

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185361	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/31/2025
NAME OF PROVIDER OR SUPPLIER Kindred Hospital - Louisville		STREET ADDRESS, CITY, STATE, ZIP CODE 1313 St. Anthony Place Louisville, KY 40205	

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 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)

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to ensure pharmaceutical services, including the accurate receipt and documentation of controlled drugs, was provided for one (Resident (R) 5) of three sampled residents reviewed for abuse. Licensed Practical Nurse (LPN) 3 failed to verify the receipt and recording of fentanyl, a Schedule II controlled drug, when it was delivered to the facility by the pharmacy. The findings include: Review of R5's Face Sheet revealed the facility admitted the resident on 01/19/2022. According to the Face Sheet, the resident had a medical history that included a diagnosis of chronic pain. Per R5's Medication Administration Record (MAR) for 10/2025, the resident had an order, dated 05/10/2025, for fentanyl 25 microgram (mcg) per hour, apply one patch every three days for chronic pain. Review of the pharmacy delivery receipt indicated two fentanyl (a schedule I controlled substance used to treat severe pain) 25 mcg patches ordered for R5 were received in the facility on 10/05/2025 by Licensed Practical Nurse (LPN)3. Review of a facility initial report, dated 10/07/2025, revealed that on 10/07/2025, LPN3 was unable to locate the two fentanyl patches ordered for R5 which were delivered to the facility on [DATE]. The facility final report, dated 10/09/2025, revealed [NAME] a thorough investigation, which included involving local law enforcement and our pharmacy partners, the facility does not substantiate controlled substance diversion or misappropriation. The facility concludes that the nurse who signed the delivery manifest for the 2 controlled substances did not realize that the contents of the disposable pharmacy bag included 2 fentanyl patches for [R5] when she threw it in the trash. During an interview on 12/29/2025 at 8:54 AM, LPN3 stated that when narcotics were delivered from the pharmacy, she would sign a paper from the delivery driver after she verified the medications that were delivered. LPN3 stated she would then take the medications to the responsible nurse, and two nurses would sign the medication in on the narcotic addition and deletion log. Per LPN3, a separate narcotic count sheet was signed by one nurse and placed in the narcotic count book on the medication cart. LPN3 stated fentanyl patches were not delivered in a box and instead, were delivered in a little plastic bag. LPN3 stated the incident involving R5's fentanyl occurred when she was working, and the pharmacy delivery driver handed her a bag of medications. LPN3 stated she did not verify the medications that were received and only felt one blister pack of pills inside the bag. LPN3 stated she threw the pharmacy bag away at the nurse's station and took the blister pack of pills to LPN8. LPN3 stated she did not realize the fentanyl was missing until two days later, on 10/07/2025, when the medication was not available to administer. LPN3 stated the pharmacy was contacted and they informed her that she signed for the fentanyl patches on 10/05/2025. LPN3 said she was surprised and immediately thought she must have thrown them away. LPN3 stated that in response, she immediately notified the Director of Nursing (DON). During an interview on 12/31/2025 at 9:36 AM, LPN8 stated she worked in the facility on 10/05/2025 and did not see R5's fentanyl patches. LPN8 stated she saw LPN3 throw away the pharmacy bag once LPN3 handed her medication that belonged to a resident she was assigned to care for. During an interview on 12/29/2025 at 2:27 PM, Registered Nurse (RN) 6 stated that when medications were delivered by the pharmacy, the nurse should review the delivery sheet, compare it to the medications that were delivered, and then sign the delivery sheet. During an interview on 12/30/2025 at 11:17 AM, the Assistant Director of Nursing (ADON) stated she thought LPN3 accidentally threw away the fentanyl patches ordered for R5. The ADON stated fentanyl patches were delivered in a sealed bag from the pharmacy inside a small plastic bag and sometimes the patches would stick to the inside of the pharmacy bag. During an interview on 12/30/2025 at 11:57 AM, the DON stated LPN3 discovered R5's fentanyl patches were missing on 10/07/2025 when she attempted to administer the 7:00 AM to 10:00 AM scheduled dose. The DON stated the Medical Director was notified, and an order was obtained to administer the fentanyl patch when it was delivered by the pharmacy. According to the DON, once LPN3 notified her, she verified the medication was never logged in on the narcotic addition and deletion log. Per the DON, LPN3 told her she threw the pharmacy bag away at the nurse's station and took another medication that was delivered to LPN8. The DON stated she expected that narcotics were verified when delivered from the pharmacy and were immediately signed in by two nurses. During an interview on 12/31/2025 at 10:10 AM, the Executive Director (ED) stated that he expected that narcotics would not be thrown away and that there was a secure handoff process. The ED stated that the nurses receiving the medications and pharmacy delivering the medication should monitor the medications delivered.</p>		