

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER Landmark of Louisville Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1155 Eastern Parkway Louisville, KY 40217	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45914</p> <p>Based on observation, interview, record review, and review of facility policy, it was determined the facility to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Observation revealed multiple food items in the pantry, refrigerator and freezer that were opened but not dated. Further observation revealed kitchen staff were not properly wearing hair restraints to prevent hair from contacting food.</p> <p>The findings include:</p> <p>The facility did not provide any policies requested by the survey team related to labeling and dating food items, food storage, or hairnets.</p> <p>Observation of the facility kitchen's dry storage pantry, on 07/08/2024 at 11:00 AM, revealed a country style gravy package opened, re-sealed and undated. A package of turkey gravy wrapped in plastic wrap but was not dated. A package of brownie mix wrapped in plastic wrap and sealed but not dated. A package of pasta noodles was sealed but not dated. A bottle of worcestershire sauce was opened, and had an original label, but no date.</p> <p>Continued observations included Refrigerator A, and revealed a sheet pan of gelatin cake stored with wax paper lying on top but not sealed properly. Further observation of the walk-in Refrigerator, revealed a large bag of shredded cheddar cheese, wrapped in plastic wrap but not dated. A package of sliced cheddar cheese was wrapped in plastic wrap but not dated. Additional observation revealed a rolling bread cart with a package of sliced bread, sealed but not dated.</p> <p>Observation of Dishwasher 1, on 07/08/2024 at 11:15 AM, revealed he was wearing a hairnet; however, the hairnet was not worn properly, and his hair hung down outside the hairnet.</p> <p>In an interview with Dishwasher 1, on 07/08/2024 at 11:20 AM, he stated he worked in the facility for about three weeks. He stated he was a dishwasher but worked in the kitchen wherever assigned. He stated he was aware that hairnets were to cover all the hair to prevent hair from falling into resident's food and cause contamination.</p> <p>(continued on next page)</p>

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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an interview with the Dietary Manager, on 07/08/2024 at 11:30 AM, he stated he worked in his position since 03/2024. He stated he was aware food items were to be labeled and dated when stored in the pantry, and/or refrigerators and freezers. Generally, he stated he was responsible for ensuring those food items were sealed, labeled, and dated. He further stated he did not want to serve residents unsafe food products.</p> <p>In an interview with the Director of Nursing (DON), on 07/12/2024 at 6:46 PM, she stated she expected all dietary staff to follow food service safety guidelines and to ensure they were wearing the hairnets properly.</p> <p>During an interview with the Administrator, on 07/12/2024 at 7:07 PM, he stated, regarding hairnets and food storage, that dietary staff should always follow CMS guidelines, state and federal regulation, and the facility policy and procedures regarding food safety and resident safety.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45990</p> <p>Based on observation, interview, record review, and facility policy review, it was determined the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections.</p> <p>Observations revealed staff entering resident rooms marked with precaution signage without donning (putting on) protective equipment. Additionally, observations of the facility laundry room revealed concerns including incorrect ventilation, lack of defined sorting areas, and no personal protective equipment available for staff use.</p> <p>The findings include:</p> <p>Review of facility policy Guidelines for Infection Prevention Control, revised 04/05/2022, revealed the purpose of the policy included to establish, maintain, and manage an effective infection prevention and control program. Added review revealed the program was designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Continued review revealed standard and transmission-based precautions were followed to prevent spread of infection. Continued review revealed facility personnel handled/stored/processed and transported linens to prevent spread of infection.</p> <p>Review of facility policy Infection Control/Isolation Guidelines revised 08/01/2023 revealed the objective of the policy was to prevent unprotected exposure of residents, visitors, and staff to potentially infectious microorganisms or diseases and to decrease the spread of in-house acquired infections. Added review revealed droplet precautions were intended to reduce the risk of respiratory droplet transmission of infectious agents. Continued review revealed transmission-based precautions were intended to be used for additional control measures beyond the standard precautions and included contact, droplet, and airborne precautions.</p> <p>Review of Post Public Health Emergency-Standard and Guidelines, reviewed 05/23/2023 revealed facility followed the Centers for Disease Control (CDC) guidelines to prevent unnecessary exposures of COVID-19.</p> <p>Review of facility policy Laundry Policies and Procedures for Laundry Personnel, undated, revealed soiled laundry/bedding was handled in manner that prevented gross microbial contamination of the air and persons handling the linen. Added review revealed anyone who handled soiled linens must wear protective gloves and other protective equipment such as gowns. Further review revealed infected/Bio-Hazard/Covid-19 Linen was placed in a yellow biohazard bag inside an approved bio-hazard transport container for transportation. Continued review revealed employees wore proper personal protective equipment (PPE) for sorting.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of facility policy C-Diff, Covid-19, MERSA, Noro Virus, Influenza Infectious Area Cleaning Policies and Procedures, undated, revealed the purpose of policy was to provide a clean and safe environment for residents, visitors, and those staff responsible for housekeeping and laundry. Added review revealed staff was to check with nursing staff on requirements for entering the room, ensure signage was posted on door and to wear appropriate personal protective equipment (PPE) such as gown, eye protection, mask, and gloves. Continued review revealed daily cleaning procedures included to clean isolation rooms last and that mop water cannot be used for more than one room.</p> <p>Review of Resident (R) 140's face sheet revealed the facility admitted resident on 09/12/2022 with diagnoses to include morbid obesity, anxiety, and depression.</p> <p>Review of Physician orders dated 07/07/2024 revealed R140 was placed in Transmission-Based/ Droplet precautions. Continued review of R140's medical record revealed the resident tested positive for Covid-19 on 07/07/2024.</p> <p>Observation on 07/09/2024 at 2:15 PM, revealed Housekeeper (HK) 2 entered R140's room which was marked with signage indicating Transmission Based/Droplet Precautions for Covid, without donning an N-95 mask (a respiratory protective device with a very close fit, and very efficient filtration of airborne particles) or a face shield, wearing only a medical blue surgical-type mask and gown. Added observation revealed HK2 removed her gown after exiting room. Continued observation revealed HK2 entered room [ROOM NUMBER] and room [ROOM NUMBER], neither designated as isolation, wearing the same mask worn in R140's room. Added observation revealed mop water was not changed; however, mopheads were changed between rooms and placed in a bag.</p> <p>Observation of the laundry room on 07/09/2024 at 9:24 AM revealed no defined sorting area for sorting dirty linens with a short distance from last washer to clean drying area. Continued observation revealed no Personal Protective Equipment (PPE) for staff to don prior to sorting dirty linens. Further observation of the laundry room revealed a large floor fan sitting at third washer with the exhaust aimed at dryers and table on clean processing side.</p> <p>During attempted interview with HK2, at 2:35 PM on 07/09/2024, she stated she was too busy to talk and refused interview. Interview was not attempted again.</p> <p>Interview at time of the laundry room tour, on 07/09/2024 at 9:24 AM, with the Laundry Supervisor, revealed when asked what PPE was worn by staff when sorting dirty linens, she stated staff wore regular gloves and gown. When asked about face protection for sorting dirty linens she did not reply. When asked about gowns worn for sorting dirty linens, the supervisor was unable to locate a gown immediately; however, she located one in the back of the room after a short time of searching. The Laundry Supervisor and Director of Nursing were unable to locate any face protection, including face shield or goggles. As the laundry room tour continued and when asked how isolation linens were processed the Laundry Supervisor stated there were separate washers in a separate room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Continued interview with Housekeeping/Laundry Supervisor on 07/12/2024 at 11:45 AM revealed she stated as Manager her expectations were for staff to follow signage on isolation room doors, don proper PPE, which included a N-95 mask for Covid rooms. She added upon learning of HK2 entering a Covid room without N-95 mask, training was immediately provided to all of her staff. When asked about changing mop water and mop heads after cleaning a Covid room, she stated mop water is not changed since the microfiber mop heads are changed after each mopping and there is disinfectant in the mop water. She continued and added the Covid rooms are cleaned once daily or as needed and wiped down with a disinfectant with a kill time of three (3) minutes. When asked how linens from a Covid room was processed, she explained those linens were placed in a dissolvable bag which was placed in a red bag then brought to laundry area and the dissolvable bag was put in a washer. She added the trash from isolation rooms was placed in a red biohazard bin in the dirty utility room on each floor. She added her concern for staff not following procedure and guidelines for isolation precautions was that germs and bacteria can be spread to other rooms.</p> <p>Interview with Licensed Practical Nurse (LPN) 11 on 07/12/2024 at 4:05 PM, Certified Nursing Assistant (CNA) 6 at 9:20 AM, LPN2 on 07/10/2024 at 1:50 PM, CNA7 on 07/10/2024 at 1:55 PM, and CNA8 on 07/11/2024 at 2:30 PM, they stated in interviews signage for isolation rooms should be followed and when entering a Covid room a N-95 mask, and face shield should be donned along with the other PPE.</p> <p>During interview with the Infection Preventionist (IP), on 07/12/2024 at 10:33 AM, with Standard precautions/ Universal precautions staff should wear gloves and if a possibility of splashing to face, a face shield and gown should be worn. She added that laundry service staff does not attend her trainings; but, attended monthly in-services which is an overall training for infection control, but not specific to laundry services. The IP nurse stated staff should, when entering a Covid room for cleaning, wear a N-95 mask, gown, gloves, and face shields. The IP nurse stated Isolation rooms should be cleaned more frequently, at least couple times a day especially for high touch surfaces. When asked about any concern for staff not following guidelines and signage for isolation rooms, she stated that germs could spread and added they are trained to don (put on) PPE prior to entering the room and doffing (remove) prior to exiting the room.</p> <p>During an interview with Director of Nursing (DON) on 07/12/2024 at 6:40 PM, revealed staff should follow infection control protocol and guidelines to prevent spread of illnesses, and she expected them to do so, stating guidelines and protocols are important. The DON stated when an infection control issue was identified, immediate education was given to staff.</p> <p>During an interview with the facility Administrator at 6:56 PM on 07/12/2024, revealed as administrator he always had concerns for infection control and as an administrator his expectations were that staff followed trainings, policies, and guidance. He continued and stated retraining was immediate if something was identified or whatever was needed to correct the problem adding following guidelines were important to prevent infection.</p>		