

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185466</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/30/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESTPORT PLACE HEALTH CAMPUS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4247 WESTPORT ROAD</b> <b>LOUISVILLE, KY 40207</b>		
(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  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/30/15 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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NAME OF PROVIDER OR SUPPLIER  WESTPORT PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 4247 WESTPORT ROAD LOUISVILLE, KY 40207		
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F 000	INITIAL COMMENTS  A Recertification Survey was initiated on 09/15/15 and concluded on 09/17/15 with deficiencies cited at the highest scope and severity of an "E".	F 000	1. Resident # 8 was asked by Charge Nurse on 9/16/15 if she wanted pneumovac at that time, however resident declined.		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334	2. All residents' immunization consents will be audited by DHS, ADHS and Medical Records by 10/29/15 to ensure every resident desiring vaccine has received vaccine . Any vaccines identified out of compliance based on the above audits will be corrected by interviewing identified residents to determine if vaccine is still desired. Vaccines will be administered per request and physician order.	10-30-15	
	The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.  The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal				

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(X6) DATE

*RCBufford*

*ED*

*10-5-15*

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OFFICE OF INSPECTOR GENERAL

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F 334	Continued From page 1 immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure the Pneumonia Vaccine consent form included documentation to indicate a resident's	F 334	3. Licensed nurses will be educated by DHS to place order on MAR by October 29th, 2015 if resident indicates desire for vaccine, initial when administered and make progress note stating resident has received vaccine.  Vaccine consents are discussed and signed during the admission process. Admissions person will forward copy of consent forms to DHS for follow up. Orders will be written for vaccines at that time and vaccine administered per physician order. Long term residents will be assessed annually for decision related to vaccinations. the DHS and ADHS will oversee this process and ensure resident wishes are followed related to vaccines. MDS nurses will also assess compliance during routine and significant change assessment periods.  4. All new admissions will be reviewed on next business day, during clinical care meeting, and orders and medication administration record will be checked to verify vaccine is given to all residents requesting vaccine. If as a result of the review it's discovered that a licensed nurse missed the documentation, then the DHS will reeducate the nurse that completed the admission.  quarterly by Medical Director. This audit will be ongoing as part of the QA process as all new admissions are to be reviewed daily during CCM process.	

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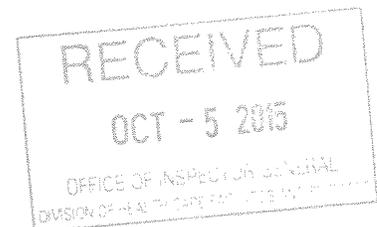
OCT - 5 2015

DIRECTOR GENERAL  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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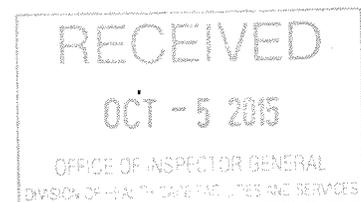
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F 334	Continued From page 2 acceptance or refusal of the pneumonia vaccine, and the signature of the witnessing staff member for one (1) of fourteen (14) sampled residents (Resident #8).  The findings include:  Review of the facility's policy regarding Guidelines for Influenza and Pneumococcal Immunizations, dated August 2014, revealed upon admission and annually each resident/responsible party would sign a Pneumococcal Immunization Education and Informed Consent form indicating the acceptance or refusal of a pneumonia vaccination. A copy of the completed form was to be placed in the medical record.  Review of Resident #8's clinical record revealed the facility admitted the resident on 09/06/15 with diagnoses of Depressive Disorder, Anxiety, Postoperative Pain, Hypothyroid, Weakness, Cataracts, Constipation, Fall, and Dysphagia.  Review of the Pneumococcal Immunization Education and Informed Consent form, dated 09/06/15, revealed Resident #8 signed the document giving his/her permission for the facility to administer the Pneumococcal Vaccine. However, review of Resident #8's medical record and Medication Administration Record (MAR) revealed no documentation or notation was present to show whether or not Resident #8 received the Pneumococcal Vaccine.  Interview with the Interim Assistant Director of Nursing (ADON), on 09/16/15 at 3:02 PM, revealed she completed a chart audit on 09/08/15 of Resident #8's chart. She stated she could not find documentation of whether or not Resident #8	F 334			



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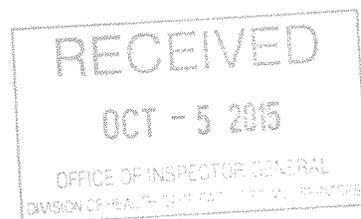
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F 334	Continued From page 3 received the Pneumococcal Vaccine. The ADON stated she reported this to the floor nurse to follow up on.  Interview on 09/17/15 at 8:42 AM, with the Director of Health Services (DHS), revealed when admitted to the facility a resident is educated about what vaccines are available and the	F 334			
F 372 SS=E	resident or their responsible party consent or refuse the vaccination. In addition, the nurse was to sign and date the vaccination consent form and document a progress note indicating the vaccine was given or refused and the reason for refusal. The DHS also, stated the ADON completed chart audits on newly admitted residents on 09/08/15. During the chart audit it was identified that it was unclear whether Resident #8 received the vaccination. The DHS stated it was her expectation that all staff nurses document that an immunization was administered or not. 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review it was determined that the facility failed to ensure sanitary disposal of garbage/refuse in two (2) of two (2) dumpsters.  The findings include:  Review of the facility's policy titled, Pest Control, which was not dated, revealed the facility should	F 372			

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F 372	Continued From page 4 not permit garbage and trash to accumulate and garbage would be removed daily.  Observation during the environmental tour, on 09/16/15 at 10:15 AM, revealed soiled gloves on the ground in front of the main dumpsters, the lid was open on the recyclable's dumpster and it was overflowing with an excess of thirteen (13) boxes on the ground around the recycle dumpster. There were scattered wet boxes in variable stages of decay. There was a rodent trap on the ground between the building and the main dumpster.  Interview with the Maintenance Director, on 09/16/15 at 10:15 AM and 09/17/15 at 1:40 PM, revealed the lids to the dumpsters were to remain closed to prevent rodent infestation. He stated the main dumpster was emptied during business hours twice each week. He stated garbage often fell out the back of the dumpster as it was being emptied. The recyclable's dumpster was emptied weekly between 3:00 AM and 4:00 AM and the 3rd shift staff often parked next to the dumpster preventing the company from accessing the dumpster to empty it. He also stated some staff don't break down their boxes which filled the recyclable's dumpster faster than it would with flattened boxes. He stated he had no routine schedule for rounding on the dumpsters or to check for illegal parking. He stated with the garbage spillage and the overflowing recyclable's it was an invitation for pests. He stated that although they hadn't had any issues with rats the Pest Control company they contracted with had expressed a concern in the past that the boxes could attract squirrels as the facility was located in a heavily wooded area next to a farm.	F 372	1. There were no residents affected by the cited deficiency. 2. IDT will ensure that rounds are made daily on the dumpster site and any spillage will be picked-up-immediately-The Dir. Of Plant Operations will round daily on the site to ensure the site is free of spillages. The ED will report in daily stand up meeting who is responsible for rounding on the dumpster area daily. The ED will validate in daily stand up meeting on the previous day findings around the dumpster site to determine if staff education needs to be reinforced. The findings will be reported on the Daily Stand Up Form utilized for the meeting as proof of documentation of rounding and findings.	10-30-15	



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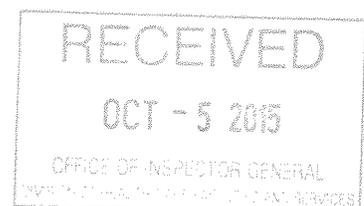
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F 372	Continued From page 5 Interview with the Central Supply Manager, on 09/16/15 at 2:15 PM, revealed she was responsible for ordering and receiving medical supplies. She reported 3rd shift Certified Nursing Assistants (CNA's) and Environmental Aids were responsible to break down the boxes and dispose of them properly. She stated she was unaware boxes weren't being consistently broken down or that the dumpster was overflowing. She was also unaware the night staff was parking in front of the dumpster gate preventing the emptying of the recyclable's dumpster. She never rounded on the dumpster. She stated the dumpsters should remain closed and the area free of garbage and debris which could lead to pest infestation and a possible infection control issue.  Interview with the Director of Food Services on 09/16/15 at 2:50 PM, revealed the kitchen received food deliveries twice a week, they unpacked and stocked their shelves and walk-ins and the cooks broke down the boxes and disposed of them in the recyclable's dumpster. He stated often when the recyclable dumpster was full of boxes they spilled out and often times the recycle bin was set back down on spilled boxes that staff couldn't remove. He was unaware someone was parking in front of the dumpster gate and expressed concern with the unsanitary state of the dumpster area as pests or rodents could infest the dumpster area.  Interview with the Director of Environmental Services, on 09/16/15 at 4:00 PM, revealed he made three to four trips to the dumpsters each day to dump resident and facility garbage and to dispose of boxes from his weekly supply order. He stated he cleaned up any spillage that he encountered when he emptied garbage as he	F 372	3. The Executive Director and Direct of Plant Operations will educate all campus staff on the expectations of the dumpster site and ensuring no trash is left on the ground and all spillage is picked up and placed in the dumpster when seen on the ground.  4. The IDT will review monthly in QA the Daily Stand Up Form and verify documentation of the rounding daily on the dumpster site. If the IDT identifies that there has been 100% compliance with daily rounding of dumpster area after minimum of three months, then the review of the daily stand up form will be moved to quarterly. If at anytime there is less than 100% compliance with daily dumpster rounding, the IDT will begin reviewing the Daily Stand Up Form monthly during QA until such time as 100% compliance is once again achieved and then moved back to quarterly.	

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F 372	Continued From page 6 wanted to avoid an infestation of mice or rats.  Interview with the Administrator, on 09/17/15 at 2:30 PM, revealed she had been aware of the issues with the recyclable dumpster and had been addressing it in her stand up meetings with 3rd shift staff, this occurred twice a month. She had been advising staff that their car would be towed if it was discovered parked in front of the dumpster gate and that signage had been posted. She expressed her expectation that the dumpster area would be clean and sanitary and was concerned with the possibility of mice.	F 372			



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Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185466	(Y2) Multiple Construction A. Building B. Wing <b>01 - WESTPORT PLACE HEALTH CAMPUS</b>	(Y3) Date of Revisit 10/30/2015
Name of Facility <b>WESTPORT PLACE HEALTH CAMPUS</b>	Street Address, City, State, Zip Code <b>4247 WESTPORT ROAD LOUISVILLE, KY 40207</b>	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # <b>NFPA 101</b> LSC <b>K0062</b>	Correction Completed <b>10/30/2015</b>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <i>[Signature]</i>	Reviewed By <i>[Signature]</i>	Date: <i>11/02/15</i>	Signature of Surveyor: <i>[Signature]</i>	Date: <i>11/2/15</i>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <b>9/16/2015</b>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <b>YES NO</b>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/21/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185466	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WESTPORT PLACE HEALTH CAMPUS B. WING _____	(X3) DATE SURVEY COMPLETED  09/16/2015
NAME OF PROVIDER OR SUPPLIER  WESTPORT PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01  PLAN APPROVAL: 2010, 2012  SURVEY UNDER: 2000-New	K 000	1. There were no residents affected by the cited deficiency. 2. The sprinkler cited will be replaced by October 29th. 3. The DPO will ensure that all campus sprinklers are inspected on a routine basis, monthly at a minimum. The DPO will maintain documentation of all sprinkler inspections. 4. The IDT will review the inspections of the sprinklers during the monthly QA meeting to ensure standards are being met. The IDT will review these inspections sheets monthly until 100% compliance is achieved with inspections after a minimum of three months. Once 100% inspection compliance is achieved, then the review of the inspection sheets will be reviewed quarterly. If it is identified to be less than 100%, the IDT will go back to reviewing inspection sheets monthly until 100% compliance is achieved.	10-30-15
	FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One (1) story, Type V (111)  SMOKE COMPARTMENTS: Seven (7) smoke compartments.  FIRE ALARM: Complete fire alarm system with heat and smoke detectors.  SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system.  GENERATOR: Type II, 150 KW generator. Fuel source is Natural Gas.  A Recertification Life Safety Code Survey was conducted on 09/16/15. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid.  The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: ED (X6) DATE: 10-5-15

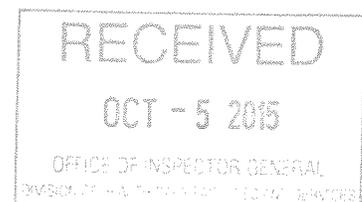
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

OCT - 5 2015

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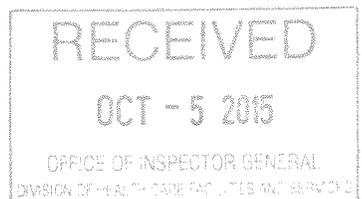
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K 000	Continued From page 1	K 000		
K 062 SS=D	Deficiencies were cited with the highest deficiency identified at D level. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		
	<p>This STANDARD is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to maintain the automatic sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility has sixty-two (62) certified beds and the census was fifty (50) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 09/16/15 at 12:47 PM, with the Director of Plant Operations revealed the side wall mounted sprinkler head located in the Medical Records Office had been damaged and incapable of providing full sprinkler coverage with the room.</p> <p>Interview, on 09/16/15 at 12:49 PM, with the Director of Plant Operations, revealed he was not aware of the damage to the sprinkler head and stated the facility's staff had recently been rearranging the metal storage cabinets within the room and inadvertently damaged the sprinkler</p>			



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K 062	Continued From page 2 head. He stated the positioning of the sprinkler would not provide full sprinkler coverage if activated.  The census of fifty (50) was verified by the Executive Director on 09/16/15. The findings were acknowledged by the Executive Director and verified by the Director of Plant Operations at the exit interview on 09/16/15.  Reference: NFPA 13 (1999 Edition)  5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply with 5-5.5.2.  2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height	K 062		



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K 062	Continued From page 3 The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where	K 062		
	quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.			

