STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185466	A BUILDING _____ B WING _____	R-C 06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT PLACE HEALTH CAMPUS	4247 WESTPORT ROAD LOUISVILLE, KY 40207

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A revisit survey was conducted 06/20/2025 and based upon implementation of the acceptable Plan of Correction, the faciltiy was deemed to be in compliance on 05/31/2025, as alleged.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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	185466	A. BUILDING _____ B. WING _____	C 05/01/2025

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WESTPORT PLACE HEALTH CAMPUS	4247 WESTPORT ROAD LOUISVILLE, KY 40207

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F 000	INITIAL COMMENTS A recertification and complaint survey was concluded on 05/01/2025. The facility was found to not be in substantial compliance with 42 CFR 483 Subpart B. Survey Dates: 04/29/2025 - 05/01/2025 Survey Census: 55 Sample Size: 55 No deficiencies were issued related to KY00045854, KY00045342, KY00038466, KY00042625, KY00043030, KY00045104, KY00041234, or KY00041891.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 880		5/31/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/23/2025

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.

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F 880	Continued From page 1 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 2	F 880		

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of facility's policies. The facility failed to follow infection control precautions for three of four sampled residents with peripherally inserted central catheters used for intravenous medication administration for Resident (R) 41, R197 and R6.

Observation on 04/29/2025 at 09:23 AM revealed R197 had a peripheral inserted central catheter in right upper arm without a protective cap placed on end of catheter hub (the entry port distal of the catheter that connects to tubing or a syringe to deliver medication intravenously) leaving hub exposed.

Observation on 04/29/2025 at 09:43 AM revealed R6 had a peripheral inserted central catheter in left upper arm without a protective cap placed on end of catheter hub, leaving hub exposed.

Observation on 04/29/2025 at 09:45 AM revealed R41 had a peripheral inserted central catheter in left upper arm without a protective cap placed on end of catheter hub, leaving hub exposed.

The findings include:

Review of the facility's policy titled, "Catheter Insertion and Care" revision date, 12/15, stated under general guidelines, step 7. "Apply a sterile end cap to the end of primary tubing when it is

**Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On May 1, 2025, the Director of Health Services (DHS)/Infection Preventionist (IP), and Assistant Director of Health Services (ADHS) completed a comprehensive review of resident #41, #197 and #6. Each resident was assessed for signs and symptoms of infection at IV insertion site, with no concerns noted. Intravenous access dressings were evaluated to ensure they were changed in accordance with physician orders and were observed to be clean, dry, intact and free from signs of infection. Additionally, intravenous tubing was reviewed for proper date labeling. All tubing reflected timely changes consistent with both physician orders and applicable regulatory standards.

**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

On May 1, 2025, the Director of Health Services (DHS)/Infection Preventionist (IP), and Assistant Director of Health

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F 880	Continued From page 3 disconnected from catheter." The facility's policy does not mention placing a protective cap at the end of peripheral inserted central catheter hub. Review of R41's "Physician Orders," located in electronic health record, revealed an order to place caps at the end of peripheral inserted central catheter. Review of R6's "Physician Orders," located in electronic health record, revealed an order to place caps at the end of peripheral inserted central catheter. Review of R197's "Physician Orders," located in electronic health record, revealed an order to place caps at the end of peripheral inserted central catheter. During an interview with Director of Nursing, acting Infection Preventionist, on 04/30/2025 at 04:10 PM, she stated she was unsure and would follow up to why one of four residents had a cap on the hub of her peripheral inserted central catheter and the others did not. She followed up with Clinical Services and she stated that all peripheral inserted catheters had to have caps at the end of their catheter hubs. During an interview with Registered Nurse (RN) 2 on 05/01/2025 at 04:44 PM, he stated after administering an intravenous medication into a peripherally inserted central catheter he would clean the catheter hub again with alcohol and place a cap at the end. During an interview with Assistant Director of Nursing, on 05/01/2025 at 04:55 PM, she stated that nurses should be cleaning the peripheral	F 880	Services (ADHS) completed a comprehensive review of all residents with intravenous vascular access. Each resident was assessed for signs and symptoms of infection, with no concerns noted. Intravenous access dressings were evaluated to ensure they were changed in accordance with physician orders and were observed to be clean, dry, intact and free from signs of infection. Additionally, intravenous tubing was reviewed for proper date labeling. All tubing reflected timely changes consistent with both physician orders and applicable regulatory standards. No deficient practice was identified in relation to intravenous vascular access management for any resident reviewed. **Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur. To prevent confusion with verbiage, the Matrix IV order set was changed from change end caps every 96 hours to change the needleless connector routinely every 96 hours. In addition, a prn order was added to change the needleless connector PRN after blood draws, prior to obtaining blood cultures and after blood transfusions. The orders were changed by our Clinical Support Nurse on 5/23/2025. On 5/23/2025, Director of Health Services, Assistant Director of Health Services, Medical Records Nurse and Executive Director began educating all	

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F 880	Continued From page 4 inserted central catheters with alcohol after disconnection of tubing or a syringe and placing a cap on the end of catheter's hub. She stated that a potential outcome could be introducing infection to the resident if not placing cap to catheter hub. During an interview with RN3 on 05/01/2025 at 05:12 PM, he stated that after he disconnects intravenous tubing or a syringe, he cleans the end of the catheter hub with alcohol, then "flushes" and then recaps the end of hub. He stated, "there is a hole there and that can introduce bacteria if you do not recap." During an interview with the Administrator, on 05/01/2025 at 05:37 PM, she stated that she is not a nurse, but she expects staff to follow facility policies.	F 880	licensed nursing staff on maintaining sterility of intravenous access devices and new intravenous order set verbiage regarding the needleless connector. A post test was completed with education to ensure staff knowledge was retained on the training material provided with a passing score of 100%. All licensed nursing staff will be educated by 5/30/2023. After 5/30/2025, any newly hired staff will be educated through orientation by the employee experience manager (EXM) with a post-test completed to ensure staff knowledge was retained on the above training material with a passing score of 100%. The campus does not use agency staff. **Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. Beginning 5/27/2025, Director of Health Services, Assistant Director of Health Services or Medical Records nurse will assess all residents with intravenous access to ensure needleless connectors are changed per orders and intravenous tubing has a sterile tube cap, 3 times weekly for 4 weeks, 2 times weekly for 4 weeks and 1 time weekly for 4 weeks. An Ad Hoc Quality Assurance meeting was held on 05/23/2025 with the Medical Director and the facility QAPI Committee Consisting of Clinical Support, DHS, and MDS to review the incident, proposed	

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F 880	Continued From page 5	F 880	Plan of Correction and ensure the implementation of the plan, and the Medical Directors expectation related to maintaining sterility of intravenous access devices and new intravenous order set. The Director of Health Services and/or Assistant Director of Health Services will present the findings from the audits to the monthly QAPI Committee consisting of the Executive Director, Director of Health Services, Assistant Director of Health Services, Medical Director, Social Services Director, MDS Coordinator and Infection Preventionist. The QA Committee will determine the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned ongoing audits. The Administrator has the oversight to ensure an effective plan is in place to meet the residents wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. Facility alleges compliance 05/31/2025.	