnosed history of dementia, based on that Moca score, I would say she certainly should carry that diagnosis of dementia going forward, she does have a Power of Attorney (POA) in place which is her daughter I would encourage her to continue to utilize her listed decision-maker for assistance with needs or medical and financial decisions going forward.A review of Resident #7's admission Agreement revealed the documentation was completed on 09/30/25 and signed by Resident #7. (The resident had a Power of Attorney (POA) that should have been asked to sign the admission paperwork). An interview with Interim Administrator (IA) #76 on 12/10/25 at 11:36 A.M. verified the admission paperwork including the admission agreement was not completed in a timely manner for Resident #7.A review of the facility policy and procedure titled admission Agreement, dated 12/2006, indicated at the time of admission, the resident (or his/her representative) must sign an admission Agreement (contract) that outlines the services covered by the basic per diem rate, as well as any additional services requested by the resident that are not covered by the basic per diem rate.-The admission Agreement (contract) will reflect all charges for covered and non-covered items, as well as identify the parties that are responsible for the payment of such services.-With respect to our admission Agreement, our facility shall not: a. Require individuals applying to reside (or residing) in our facility to waive their rights to benefits under Medicare/Medicaid; b. Require oral or written assurances that such residents or applicants are not entitled or eligible for such benefits; c. Require oral or written assurances that such residents or applicants will not apply for such benefits; d. Require that the sponsor or legal guardian guarantee payment as a condition of admission, or to expedite the admission. (Note: An individual, or guardian, who has access to the resident's income or resources will be required to sign the admission Agreement guaranteeing payment from such funds for the care and services provided to the resident in accordance with the admission Agreement.); and e. In the case of a resident or applicant who is entitled to Medicare/Medicaid benefits for nursing care, charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under Medicare/Medicaid programs, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the applicant to the facility or as a requirement for a resident's continued stay in the facility. (Note: This shall not be construed as preventing the facility from charging Medicare/Medicaid recipients for services the resident requested that are not covered by the facility's per diem rate.)- [NAME]-fide contributions may be accepted and solicited by the facility from a charitable, religious, or philanthropic organization or from a person unrelated to a resident (or potential resident), but only to the extent that such contribution is not a condition of admission, expediting admission, or continued stay in the facility.-A copy of the admission Agreement will be provided to the resident or his/her representative (sponsor), and a copy will be placed in the resident's permanent file.-Residents will be informed of any change(s) in the costs or availability of services at least sixty (60) days prior to such change(s) taking effect. Changes in services, charges, payments, etc., will require that new agreements be signed -Inquiries concerning the facility's admission Agreement should be referred to the Administrator

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, interviews, review of the Centers for Disease Control and Prevention (CDC) guidelines and facility policy review, the facility failed to maintain infection control practices to prevent the spread of the coronavirus-19 infection (COVID-19 / SA RS-Co Y-2) in the facility and failed to ensure staff performed hand hygiene to prevent cross contamination of germs during Resident #56's incontinence care. This affected four residents (#7, #30, #51, and #45) of 16 residents (#3, #6, #7, #14, #17, #26, #27, #30, #38, #44, #45, #51, #55, #56, #65, and #67) with a positive COVID-19 infection, one resident (#31) out of four residents reviewed for smoking tobacco products, one resident (#56) out of three residents reviewed for incontinence care. This had the potential to affect all the residents in the facility. The facility census was 66. Findings include:The facility identified 16 residents (Resident #3, Resident #6, Resident #7, Resident #14, Resident #17, Resident #26, Resident #27, Resident #30, Resident #38, Resident #44, Resident #45, Resident #51, Resident #55, Resident #56, Resident #65, Resident #67) who tested positive for COVID-19 in the facility from 11/26/25 to 12/09/25. A review of each of the residents' record listed above revealed a positive test for COVID-19 and a physician order for droplet isolation precautions.1. A review of Resident #7's clinical record revealed an admission date of 03/31/25 and readmission date of 05/11/25 with diagnoses including chronic obstructive pulmonary disease, pulmonary embolism, mild dementia with agitation, deep vein thrombosis of lower extremity, asthma, depression, diabetes mellitus, type two, gastroesophageal reflux disease, heart failure, high blood pressure and cholesterol, and iron deficiency anemia,A review of Resident #7's nursing progress note dated 12/08/25 indicated Resident #7's daughter, Power of Attorney (POA), was notified that Resident #7 had tested positive for COVID-19 infection.An observation on 12/09/25 at 9:24 A.M. of Resident #7's room revealed no signage to alert staff and visitors that personal protective equipment (PPE) should be worn due to isolation precautions for a resident who tested positive for the COVID-19 infection.An interview with Licensed Practical Nurse (LPN) #70 on 12/09/25 at 9:24 A.M. verified Resident #7 had tested positive for COVID-19 infection on 12/08/25, and staff should have placed a sign outside her room to alert the staff/visitors to wear PPE. LPN #70 verified there was no signage outside of Resident #7's room.An interview with the Director of Nursing (DON) on 12/09/25 at 9:58 A.M. stated the facility had an outbreak of COVID-19 infections. All residents who had tested positive for COVID-19 were supposed to have a sign posted on the door outside their room to alert staff and visitors to see the nurse before entering the resident's room and to wear PPE for isolation precautions. The facility followed CDC guidance to control the spread of the COVID-19 viral infection. The facility had six additional residents who had tested positive for COVID-19 on 12/08/25 and currently had 16 residents (#3, #6, #7, #14, #17, #26, #27, #30, #38, #44, #45, #51, #55, #56, #65, and #67) who had tested positive for COVID-19 with one resident (#67) currently in the hospital. 2. An interview with Resident #31 on 12/09/25 at 9:46 A.M. revealed she was concerned about contracting the COVID-19 virus. Resident #31 stated the staff allowed the residents who had tested positive for the COVID-19 viral infection to smoke at the same time as the residents who had tested negative for the COVID-19 infection.An interview with the DON on 12/09/25 at 9:58 A.M. verified the staff had allowed Resident #7 who had tested positive for COVID-19 to smoke with the residents who had tested negative for COVID-19 on 12/08/25.An interview with Resident #7 on 12/09/25 at 1:15 P.M. verified she had tested positive for COVID-19 infection on 12/08/25 and was allowed to smoke with the rest of the residents including the residents who had tested negative for COVID-19 infection.3. An observation and interview with Laundry Aide (LA) #72 on 12/11/25 at 7:15 A.M. revealed she was concerned about the way the facility was handling the COVID-19 outbreak in the facility. LA #72 stated she had asked her manager, Housekeeping Manager (HM) #73, to have the laundry from residents who had tested positive for COVID-19 separated in a biohazard bag or some other process from the other residents' who had tested negative prior to delivering the soiled laundry to the laundry room. LA #72 stated HM #73 told her the facility did not use biohazard bags to differentiate the COVID-19 soiled linens from the non-COVID-19 soiled linens or any other process for the staff in the laundry room to determine which soiled linen/laundry items were from a resident with a positive COVID-19 infection. LA #72 stated she was very worried about cross contamination of the laundry to spread the COVID-19 infection to the staff in the laundry room and spreading the infection at home to her family. LA #72 lifted the lid of a large red biohazard plastic bin located in the laundry room and showed the receptacle was empty. LA #72 stated all laundry was mixed together and delivered to the laundry room and placed in