

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Louisville Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4466 Lynnhaven Avenue 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, payroll-based journal review, facility assessment review, policy review and interview, the facility failed to ensure adequate staffing to meet resident needs. This had the potential to affect all residents residing within the facility. The facility census was 53. Findings include: 1. Review of the Facility Assessment Tool updated 08/11/25 revealed the staffing included seven nurses per day; ten certified nursing assistants (CNAs) per day; two other nursing personnel; one dietitian, seven food and nutrition services staff, and one respiratory care services staff. The facility provides adequate staffing to meet needed residents' daily needs, preferences, and routines to help each resident attain or maintain the highest practicable physical, mental, and psychosocial well-being. This includes services of a registered nurse (RN) for at least (8) consecutive hours a day, seven days a week and a designated licensed nurse to serve as a charge nurse on each tour of duty as well as adequate staffing on each shift to ensure that the resident's needs and services were met by registered and licensed nursing staff, certified/state tested nursing assistants, and other support services that include but were not limited to dietary, activities/recreational, social, therapy and environmental. Review of the second quarter (2025) PBJ revealed the facility had a one-star rating. Review of resident records revealed Residents #6, #14, #21, #27, #31, #47 and #48 did not receive showers as scheduled. Interview on 09/02/25 at 9:13 A.M. with Licensed Practical Nurse (LPN) #539 confirmed there were not enough staff at times, and showers, as well as appointments, were always an issue. Interview on 09/02/25 at 9:16 A.M. with CNA #506 revealed there used to be a shower aide, and the facility took the shower aide away. CNA #506 stated she could not complete showers timely due to lack of staffing. Interview on 09/02/25 at 10:38 A.M. with Resident #49 revealed she had to wait 30 to 40 minutes for a call light response depending on the day. Interview on 09/02/25 at 10:41 A.M. with Resident #47 revealed the call light was not answered timely due to lack of staffing. Interview on 09/02/25 at 10:45 A.M. with Resident #25 revealed there were not enough staff, and she regularly had to wait 90 minutes for care. Interview on 09/02/25 at 11:47 A.M. with Resident #21 revealed there was not enough staff for timely resident care. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Staffing policy, dated 03/09/22, revealed the facility was to provide adequate staffing to meet the care and services the resident population required. Under the heading titled Policy Interpretation and Implementation revealed the following: section one of the policy noted the facility provided staffing to ensure resident care needs and services were met by licensed nursing staff, and section two noted that CNAs were available to meet needed resident care and services. 2. Observation on 09/02/25 at 4:35 P.M. revealed two call lights were on upon arrival to the 400-unit, including Resident #1's call light and Resident #60's call light. The nurse was in hall at the medication cart preparing medications, talking loudly and giggling (nobody else was near the medication cart). No aides were observed on the unit. Observation on 09/02/25 revealed the meal cart arrived and was left in hall by nursing station at 4:40 P.M. Observation of Resident #42's call light on 09/02/25 at 4:50 P.M. revealed it was triggered while RN #585 was in the resident's room administering medications. RN #585 exited the room a few minutes later, leaving the call light on. After exiting the room, RN #585 was heard asking another staff member walking briefly through the hall with a clipboard if there was an aide assigned to the unit, adding that the meals needed passed and there were three call lights that needed answered. That staff member responded that they did not know. RN #585 was then observed entering the secured memory care unit, leaving the meals undelivered and three call lights unanswered. Observation on 09/02/25 from 5:00 P.M. to 5:08 P.M. revealed CNA #502 exited the secured memory care unit and began passing meal trays and responding to call lights. Response to the call light were as follows: Resident #42's call light was answered at 5:03 P.M. (13 minutes). Resident #1's call light was answered at 5:06 P.M. (after 31 minutes observed). Resident #60's call light was answered at 5:08 P.M. (after 33 minutes observed). Observations further revealed the last dinner tray was delivered at 5:08 P.M. (28 min. to get trays passed after arriving on the unit). Interview on 09/02/25 at 5:10 P.M. with CNA #502 confirmed she was not the assigned aide for the 400 unit and did not know where the aide was but was instructed by the nurse to deliver trays and respond to call lights. Interview on 09/02/25 at 5:14 P.M. with RN #585 acknowledged Resident #1 and #60 had their call lights on when the surveyor entered the hall and confirmed she was not made aware that there was no aide for the unit. During the interview, RN #585 only became aware there was no aide when she got to the end of the hall near the nurses' station and saw that call lights remained unanswered and the meal trays remained undelivered. She requested the memory care aide pass trays and answer call lights while she passed medications and monitored the dining on the memory care unit. Interview on 09/02/25 at 5:22 P.M. with the Director of Nursing (DON) confirmed there should have been an aide scheduled for the 400 unit and was unaware that no aide was there. As far as expectations for timely response to call lights, the DON responded it depends on whether meal trays (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	were being passed or what else was going on at the time, but call lights should not go unanswered for longer than 30 minutes. Interview on 09/03/25 at 9:50 A.M. with CNA #567 revealed concerns getting assistance for two person tasks, stating the nurse working the unit on 09/02/25 (LPN #586) did not sign any of the shower sheets upon CNA #567's request and refused to assist with the transfer and toileting of Resident #23. CNA #567 reported the inability to have the aide from memory care assist because the unit should not be left unattended and had to get a nurse from another unit to come help with Resident #23's care. During the interview, CNA #567 reported that the aide that was scheduled at 3:00 P.M. on 09/01/25 and on 09/02/25 did not show up and had been a no-call, no-show several times. CNA #567 further reported informing the scheduler there was no aide to relieve her and later received a text message thanking her for staying and then telling CNA #567 that she was good to go home. CNA #567 confirmed leaving the facility with only one nurse working on the 400 unit and no aide on the afternoon shift of 09/02/25. Interview on 09/03/25 5:10 P.M. interview with Resident #1 confirmed he had placed his call light on just before dinner on 09/02/25, and it remained unanswered for greater than 30 minutes. By the time someone came in the room with his dinner tray, he had forgotten why he activated the light on in the first place (during the interview, Resident #1 recalled he had some bleeding from his backside he thought he should report to someone). Review of the policy titled Answering the Call Light, last revised March 2021, revealed staff were to provide a timely response to resident's requests and needs. The policy further revealed that if staff were able to perform the requested task, it should be completed within five minutes of knowledge of what they needed/requested. This deficient practice represents noncompliance investigated under Complaint Number 1395034 (OH00167579).		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to ensure care conferences were completed at least quarterly for Residents #5, #21, and #27, and the facility failed to ensure care plan accuracy regarding incontinence care for Resident #40 and an updated care plan to reflect Resident #51's fall. This finding affected three (Residents #5, #21, #27) of three residents reviewed for care conferences and two (Residents #51 and #40) of 25 residents reviewed for care planning. The facility census was 53. Findings include: 1. Review of the medical record for Resident #27 revealed in admission date of 12/02/24 24. Diagnoses included cognitive communication deficit, depression, muscle weakness, anxiety, insomnia and diabetes. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #27 was cognitively intact. She required setup help for eating and partial to moderate assistance for oral hygiene, toileting, showering, dressing, and hygiene. Interview on 09/02/25 at 9:47 A.M. with Resident #27 revealed she did not get invited to care conferences. Review of the social service notes dated 12/04/24 through 09/04/25 revealed the resident had a 72-hour meeting on 12/04/24 to discuss care needs, and a care conference was scheduled for 07/22/25. There was no documented evidence this meeting occurred. Interview on 09/04/25 at 12:53 P.M. with the Administrator confirmed there were no formal care conferences for Resident #27 because the social service designee (SSD) was in regular contact with Resident #27's son; however, she identified the necessity for a care conference in which the resident would be included. 2. Review of the medical record for Resident #40 revealed an admission date of 04/04/25. Diagnoses included cognitive communication deficit, dementia, anxiety, depression, elevated blood pressure, chronic obstructive pulmonary disease, and hyperlipidemia. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #40 was cognitively intact. She required setup help for eating, oral hygiene, toileting, personal hygiene and substantial or maximum assistance for showering. She was always continent of bowel and bladder. Review of the care plan dated 07/03/25 revealed Resident #40 was at risk for developing complications secondary to bowel incontinence. Interventions included checking the resident every two hours and assisting with toileting as needed, observing for patterns of incontinence and initiating a toileting schedule if necessary and providing a bedside commode. Resident #40 was also at risk for bladder incontinence and had an indwelling urinary catheter. Interventions included cleaning the peri area with each incontinent episode, ensuring the resident had an unobstructed path to the bathroom, ensuring her call light was within reach and monitoring, documenting and reporting possible causes for incontinence. Interview on 09/03/25 at 3:05 P.M. with Resident #40 revealed she did not need help to go to the bathroom; she used the bathroom on her own and did not wear an incontinence brief. She also revealed she never had accidents of either bowel or bladder. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 09/03/25 at 3:08 P.M. with Licensed Practical Nurse (LPN) #539 revealed she had no knowledge of Resident #40 ever having a catheter and confirmed she was continent of both bowel and bladder. Interview on 09/04/25 at 9:16 A.M. with the Director of Nursing (DON) confirmed Resident #40 had never had a catheter, and she could not explain why her care plan identified her as incontinent of both bowel and bladder when she was in fact continent. Review of the facility policy titled Care Plans, Comprehensive Perso-Centered revealed care plan interventions were chosen after gathering data and careful consideration of the relationship between the resident's problems and their causes and relevant clinical decision making. Assessments were ongoing and care plans would be revised as conditions changed. The interdisciplinary team would review and update the care plan when there was a significant change in the resident's condition or at least quarterly in conjunction with their required quarterly MDS assessment. 3. Review of the medical record for Resident #51 revealed an admission date of 02/24/25 with diagnoses including hypertensive heart disease with heart failure, anxiety, major depressive disorder, morbid obesity, obstructive sleep apnea, chronic pain, restless leg syndrome, and generalized muscle weakness. Further review of the medical record revealed diagnoses were added in June 2025, including unstable burst fracture of the second lumbar vertebrae, fusion of lumbar and thoracic region of the spine, urinary retention, thrombocytopenia, type II diabetes mellitus, and lymphedema. Review of the care plan initiated on 02/27/25 revealed Resident #51 was at increased risk for falls related to deconditioning, gait and balance problems, age-related debility, and use of a straight cane for mobility. Interventions included encouraging Resident #51 to use the call light for assistance as needed, provide physical therapy evaluation or treatment as ordered or as needed, keep the floors clean from spills and/or clutter, and provide adequate, glare-free lighting. Further review of the care plan revealed the last intervention was added on 02/28/25 for therapy to evaluate Resident #51 for appropriate assistive devices for ambulation. There were no care plan updates indicating Resident #51 sustained a fall with major injury or any revision of the fall care plan focus or intervention section after the fall (sustained on 05/20/25). Review of the quarterly MDS 3.0 assessment completed on 06/06/25 revealed Resident #51 had intact cognition, used a walker as a mobility device, and needed supervision or touching assistance for transfers from the chair to the bed. Further review of the MDS revealed Resident #51 sustained one fall with major injury since facility admission or re-entry. Review of the progress notes revealed a note dated 06/10/25 at 5:36 P.M. indicating Resident #51 requested to go to the emergency department due to an increase in back pain. Review of the hospital discharge paperwork revealed Resident #51 was admitted to the hospital for increased back pain since a fall at the facility. The hospital paperwork further revealed Resident #51 had magnetic resonance imaging (MRI) of the spine on 06/12/25 which revealed a burst fracture of the second lumbar spine (L2 fracture) which required surgery. Interview on 09/02/25 at 11:25 A.M. with Resident #51 revealed her L2 vertebra exploded when she fell at the facility in May 2025. Resident #51 further revealed she had immediate back pain that worsened over time, and the fracture was not found until a few weeks later, but was attributed to the fall. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the fall investigation with the DON on 09/03/25 at 1:40 P.M. revealed the immediate interventions post fall included to educate Resident #51 to use the call light, do a therapy evaluation, and declutter the room. The DON further confirmed the care plan had these interventions in place at the time of the fall. Interview on 09/03/25 at 2:53 P.M. with the DON confirmed that when the facility learned Resident #51 had a major injury related to the fall sustained on 05/20/25 (which required an acute care inpatient stay and surgery), the fall care plan was not updated upon Resident #51's return to the facility. Review of the policy titled Care Plans, Comprehensive Person-Centered, last updated in March 2022, revealed care plans were to be revised or updated as changes occurred, when the desired outcome was not met, and after inpatient hospitalizations. Review of the policy titled Falls and Fall Risk, last revised December 2007, revealed that if a resident fell, despite the initial interventions put into place, staff were to implement additional or different interventions or indicate why new approaches were not implemented. 4. Review of Resident #5's medical record revealed the resident was admitted on [DATE] with diagnoses including Parkinson's disease, bipolar disorder and unspecified dementia. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #5 exhibited intact cognition. Review of Resident #5's medical record revealed the resident was her own responsible party and she had a guardian of person. Review of Resident #5's medical record revealed a care conference was held for the resident on 04/24/25. The medical record did not have evidence care conferences were held for the fourth quarter 2024, the first quarter 2025 or the third quarter 2025. Interview on 09/04/25 at 9:00 A.M. with SSD #566 confirmed the above findings. Review of the Comprehensive Person-Centered Care Plans policy, revised 03/2022, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The interdisciplinary team reviews and updates the care plan at least quarterly, in conjunction with the required quarterly MDS assessment. 5. Review of Resident #21's medical record revealed an admission date of 04/02/25 with diagnoses including schizoaffective disorder bipolar type, paranoid schizophrenia, anxiety, psychosis, diabetes mellitus type II, asthma, chronic pain, and non-Hodgkin lymphoma. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #21 was cognitively intact and required minimal assistance with activities of daily living. Interview on 09/02/25 at 11:50 A.M. with Resident #21 revealed they did not get invited to care conferences. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed a social services progress note for an initial care conference on 04/17/25, with no other care conferences documented. Interview on 09/04/25 at 10:18 A.M. with SSD #566 confirmed a care conference was not completed for the third quarter of 2025. Review of the facility policy titled Care Plans, Comprehensive Perso-Centered revealed care plan interventions were chosen after gathering data and careful consideration of the relationship between the resident's problems and their causes and relevant clinical decision making. Assessments were ongoing and care plans would be revised as conditions changed. The interdisciplinary team would review and update the care plan when there was a significant change in the resident's condition or at least quarterly in conjunction with their required quarterly MDS assessment.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 on record reviews, interviews and facility policy review, the facility failed to ensure residents received showers as scheduled. This finding affected seven residents (Residents #6, #14, #21, #27, #31, #47 and #48) of seven residents reviewed for activities of daily living (ADL) and had the potential to affect 30 additional residents (Residents #3, #5, #7, #8, #9, #11, #12, #13, #18, #20, #25, #28, #29, #30, #32, #33, #35, #36, #37, #39, #40, #42, #43, #44, #45, #46, #51, #52, #58 and #59) the facility identified as requiring extensive assistance or totally dependent on staff assistance for showers. The facility census was 53. Findings include: 1. Review of Resident #14's medical record revealed the resident was readmitted to the facility on [DATE] with diagnoses including unspecified dementia, urinary incontinence and emphysema. Review of Resident #14's ADL self-care care plan revealed an intervention dated 05/23/25 indicating the resident's usual performance was partial/moderate assist with showers. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #14 exhibited intact cognition. Review of the shower schedules revealed Resident #14 was scheduled for showers on Tuesdays and Fridays on the 6:00 A.M. to 6:00 P.M. shift. Review of Resident #14's shower documentation from 08/02/25 to 09/02/25 revealed the resident received showers on 08/07/25, 08/12/25, 08/15/25, 08/19/25, 08/28/25 and 08/30/25. Resident #14 did not receive showers as scheduled on 08/01/25, 08/05/25 and 08/22/25. Interview on 09/03/25 at 9:15 A.M. with Licensed Practical Nurse (LPN) #536 confirmed Resident #14 did not receive showers as scheduled. Review of the Shower/Tub Bath policy, revised 10/2010, revealed the purposes of the procedure was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. 2. Review of the medical record for Resident #6 revealed an admission date of 08/02/25. Diagnoses included systemic lupus erythematosus (an autoimmune disease), muscle weakness, adult failure to thrive, and dysphagia (difficulty swallowing). Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #6 was cognitively intact and was dependent on staff for all care needs. Review of the activity assessment dated [DATE] revealed it was somewhat important for Resident #6 to choose between a tub bath, shower, bed bath, or sponge bath. Review of the care plan dated 08/04/25 revealed Resident #6 has a self-care deficit related to disease process. Interventions included the resident was dependent for shower care, dressing, and bed mobility. Review of the shower schedule revealed Resident #6 was scheduled to receive a shower on Wednesdays and Saturdays. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower sheets for 08/2025 revealed Resident #6 received a bed bath on 08/08/25, a shower on 08/13/25, a shower on 08/16/25, 08/20/25, and a shower on 08/23/25. Interview on 09/04/25 1:44 P.M. with the Administrator confirmed she was aware the facility had not been consistently providing showers to residents. 3. Review of the medical record for Resident #21 revealed an admission date of 04/02/25. Diagnoses including schizoaffective disorder bipolar type, paranoid schizophrenia, anxiety, psychosis, diabetes mellitus type II, asthma, chronic pain, and non-Hodgkin lymphoma. Review of the care plan dated 05/07/25 revealed Resident #21 had a self-care deficit related to disease process. Interventions include avoid scrubbing and pat dry sensitive skin, set up and supervision from staff for showering, and showering two times a week and as needed. Review of the activity assessment dated [DATE] revealed it was very important for Resident #21 to choose between a tub bath, shower, bed bath, or sponge bath Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #21 was cognitively intact and required minimal assistance with ADL. Review of the shower schedule revealed Resident #21 was scheduled to receive a shower on Tuesdays and Saturdays. Review of the shower sheets for 08/2025 revealed Resident #21 had a shower on 08/02/25, a shower on 08/10/25, a shower on 08/12/25, a shower on 08/16/25, a shower on 08/19/25, a shower on 08/23/25, and a shower on 08/31/25. Interview on 09/02/25 at 11:45 A.M. with Resident #21 revealed she did not always get showers twice a week. Interview on 09/04/25 1:44 P.M. with the Administrator confirmed she was aware the facility had not been consistently providing showers to residents. 4. Review of the medical record for Resident #48 revealed an admission date of 01/02/18. Diagnoses included aphasia (a communication disorder), dysphagia (a swallowing disorder), cognitive communication deficit, hemiplegia (paralysis on one side of the body), hemiparesis (one sided muscle weakness), and muscle contracture. Review of the activity assessment dated [DATE] revealed it was very important for Resident #48 to choose between a tub bath, shower, bed bath, or sponge bath. Review of Resident #48's care plan dated 06/12/25 revealed a self-care deficit related to disease process. Interventions included extensive one-person assistance for showering, showering twice a week, and showering as needed. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #48 was cognitively intact and required maximal assistance for showering. Review of the shower schedule revealed Resident #48 was scheduled to receive a shower on (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Mondays. (His preference was one to two showers a week). Review of the shower sheets for 08/2025 revealed Resident #48 had a shower on 08/04/25, refused a shower on 08/07/25 due to a dental appointment, a shower on 08/08/25, a shower on 08/11/25, refused a shower on 08/14/25, a shower on 08/21/25, and refused a shower on 08/25/25 due to not feeling well. There was no documented evidence Resident #48 was offered a bed bath or shower on a different day or time after the refusal of the showers except for the refusal on 08/07/25. Interview on 09/03/25 at 9:54 A.M. with Resident #48 revealed they don't always get twice weekly showers. Interview on 09/03/25 at 1:31 P.M. with LPN #538 verified showers aren't always being completed twice weekly. Interview on 09/04/25 at 11:25 A.M. with Certified Nurses Aid (CNA) #590 verified they weren't able to get all assigned showers completed on 09/03/25. Interview on 09/04/25 1:44 PM. with the Administrator confirmed she was aware the facility had not been consistently providing showers for residents. Review of the Shower/Tub Bath policy, revised 10/2010, revealed the purposes of the procedure were to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. 5. Review of the medical record for Resident #27 revealed in admission date of 12/02/24. Diagnoses included cognitive communication deficit, depression, muscle weakness, anxiety, insomnia, and diabetes. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed it was very important for Resident #27 to choose between a tub bath, shower, bed bath or sponge bath. Review of the care plan dated 07/08/25 revealed Resident #27 had an ADL performance deficit due to musculoskeletal impairment. Interventions included providing a sponge bath, a full bath or shower could not be tolerated and avoiding scrubbing the skin. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #27 was cognitively intact. She required set-up help for eating and partial to moderate assistance for oral hygiene, toileting showering dressing and hygiene. Interview on 09/02/25 at 9:47 A.M. with Resident #27 revealed she did not always get showers at least twice weekly. Review of the shower schedule revealed Resident #27 was scheduled to receive showers on Sundays and Fridays. Review of the shower sheets for August 2025 revealed Resident #27 received a shower on 08/08/25, 08/14/25, 08/17/25 and 08/26/25. She received a bed bath after refusing a shower on 08/22/25. Interview on 09/04/25 1:44 P.M. with the Administrator confirmed she was aware the facility had not (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Louisville Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4466 Lynnhaven Avenue NE Louisville, OH 44641	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been consistently providing showers to residents. 6. Review of the medical record for Resident #31 revealed an admission date of 01/19/23. Diagnoses included Multiple Sclerosis, muscle weakness, heart disease, left hip prosthesis, anxiety, and cervical disc degeneration. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed it was very important for Resident #31 to choose between a tub bath, shower, bed bath or sponge bath. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #31 was cognitively intact. She required set-up assistance for eating and oral hygiene, partial to moderate assistance for dressing and hygiene and substantial to maximum assistance for showering Review of the care plan dated 07/03/25 revealed Resident #31 needed assistance with showers. Interventions included the residents' preference for showers on Tuesdays and Friday evenings between 2:00 P.M. and 8:00 P.M., asking the resident their bathing preference quarterly and as needed, filling out shower sheets upon completing a resident shower or bath and notifying the charge nurse of shower or bath refusals. Review of the shower schedule revealed Resident #31 was scheduled to receive showers on Tuesdays and Fridays. Review of the nursing note dated 08/19/25 at 10:25 P.M. revealed Resident #31 refused a shower due to chronic pain; the shower was rescheduled for 8/20/25. Review of the shower sheets for August 2025 revealed Resident #31 received a shower on 08/05/25, 08/13/25, 08/20/25 and 08/29/25. She refused a shower on 08/08/25 and 08/19/25. There was no documented evidence Resident #31 was offered a bed bath or shower on a different day or time after the refusal of the showers. Interview on 09/02/25 at 10:28 A.M. with Resident #31 revealed she didn't get showers like she wanted because the facility no longer had a shower aide. Interview on 09/04/25 1:44 P.M. with the Administrator confirmed she was aware the facility had not been consistently providing showers to residents. 7. Review of the medical record for Resident #47 revealed an admission date of 08/22/23. Diagnoses included schizoaffective disorder, diabetes, muscle weakness, asthma, and post-traumatic stress disorder. Review of the comprehensive MDS 3.0 assessment dated [DATE] revealed it was very important for Resident #47 to choose between a tub bath, shower, bed bath or sponge bath. Review of the care plan dated 06/30/25 profile Resident #47 had an ADL self-care performance deficit due to the disease process. Interventions included two staff members assisting the resident with a shower twice per week, offering a bed bath if a shower was refused and filling out the shower sheet upon completion of the shower or bed bath, notifying the nurse if the resident refuses. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #47 was cognitively (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intact. She was totally dependent on staff for all ADL. Review of the shower schedule revealed Resident #47 was scheduled to receive showers on Sundays and Wednesdays. Review of the shower sheets for August 2025 revealed Resident #47 revealed she received a shower on 08/24/25 and a bed bath on 08/10/25. She refused a shower on 08/13/25, 08/17/25, 08/20/25 and 08/27/25. There was no documented evidence Resident #47 was offered a bed bath or shower on a different day or time after the refusal of the showers. Interview on 09/02/25 at 10:39 A.M. with Resident #47 revealed she did not get showers because the facility no longer had a shower aide. Interview on 09/04/25 at 7:50 A.M. with CNA #508 revealed she was often not able to get all showers completed each day. Interview on 09/04/25 1:44 P.M. with the Administrator confirmed she was aware the facility had not been consistently providing showers to residents. Review of the facility policy titled Shower/Tub Bath, dated 2001, revealed the facility would document the date and time the shower or bath was performed and the name of the individual assisting the resident with the shower or bath. If the resident refused, the reasons why and the interventions taken would be documented as well. This deficiency represents noncompliance investigated under Complaint Number 1395034 (OH00167579).		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, interview and facility policy review, the facility failed to ensure meals were served as stated in the dietary menus. This finding had the potential to affect all residents who receive mechanical soft diets and residents who require gravy during meals including Residents #2, #5, #15, #22, #25, #28, #32, #37, #38, #43, #47, #51 and #53. The facility census was 53. Findings include: Review of the Daily Production Lunch Menu dated 09/02/25 revealed the meal consisted of eight ounces of beefy tater casserole with one to two ounces of gravy on the side for mechanical soft diets, four ounces of mixed vegetables (four ounces of carrots for residents on a mechanical soft diet), four ounces of mandarin oranges with whipped topping and eight ounces of iced tea/lemonade/fruit punch. Observation of staff plating the lunch meal on 09/02/25 at 11:22 A.M. revealed the lunch meal consisted of beefy tater tot casserole two four-ounce scoops, four ounces of mixed vegetables (carrots for mechanical soft diets and mixed vegetables for regular diets), four ounces of mandarin oranges and iced tea/lemonade/fruit punch. Observations did not reveal evidence of gravy placed on the side for the residents who required gravy or for residents on mechanical soft diets and the mandarin oranges did not have whipped cream on top. Interview on 09/02/25 at 11:33 A.M. with Dietary Manager (DM) #543 confirmed the facility ran out of the whipped topping for the mandarin oranges. Interview on 09/02/25 at 12:10 P.M. with DM #543 confirmed she was not aware the menu included gravy for those residents on mechanical soft diets. Review of resident diets revealed Residents #2, #5, #15, #22, #25, #28, #32, #37, #38, #43, #47, #51 and #53 were ordered mechanical soft diets or required gravy on the side or with meat items. Review of the Food and Nutrition Services policy, revised 10/2017, revealed each resident was provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on review of the medical record, interview, and review of facility policy, the facility failed to ensure resident wishes regarding advanced directives were accurately identified or that the medical record contained the appropriate documentation of these wishes. This affected one resident (Resident #51) of one resident reviewed for advanced directives. The facility census was 53. Findings include: Review of the medical record for Resident #51 revealed an admission date of 02/24/25. Diagnoses included hypertensive heart disease with heart failure, anxiety, major depressive disorder, morbid obesity, obstructive sleep apnea, chronic pain, restless leg syndrome, generalized muscle weakness, unstable burst fracture of second lumbar vertebrae, fusion of lumbar and thoracic region of the spine, urinary retention, thrombocytopenia, type two diabetes mellitus, and lymphedema. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 06/06/25 revealed Resident #51 had intact cognition and minimal signs of depression. Review of the physician orders in the electronic medical record (EMR) revealed two active orders regarding resuscitation in the event of cardiac or respiratory arrest. The first order was dated 08/28/25 at 2:28 P.M. indicating Resident #51 was a full code (use all available life saving measures in the event of an emergency, including cardiopulmonary resuscitation). The second order was dated 08/28/25 at 3:49 P.M. indicating Resident #51 was a Do Not Resuscitate Comfort Care- Arrest (DNRCC-A), life-saving treatments may be administered before respiratory or cardiac arrest, but not after an arrest. Once cardiac or respiratory arrest occurs, only comfort care measures may be provided. Interview on 09/02/25 at 12:48 P.M. with Licensed Practical Nurse (LPN) #586 confirmed the hard chart (paper chart at the nurses' station) should contain the signed do not resuscitate (DNR) orders if a resident was not a full code. When informed there were advanced directives in the hard chart, LPN #586 opened the resident profile in the EMR and stated that Resident #51 was a DNRCC-A and would have to locate the order, print it, and place it in the chart. Interview on 09/02/25 at 12:55 P.M. with the Director of Nursing (DON) confirmed that if a resident was a DNR, the order should be in the hard chart. During the interview, the DON confirmed that there were two active orders for Resident #51 in the event of an arrest, including one order listing Resident #51 as a full code and one order listing Resident #51 as a DNRCC-A, which the DON stated she did not believe was correct. The DON was unable to confirm Resident #51's code status at the time of this interview. Interview on 09/02/2025 at 1:06 P.M. with LPN #536 revealed LPN #586 located the signed DNR order form dated 08/28/25 in a pile of paperwork to be filed. During the interview, LPN #536 confirmed there was no DNR order form in either the EMR or the hard chart. Review of the policy titled Advanced Directives, last revised September 2022, revealed the wishes of each resident related to advanced directives were to be communicated appropriately to direct care staff and placed in a prominent, accessible location in the medical record.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a baseline care plan was completed as required for Resident #21. This affected one resident (Resident #21) out of one resident sampled for baseline care plans. The facility census was 53. Findings include: Review of Resident #21's medical record revealed an admission date of 04/02/25 with diagnoses including schizoaffective disorder bipolar type, paranoid schizophrenia, anxiety, psychosis, diabetes mellitus type II, asthma, chronic pain, and non-Hodgkin lymphoma. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #21 was cognitively intact. Review of the medical record revealed the absence of a baseline care plan. Interview on 09/04/25 at 10:28 A.M. with the Director of Nursing (DON) confirmed the absence of a baseline care plan for Resident #21.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of the facility nurse signature list and review of facility policy, the facility failed to ensure nurses followed appropriate professional standards when documenting medication administration. This affected one resident (Resident #20) of three residents who were observed for medication administration. The facility census was 53. Findings include: Review of the medical record for Resident #20 revealed an admission date of 08/11/25 with diagnoses including hereditary and idiopathic neuropathy, retention of urine, type two diabetes mellitus, acute kidney failure, atrial fibrillation, unspecified protein-calorie malnutrition, gastroesophageal reflux disease (GERD), cognitive communication deficit, irritable bowel syndrome (IBS), depression, epilepsy, and gastroparesis. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #20 had intact cognition with no rejection of care or other behaviors. Further review of the MDS revealed Resident #20 received medications from high-risk categories, including antidepressant, antibiotic, antiplatelet, hypoglycemic, and anticonvulsant. Review of the current physician's orders revealed orders for morning medications that were scheduled for administration at 8:00 A.M. and 9:00 A.M., including: Citalopram hydrochloride (HCL) 40 milligram (mg) oral tablet, one tablet by mouth daily for depression Letrozole 2.5 mg tablet, one tablet by mouth every day for breast cancer Nadolol 20 mg, give one tablet by mouth once daily for hypertension Clopidogrel bisulfate 75 mg tablet once daily for cerebrovascular accident (CVA) Vitamin E oral tablet 400 international units (IU) by mouth once daily for vitamin deficiency Hydralazine hydrochloride oral tablet, 25 mg by mouth twice daily for hypertension Levetiracetam (Keppra) 500 mg by mouth twice a day for seizures Metformin HCL 250 mg by mouth twice a day for diabetes mellitus Pantoprazole sodium oral delayed release (DR) tablet, one tablet by mouth two times a day for GERD Rifaximin 550 mg tablet, one tablet by mouth two times a day for IBS Sucralfate (Carafate) one gram by mouth two times a day for GERD Dicyclomine HCL 10 mg oral capsule, one capsule by mouth three times a day related to gastroparesis Review of the current physician's orders also revealed Resident #20 was to have blood sugar checks every morning with a blood glucose meter (BGM). Observation on 09/02/25 from 8:10 A.M. to 8:20 A.M. revealed Licensed Practical Nurse (LPN) #600 prepared the morning medications and blood glucose meter for the blood sugar test for Resident #20, entered the resident's room, and checked Resident #20's blood sugar with the BGM with no noted concerns. Continued observation revealed Resident #20 pulled a pill out of the medicine cup, handed the pill to the nurse, immediately took the rest of the medications that were in the medication cup, and then informed LPN #600 she was no longer taking Keppra because it upset her stomach. LPN #600 informed Resident #20 the pill she handed over was Carafate (sucralfate) to help coat her stomach and that she already swallowed the Keppra. Resident #20 continued to refuse the sucralfate after education was provided, and LPN #600 was observed dropping the tablet into the trash can at the bedside. After exiting the room of Resident #20, LPN #600 was observed beginning to give report to the nurse who just arrived for duty. There was no observation of medication administration documentation at that time. Follow-up interview on 09/02/2025 at 9:33 A.M. with Resident #20 confirmed that she did not take the morning dose of sucralfate. Review of the medication administration record (MAR) revealed a nurse with the initials AATT signed off the administration of all ordered medications and blood glucose monitoring scheduled for 8:00 A.M. and 9:00 A.M. on 09/02/25, including the successful administration of sucralfate (the medication Resident #20 was observed removing and discarding the during medication administration). Upon further review, the MAR appeared to be signed off using initials that did not belong to LPN #600. Review of the facility signature list revealed the initials AATT belonged to LPN #586 and not LPN #600. Further review of the signature list revealed LPN #600's initials for MAR documentation were THCB. Telephone interview on 09/03/25 at 2:04 P.M. with LPN #586 confirmed she signed off all the scheduled morning medications for Resident #20 but had not given any of them. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #586 further revealed LPN #600 told her she was unable to sign for the morning medication and told LPN #586 it was okay for her to sign all the morning medications and treatments off as completed. During the interview, LPN #586 did admit to being informed earlier that Resident #20 refused one of her medications, but wasn't sure which one, just that it was not the Keppra. Interview on 09/02/25 at 2:50 P.M. with the Director of Nursing (DON) confirmed LPN #600 had access to chart in the electronic medical record, and the DON was never informed by LPN #600 that there was an access issue. During the interview, the DON confirmed that the nurse that administered the medication was the nurse required to document the medication administration, and no nurse should ever sign for care rendered by someone else. Review of the policy titled Administering Medications, last revised in April 2019, revealed the person administering the medications was required to document administration in the medical record. The policy further revealed when a drug was refused, the nurse responsible for that medication administration was to complete the appropriate documentation in the MAR related to that omitted drug and dose.		

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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, review of pharmacy invoices, interview and facility policy review, the facility failed to ensure Resident #16's skin treatments were implemented as ordered and Resident #1's dialysis medications were available for resident use. This finding affected one resident (Resident #16) of three residents reviewed for pressure ulcers and general skin conditions and one resident (Resident #1) of one resident reviewed for dialysis services. The facility census was 53. Findings include: 1. Review of the medical record revealed Resident #16 was admitted on [DATE] with diagnoses including dementia, cognitive communication deficit, and muscle weakness. Review of the wound grid dated 06/18/25 revealed Resident #16 had a left buttock Stage II pressure ulcer (partial-thickness loss of skin, affecting only the epidermis and dermis layers, which appears as a shallow open wound or a serum-filled blister) which measured zero cm (centimeters) length, zero cm width and zero cm depth which improved with delayed wound closure and 70% (percent) epithelial and 30% granulation tissue with attached intact scarring. Review of Resident #16's physician's orders dated 06/18/25 revealed an order dated 06/18/25 to apply Skin Prep (creates a protective film) to the left sacrum and cover with a bordered dressing every Monday, Wednesday and Friday for preventative measures. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #16 exhibited intact cognition. Interview on 09/03/25 at 1:42 P.M. with Licensed Practical Nurse (LPN) #536 confirmed Resident #16's left sacrum Stage II pressure wound healed on 06/22/25, and the facility put treatments in place to prevent the area from reopening. Observation on 09/03/25 at 2:25 P.M. with Nurse Practitioner (NP) #850 and LPN #536 of Resident #16's left sacrum wound care revealed LPN #536 washed both hands, put on gloves, removed the existing dressing to the left sacrum which was dated 08/28/25, removed the gloves, washed the hands, replaced the gloves and completed the wound care as ordered. Interview on 09/03/25 at 2:30 P.M. with LPN #536 confirmed Resident #16's left sacrum dressing should have been changed on 09/01/25 per the physician's order, and LPN #851 documented on the treatment administration record (TAR) dated 09/01/25 that Resident #16's left sacrum wound care was completed. LPN #536 also confirmed LPN #539 documented on 09/02/25 that Resident #16's left sacrum wound care was completed in error. Interview on 09/03/25 at 3:09 P.M. with LPN #539 revealed the nurse had documented Resident #16's left sacrum wound care was completed on 09/02/25 in error and the nurse thought the documentation was to confirm the dressing was intact. Review of the Pressure Ulcers/Injuries Overview policy, revised 07/2017, revealed the purpose of the procedure was to provide information regarding clinical identification of pressure ulcers/injuries and associated risk factors. 2. Review of the medical record for Resident #1 revealed an admission date of 05/19/25 with diagnoses including end stage renal disease, unspecified protein-calorie malnutrition, paroxysmal (continued on next page)		

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	atrial fibrillation, major depressive disorder, essential (primary) hypertension, ventricular tachycardia, type II diabetes mellitus, diabetic neuropathy, acquired absence of right leg below knee, acquired absence of the left leg below the knee, and dependence on renal dialysis. Review of the quarterly MDS 3.0 assessment completed on 07/17/25 revealed Resident #1 had intact cognition and end stage renal disease. Further review of the MDS revealed Resident #1 received dialysis. Review of the care plan dated 05/21/25 through 10/15/25 revealed Resident #1 was at risk for malnutrition due to obesity, blood pressure problems, wounds, unspecified protein-calorie malnutrition, and end stage renal disease with dialysis. Interventions included providing all dietary interventions and medications as prescribed. Review of the orders revealed an order dated 06/26/25 for Resident #1 to begin at 6:00 A.M. on 06/27/25 to take sevelamer hydrochloride (HCL) 800 milligram (mg) tablets, two tablets by mouth before meals as a potassium binder. Further review of the order revealed instructions for staff to call the number listed on the paper in the chart and provide the identification (I.D.) number to reorder the sevelamer. Review of the July 2025 medication administration record (MAR) revealed the ordered sevelamer to be taken before meals not given 07/01/25 through 07/05/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M., 07/06/25 at 6:00 A.M. or 11:00 A.M., 07/07/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M., 07/08/25 at 4:00 P.M., or 07/09/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M. Review of the progress notes from 07/05/25 through 07/31/25 revealed the following linked electronic MAR (eMAR) notes when the sevelamer was not given: 07/05/25 at 6:26 A.M. pending dialysis providing 07/05/25 at 9:36 A.M. Unavailable 07/05/25 at 10:32 A.M. medication was unavailable and awaiting delivery from dialysis. The note also indicated the physician was aware. 07/05/25 at 3:50 P.M. medication was unavailable, and the physician was aware. 07/06/25 at 9:49 A.M., 10:33 A.M., and 4:18 P.M. notes revealed the medication was unavailable 07/07/25 at 5:18 A.M. and 4:42 P.M. the notes indicated the medication was on order and pharmacy was to send it. 07/08/25 at 7:56 A.M. and 4:31 P.M. the notes indicated the medication was not in the medication cart. 07/09/25 at 5:09 A.M. and 4:52 P.M. revealed the medication was not in the cart. 07/09/25 at 12:01 P.M. the note revealed the nurse spoke with the pharmacy, verified medication was sent, and would arrive at the facility in three to five days. The note further revealed the physician was notified. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Louisville Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4466 Lynnhaven Avenue NE Louisville, OH 44641	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The notes further revealed Resident #1 was transferred to the hospital at 9:00 P.M. and remained hospitalized until 07/12/25 at 11:30 A.M. Review of the August 2025 MAR revealed sevelamer was not given on 08/08/25 at 11:00 A.M. or 4:00 P.M., 08/09/25 at 6:00 A.M., 08/13/25 at 4:00 P.M., 08/15/25 at 4:00 P.M., 08/24/25 at 4:00 P.M., 08/25/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M., 08/26/25 at 6:00 A.M. and 11:00 A.M., or 4:00 P.M., 08/27/25 at 6:00 A.M. or 11:00 A.M., 08/28/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M., 08/29/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M., 08/30/25 at 11:00 A.M. or 4:00 P.M., and 08/31/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M. Review of the progress notes from 08/01/25 through 08/31/25 revealed the following linked eMAR notes: 08/08/25 at 4:14 P.M. revealed the medication was not available. 08/09/25 at 5:32 A.M. revealed the medication was on order from the pharmacy, and the nurse practitioner was aware. 08/15/25 at 4:57 P.M. revealed the medication was not available and reordered. 08/24/25 at 4:08 P.M. revealed the medication was not available and on order. 08/25/25 at 5:13 A.M. and 5:01 P.M. and 08/26/25 at 5:10 A.M. revealed the medication was not available. 08/26/25 at 10:10 A.M. revealed the pharmacy rejected the medication and it would not be delivered. 08/26/25 at 1:50 P.M. revealed the medication was no available. 08/27/25 at 5:21 A.M. and 6:26 P.M. revealed the medication was not available and further revealed a call was placed to the dialysis center. 08/28/25 at 5:15 A.M. and 10:58 A.M. revealed the medication was on order. 08/29/25 at 6:39 A.M. revealed the medication was on order. 08/30/25 at 10:27 A.M. and 3:57 P.M. revealed the medication was not available. 08/31/25 at 5:05 A.M., 12:07 P.M., and 3:56 P.M. revealed the medication was not available. Review of the September 2025 MAR revealed Resident #1 did not receive the ordered sevelamer on 09/01/25 at 6:00 A.M., 11:00 A.M., or 4:00 P.M. or on 09/02/25 at 6:00 A.M. Review of the progress notes from 09/01/25 through 09/04/25 revealed the following linked eMAR notes: 09/01/25 at 5:09 A.M. and 4:14 P.M. revealed the medication was not available, and notes for the lunch dose revealed Resident #1 was at dialysis. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/02/25 at 5:25 A.M. revealed the medication was not available Interview with Resident #1 on 09/02/2025 at 9:02 A.M. revealed he had not been getting his phosphorus binder, the sevelamer, for at least a week or more. The dialysis physician had told him it was taken care of, and nobody was able to explain why he still did not have the medication. Interview on 09/04/2025 at 10:12 A.M. with Resident #1 confirmed he received the sevelamer the last two days, but there were gaps when he did not receive the medication for several days at a time. Resident #1 further revealed when not taking the medication, he felt nauseous and would often experience diarrhea, with more prominent symptoms after meals. Interview on 09/04/2025 at 10:16 AM with Licensed Practical Nurse (LPN) #589 confirmed she thought the pharmacy had not been sending the sevelamer, but then another nurse had told her it had to be special ordered. During the interview, LPN #589 also reported once the medication was ordered, it seemed to take a long time before it was delivered. Review of the medication bottle at the time of the interview revealed the medication came from Health [NAME] Pharmacy in Lakeland, Florida. Interview on 09/04/2025 at 1:35 PM with the Director of Nursing (DON) verified the dates the sevelamer was reordered included 07/08/25 and 08/27/25. During the interview, the DON was unable to confirm the date the medication was received by the facility, stating the medication went directly to the resident, and the facility did not have a process to record receipt of medications from this particular pharmacy. Review of the prescription reorder information form revealed sevelamer was reordered on 07/08/25 and 08/27/25. Review of the shipping invoice from Health [NAME] Pharmacy revealed the sevelamer was last shipped to the facility, to the attention of the DON, on 08/27/25. The facility did not have the shipping invoice for previous sevelamer orders. Review of the policy titled Medication Orders and Receipt Record, last revised April 2007, revealed the charge nurse was to maintain medication order and receipt records and that medications were to be ordered in advance based on the pharmacy's required lead time. This deficiency represents noncompliance investigated under Master Complaint Number 2600257 and Complaint Number 1395034 (OH00167579).		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THIS IS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on medical record review, witness statement reviews, interview and facility policy review, the facility failed to ensure Resident #45 was provided with adequate supervision to prevent a burn. This finding affected one resident (Resident #45) of six residents reviewed for accidents and hazards. The facility census was 53. Findings include: Review of Resident #21's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, adult failure to thrive, and schizoaffective disorder. Review of Resident #45's medical record revealed the resident was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, schizoaffective disorder, and anxiety. Review of Resident #45's malnutrition care plan revealed an intervention dated 09/16/24 to provide the physician prescribed diet and notify nursing of any changes in appetite, feeding performance, or compliance concerns. Provide assistance with all meals, snacks and supplements as needed. Review of Resident #45's physician orders revealed an order dated 01/13/25 revealed the resident self-propels in a custom wheelchair without footrests; and an order dated 01/13/25 for a regular diet, regular texture with a regular thin consistency. Review of Resident #45's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident exhibited intact cognition. Review of Resident #45's progress note dated 06/16/25 at 5:16 A.M. authored by Licensed Practical Nurse (LPN) #855 indicated Resident #45 was given coffee by another resident (Resident #21) in the common area, and the resident spilled the coffee on herself and had a reddened area in the shape of a C on the left abdominal side. Resident #45 complained of pain with wincing and saying ouch, oh!. The resident was washed with cool water and the resident's shirt was changed. Review of Resident #45's progress note dated 06/16/25 at 2:13 P.M. (documented as a late entry) authored by the Director of Nursing (DON) which indicated the provider was notified the resident spilled coffee with no injury present. The Wound Nurse Practitioner (NP) #850 was notified as well. Review of Resident #45's progress note dated 06/16/25 at 2:42 P.M. authored by Registered Dietitian (RD) #853 revealed she was notified by the DON on this date that the resident spilled some of her coffee beverage on her stomach. The skin was assessed and slightly red. No open areas were noted. The RD did not anticipate increased needs related to the resident's skin at this time. Review of Resident #45's physician progress note dated 06/16/25 at 11:59 P.M. revealed at the time of the documentation, the resident was independent with bed mobility, required assistance for sit-to-stand, all transfers, and toileting. The resident also required assistance for putting on footwear, dressing, bathing and required partial assistance for oral hygiene. She required supervision with eating. Review of Resident #45's witness statement dated 07/09/25 at 10:48 A.M. authored by certified Nursing Assistant (CNA) #509 revealed after the coffee incident with Residents #21 and #45, the DON and CNA #509 immediately informed Resident #21 that coffee cannot be provided to certain residents because the resident could not hold it properly. Resident #45 was also educated that the resident needed to make sure the coffee cups had a lid and a straw so that she did not harm herself with hot coffee and to ask for help for coffee. Interview on 09/03/25 at 2:46 P.M. with the DON revealed Resident #21 provided Resident #45 a cup of hot coffee from the servy on the 100/200 unit adjacent to the common area. The DON revealed Resident #45's coffee cup did not have a lid, and the resident spilled the coffee on her stomach which caused a reddened burn, but the burn did not blister. Review of the Food and Nutrition Services policy, revised 10/2017, revealed each resident was provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The deficiency was corrected on 06/18/25 when the facility implemented the following corrective actions: On 06/16/25 at 5:16 A.M., CNA #509 assessed Resident #45 after (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identification of the abdominal burn, washed the abdomen with cool water and changed the resident's shirt. On 06/16/25 at 2:13 P.M. LPN #852 notified the physician of Resident #45's abdominal burn. On 06/16/25 at 3:51 P.M., LPN #852 completed a skin assessment for Resident #45's abdominal burn. The assessment revealed the abdomen had a pink area related to the spill. No sizes were identified on the form. On 06/16/25 at 4:00 P.M., LPN #852 completed a pain assessment for Resident #45's abdominal burn. The assessment indicated the resident had mild pain. On 06/16/25, Rehab Director #573 screened Resident #45 for occupational therapy (OT). The determination was that it was an isolated event with lids on drinks, and the resident was put on the caseload. On 06/16/25, Maintenance Director #507 turned off the hot water to the servery on the 100/200 units. On 06/16/25, CNA #509 and the DON educated Residents #21 and #45 to ask for assistance for hot coffee, and Resident #21 was educated to not provide hot coffee to other residents. On 06/16/25, Dietary Manager #543 started audits of hot liquids served in cups three times a week for eight weeks with no negative findings. On 06/17/25, the DON obtained a work order to remove the hot water valve on the servery on the 100/200 units. The work was completed on 06/18/25. On 06/19/25 at 1:08 P.M., LPN #519 completed a skin assessment for Resident #45, and no redness or blisters were identified. On 06/26/25, LPN #582 completed a skin assessment for Resident #45 and no redness or blisters were identified. On 06/26/25, the DON completed an in-service for all nursing staff including all nurses and CNAs. The education stated residents must be assisted with getting coffee and ensure the coffee was in a cup with a lid.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on review of the medical record, interview and review of the facility policy, the facility failed to ensure appropriate assessments were consistently completed before and after dialysis. This affected one resident (Resident #1) of one resident reviewed for dialysis. The facility census was 53. Findings include: Review of the medical record for Resident #1 revealed an admission date of 05/19/25 with diagnoses including end stage renal disease, unspecified protein-calorie malnutrition, paroxysmal atrial fibrillation, major depressive disorder, essential (primary) hypertension, ventricular tachycardia, type II diabetes mellitus, diabetic neuropathy, acquired absence of the right leg below the knee, acquired absence of the left leg below the knee, and dependence on renal dialysis. Review of the physician orders revealed an order dated 05/20/25 that Resident #1 was to receive dialysis every Monday, Wednesday, and Friday and for facility staff to check for a bruit (a swishing sound heard over a blood vessel) and thrill (a palpable vibrating sensation over a blood vessel) to the left arteriovenous (AV) fistula every shift. Further review revealed orders initially dated 05/21/25 to monitor the left arm fistula site for infection every shift and to weigh Resident #1 three days a week prior to dialysis. Review of the care plan dated 05/21/25 through 10/15/25 revealed Resident #1 was at risk for developing complications related to hemodialysis. Interventions included monitoring for a bruit and thrill every shift, monitoring and reporting any signs of infection to the dialysis access site and reporting significant changes in vital signs immediately. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 07/17/25 revealed Resident #1 had intact cognition and end stage renal disease. Further review of the MDS revealed Resident #1 received dialysis. Review of the July 2025 treatment administration record (TAR) revealed no documentation of weights 07/09/25 (listed as refused), 07/11/25 (Resident #1 was in the hospital), 07/14/25, and 07/16/25, 07/18/25 (listed as refused), 07/21/25, and 07/28/25. The July TAR further revealed no documentation the nurse assessed for a bruit and thrill on 07/25/25 or 07/27/25 on night shift and that the assessment was not applicable on 07/26/25. The July TAR review also revealed no documentation the AV shunt site was assessed for signs and symptoms of infection on 07/25/25 on night shift. Review of the August 2025 TAR revealed no documentation that Resident #1 went to dialysis on 08/13/25, 08/18/25, or 08/29/25 or that weights were obtained on 08/08/25, 08/13/25, 08/15/25, 08/18/25, 08/29/25. Further review of the August TAR revealed no documentation on 08/13/25 morning shift, 08/18/25 morning shift, 08/26/25 morning shift, or 08/29/25 morning shift that Resident #1's AV fistula was assessed for a bruit and a thrill. Also, the presence of the bruit or thrill was documented as not applicable on 09/01/25, 09/02/25, and 09/10/25 night shifts. Review of the August TAR also revealed that there was no documentation of assessment for signs and symptoms of infection of the AV fistula site on 08/13/25 day shift, 08/15/25 day shift, 08/18/25 day shift, 08/26/25 day shift, and 08/29/25 day shift. Review of the September 2025 TAR revealed no documentation that Resident #1 was weighed before dialysis, no documentation the AV fistula was assessed for signs of infection and no documentation that the nurse checked for a bruit or thrill during day shift on 09/01/25. Interview on 09/02/2025 at 9:02 A.M. with Resident #1 revealed the facility was supposed to obtain a weight prior to leaving for dialysis, but there were recent dialysis treatment dates that the weight was not obtained before leaving for dialysis because there was only one aide on the unit when it was time for him to get ready to depart for dialysis. Interview on 09/04/2025 at 10:16 A.M. with Licensed Practical Nurse (LPN) #589 confirmed there was a folder for dialysis communications regarding Resident #1 and that Resident #1 often takes off for dialysis without taking his folder or getting weighed. During the interview, LPN #589 confirmed the scale was not on the resident's unit (400 hall) but located up front near the 100 and 200 halls. LPN #589 was unable to locate the dialysis binder for Resident #1 at the time of this interview but sent Certified Nurse Aide (CNA) #567 to find it. Interview on 09/04/2025 at 10:26 A.M. with the Director of Nursing (DON) confirmed the INPOC Dialysis assessments were to be completed daily when residents were scheduled for dialysis, both before and after dialysis. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/04/2025 at 10:27 A.M. with LPN #589 revealed the belief the facility was only supposed to perform a pre dialysis assessment. Review of the list of dates between 07/01/25 and 09/04/25 provided by the Administrator revealed Resident #1 received dialysis on 07/02/25, 07/04/25, 07/07/25, 07/15/25, 07/16/25, 07/18/25, 07/21/25, 07/23/25, 07/25/25, 07/28/25, 07/30/25, 08/01/25, 08/04/25, 08/06/25, 08/11/25, 08/13/25, 08/15/25, 08/18/25, 08/20/25, 08/22/25, 08/25/25, 08/27/25, 08/29/25, 09/01/25, and 09/03/25. Review of the assessment titled INPOC Dialysis completed between 06/01/25 and 09/03/25 revealed this assessment had been completed pre and post dialysis on 06/02/25, 06/04/25, and 06/27/25 and on 07/23/25 at 12:26 P.M. Further review of the INPOC Dialysis assessments revealed the assessment forms contained no prompts or assessment data related to vital signs, including a blood pressure, or resident weight. There were no INPOC Dialysis assessments completed after 07/23/25. Review of the Dialysis Communication Record revealed this was a form for interfacility communication (between the facility and the dialysis center) on dialysis days. Further review of the dialysis communication records revealed the facility was to complete the pre-dialysis assessment and send with the resident and the dialysis staff sent back the post assessment completed on the bottom of the form, when it was sent with the resident. Dialysis Communication Records that were available included: 06/04/25 with no weight or nurse signature for the preassessment. The post assessment completed by the dialysis center contained only Resident #1's weight. 06/09/25 had no weight or assessment of the dialysis site. 06/11/25, 06/13/25, and 06/16/25 had the facility's pre-dialysis assessment completed. 06/18/25 and 06/23/25 had no assessment of the dialysis site on the pre-dialysis facility assessment. 06/20/25 had no assessment of the dialysis site on the pre-dialysis facility assessment and no evidence the center (or the facility) conducted a post-dialysis assessment. 06/25/25, 06/27/25, and 06/30/25 had the pre-dialysis assessment completed by facility staff. 07/25/25 with no pre-dialysis facility assessment of the dialysis access site. 07/30/25 with no pre-dialysis weight. 08/25/25 with no dialysis access site assessment pre-dialysis. There were three completed undated pre-dialysis communication notes. None of the three contained the dialysis access site assessment and one contained no post-dialysis assessment from the dialysis center. None of the above Dialysis Communication Records contained a facility post-dialysis assessment. There were no Dialysis Communication Records completed on 07/02/25, 07/07/25, 07/15/25, 07/16/25, 07/18/25, 07/21/25, 07/28/25, 08/01/25, 08/04/25, 08/06/25, 08/11/25, 08/13/25, 08/15/25, 08/18/25, 08/20/25, 08/22/25, 08/27/25, 08/29/25, 09/01/25, or 09/03/25. Interview on 09/04/25 at 1:35 P.M. the DON confirmed there were no additional pre or post dialysis assessments other than what had been already provided. Review of the policy titled End-Stage Renal Disease, Care of Resident with, last revised September 2010, revealed staff caring for residents receiving dialysis would be trained on the type of assessment data that must be collected on a daily or per shift basis, how to recognize and intervene in medical emergencies, such as hemorrhaging or sepsis, recognize and properly manage equipment-related complications, timing and administration of medications before and after dialysis, and care of grafts or fistulas. There was no record of what facility staff education consisted of related to required pre and post dialysis assessments. Review of the Nursing Home Dialysis Transfer Agreement in effect 07/20/22 revealed the facility was to provide for the interchange of information necessary for the care of the dialysis resident. Review of the policy titled Hemodialysis Access Care, last revised September 2010, revealed the nursing staff were to document post-dialysis observations.		