

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 01/30/2025
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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46659</p> <p>Based on observation, interview and facility policy review, the facility failed to provide a clean environment in 11 of 38 residents' rooms.</p> <p>Observation revealed the facility had not maintained cleanliness in residents' Rooms 304, 307, 326, 328, 332, 333, 335, 338, 382, 383, and 384.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Patient's Environment, dated 10/2022, revealed, 4. Housekeeping and maintenance services are provided to maintain a sanitary, orderly, and comfortable interior.</p> <p>However, observation of residents' rooms revealed the following:</p> <p>1. On 01/28/2025, the following was observed:</p> <ul style="list-style-type: none"> - At 2:28 PM, an uncleaned intravenous (IV) pole and ventilator machine in room [ROOM NUMBER]; - At 2:35 PM, an uncleaned IV pole and dried tube feeding on the floor and on the geriatric (geri) chair in room [ROOM NUMBER]; - At 2:40 PM, dried tube feeding formula on an IV pole in room [ROOM NUMBER]; - At 2:43 PM, an uncleaned IV pole and ventilator machine in room [ROOM NUMBER]; - At 2:46 PM, an uncleaned IV pole and ventilator machine in room [ROOM NUMBER]; - And at 2:50 PM, dried tube feeding formula on an IV pole in room [ROOM NUMBER]. <p>On 01/29/2025, the following continued to be observed:</p> <ul style="list-style-type: none"> - At 8:05 AM, an uncleaned IV pole and ventilator machine in room [ROOM NUMBER]; - At 8:10 AM, an uncleaned IV pole and dried tube feeing on the floor and geri chair in room [ROOM NUMBER]; <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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- At 8:18 AM, dried tube feeding formula on an IV pole in room [ROOM NUMBER];</p> <p>- At 8:20 AM, an uncleaned IV pole and ventilator machine in room [ROOM NUMBER];</p> <p>- At 8:25 AM, an uncleaned IV pole and ventilator machine in room [ROOM NUMBER];</p> <p>- And at 8:30 AM, dried tube feeding formula on an IV pole in room [ROOM NUMBER].</p> <p>During interview on 01/30/2025 at 9:40 AM, Patient Room Cleaner (PRC) 12 stated she did not clean IV poles or ventilator machines (as part of her assigned tasks). The PRC stated she had never been told to clean the IV poles or ventilator machines. PRC 12 further stated the IV pole in room [ROOM NUMBER] was rusty and had tube feeding formula on it.</p> <p>During interview on 01/30/2025 at 9:44 AM, Respiratory Therapist (RT) 1 stated room [ROOM NUMBER] had a dirty IV pole.</p> <p>During interview on 01/30/2025 at 9:50 AM, RT 1 stated the IV pole in room [ROOM NUMBER] had tube feeding milk splattered on it and the legs of the ventilator machine and the geri chair were dirty. RT 1 further stated respiratory therapy was responsible for the cleaning of the ventilator machines.</p> <p>During interview on 01/30/2025 at 10:01 AM and at 10:05, Registered Nurse (RN) 2 stated the IV pole in room [ROOM NUMBER] was rusty/dirty. RN 2 further stated the geri chair in room [ROOM NUMBER] was dirty and the IV pole had tube feeding formula on it.</p> <p>During interview on 01/30/2025 at 10:30 AM, the Assistant Director of Environmental Services (ADEVS) stated he thought nursing was responsible for cleaning the IV poles and was not sure who was responsible for cleaning the ventilator machines. Per the ADEVS, he expected housekeeping staff to clean the geri chairs.</p> <p>During interview on 01/30/2025 at 3:40 PM, the Director of Nursing (DON) stated she expected housekeeping to keep the facility's environment clean. The DON further stated she expected nursing and other departments to keep the equipment clean, such as IV poles and ventilator machines.</p> <p>During interview on 01/30/2025 at 4:21 PM, the Executive Director (ED) stated he expected all the departments to work together to keep the facility clean. He further stated he did not have a policy on which departments were responsible to clean which equipment; however, expected the department that used the equipment to keep their own equipment clean.</p> <p>22445</p> <p>2. On 01/28/2025, the following was observed:</p> <p>- At 2:30 PM, dried tube feeding formula on the nightstand and feeding pump pole and a build-up of dust on the bedframe in room [ROOM NUMBER];</p> <p>- At 2:40 PM, a dirty tube feeding pump in room [ROOM NUMBER];</p> <p>- At 2:45 PM, a dirty IV pole in room [ROOM NUMBER];</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- At 2:50 PM, the window shade, IV pole, and nightstand in room [ROOM NUMBER] had dried tube feeding formula on it and trash lying on the floor behind the nightstand and in the bathroom;</p> <p>- And at 2:55 PM, there was dried tube feeding formula on the feeding tube pole and nightstand in room [ROOM NUMBER].</p> <p>During interview on 01/30/2025 at 9:00 AM, PRC 26 stated environmental services staff wiped poles, bed rails, and tables in residents' rooms on a daily basis. The PRC further stated however, environmental services was not responsible for cleaning the areas of dried tube feeding formula, as that was the responsibility of the staff who made the mess.</p> <p>During observation on 01/30/2025 at 9:08 AM, with RN 9 of residents' Rooms 332, 333 and 335, the RN confirmed the tube feeding poles had dried tube feeding formula on them and on the surrounding furniture. In interview at the time of observation, RN 9 stated either the nurses or the certified nursing assistants (CNAs) were responsible for cleaning the tube feeding poles daily and removing any spilled tube feeding. The RN said the person who spilled the tube feeding formula was the one responsible for cleaning the formula up because when the tube feeding formula dried it became extremely hard to remove. RN 9 reported if the person that spilled the tube feeding formula failed to clean it up, then whoever found it should clean the formula spill.</p> <p>During observation on 01/30/2025 at 9:53 AM, with CNA 12 of resident room [ROOM NUMBER], the CNA observed the tube feeding pole in the room, and stated the pole was dirty and needed to be cleaned as did the top of the nightstand. The CNA stated the nurses were responsible for cleaning the tube feeding poles and the respiratory therapists were responsible for cleaning the bases of the ventilator machines. CNA 12 further stated both items had dried tube feeding formula on them.</p> <p>During interview on 01/30/2025 at 10:27 AM, the ADEVS stated he expected the housekeepers to clean the resident furniture if needed, and the furniture needed to be moved daily to get any trash underneath. He reported nursing staff was responsible for cleaning the tube feeding and IV poles. The ADEVS further stated the housekeeping department did not clean the ventilator machines.</p> <p>During observation on 01/30/2025 at 10:51 AM, the ADEVS pulled the nightstand from the wall in room [ROOM NUMBER] and saw the trash lying on the floor. The ADEVS stated, at that time, there was no excuse for the trash to be behind the nightstand, and that he expected the housekeepers to clean behind furniture.</p> <p>During interview on 01/30/2025 at 4:43 PM, the ED stated he expected the housekeepers to keep a clean environment and to follow their room cleaning procedures. He reported he expected the tube feeding poles and ventilator machine bases to be as free as possible of tube feeding formula and added high surface dusting was expected to be completed daily. The ED further stated furniture in residents' rooms should be moved to remove the trash from behind the furniture.</p>		

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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>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46659</p> <p>Based on observation, interview, and facility document and policy review, the facility failed to ensure it followed proper food handling practices had the potential to affect all residents who received food from the kitchen.</p> <p>Male dietary staff were observed to not have beard restraints in place while they were in the kitchen. Additionally, review of documentation revealed dietary staff failed to note food temperatures as directed by the policy.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Personal Hygiene, dated 12/05/2022, revealed, 4. Hair Restraints/False Eyelashes: a. Hair restraints are required for any person entering the foodservice areas (kitchen, behind the line cafe, food/supply storage areas) .c. [NAME] & mustache guards must be worn in all foodservice areas as defined above. Guards must fully cover facial hair.</p> <p>Observation on 01/29/2025 at 11:44 AM, revealed [NAME] 18 and the Dishwasher (DW) were in the kitchen without wearing beard restraints.</p> <p>During interview on 01/29/2025 at 12:08 PM, the DW stated he did not know he was supposed to wear a beard net or not.</p> <p>During interview on 01/29/2025 at 12:13 PM, [NAME] 18 stated he knew he was supposed to wear a beard net; however, had forgotten to get one.</p> <p>During interview on 01/29/2025 at 12:17 PM, the Food Service Team Lead Supervisor stated she expected the male dietary staff to wear beard nets.</p> <p>During interview on 01/29/2025 at 12:21 PM, the Dietary Services Manager stated he expected the male dietary staff to wear beard nets.</p> <p>During interview on 01/30/2025 at 4:21 PM, the Executive Director (ED) stated he expected the male kitchen staff to wear beard nets as required.</p> <p>2. Review of the facility policy titled, Food Temperature Measurement, dated 06/2023, revealed, Food temperature also impacts palatability and measurements must be taken prior to service. The policy specified, 7. All temperatures measurements are documented on the standard food temperature log.</p> <p>Review of the facility Taste/Temperature Record, for the timeframe 01/22/2025 to 01/29/2025, revealed no documented evidence of food temperatures for the lunch meal on 01/28/2025 or for the breakfast meal on 01/29/2025.</p> <p>(continued on next page)</p>

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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>During interview on 01/29/2025 at 11:48 AM, [NAME] 19 stated steamtable logs were to be completed at each meal. He said he was not sure why the steamtable logs had some meals with no temperatures charted. [NAME] 19 reported he must have forgotten to write them down on those days.</p> <p>During interview on 01/29/2025 at 12:13 PM, [NAME] 18 stated he forgot to write down the steamtable temperatures for breakfast on 01/29/2025. He said he had gotten busy and had not written them down.</p> <p>During interview on 01/29/2025 at 12:17 PM, the Food Service Team Lead Supervisor stated she expected the logbooks to be completed and expected staff to follow the facility's policies.</p> <p>During interview on 01/29/2025 at 12:21 PM, the Dietary Services Manager (DSM) stated he expected the steam table logs to be kept up to date. Per the DSM, the steam table logs being incomplete was unacceptable. He said he failed to review the steamtable log books for completeness.</p> <p>During interview on 01/30/2025 at 4:21 PM, the ED stated that he expected the dietary/kitchen staff to keep the food temperature logs up to date and complete.</p>		