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	02/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westport Place Health Campus	4247 Westport Road Louisville, KY 40207

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Number of residents sampled: Number of residents cited: Review of facility policy titled, Medication Administration - General Guidelines, revised 11/2018, indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The policy revealed, B. Administration included, 13) Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. Review of facility policy titled, Guidelines for Self-Administration of Medications, last reviewed 12/16/2025, indicated, The purpose of this policy is: To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is a part of their plan of care. The policy revealed the Procedure included, Residents requesting to self-medicate or has self-medication as a part of their plan of care shall be assessed using the [the facility's parent company's name] Self-Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self-medication. 1. Review of Resident Face Sheet indicated the facility admitted Resident #10 on 01/28/2022. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of gastro-esophageal reflux disease (GERD) without esophagitis. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/08/2026, revealed the facility assessed Resident #10 with a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Review of Resident #10's Care Plan included a problem area initiated 03/17/2023, that indicated the resident was malnourished or was at risk for malnutrition. Interventions directed staff to provide diet, supplements, medications, and adaptive equipment as ordered (initiated 03/17/2023). Continued review revealed the resident's Care Plan did not include information about the resident self-administering medications or leaving medications at the resident's bedside. An observation on 02/09/2026 at 2:04 PM revealed Resident #10 had three antacids at their bedside. During an interview at that time, the resident stated they wanted to self-administer their medications as needed and to keep them at the bedside and did not recall who the nurse was who gave them the medication. An observation on 02/10/2026 at 9:07 AM revealed a cup of antacids on Resident #10's bedside table. An observation on 02/12/2026 at 10:05 AM revealed Resident #10 sitting in their recliner with a medication cup with three antacids in it on the over-the-bed table in front of them. Review of Resident #10's physician Order History, for the timeframe from 01/14/2026 to 02/14/2026, revealed an order, dated 02/27/2022, for calcium carbonate (an antacid) chewable tablets 500 milligrams (mg) orally four times a day as needed (PRN). The Order History revealed no order to self-administer the medication or leave the medication at the resident's bedside. During an interview on 02/12/2026 at 11:10 AM, Registered Nurse (RN) #7 stated medications should not be left at the bedside. Upon entering Resident #10's room, RN #7 confirmed that the resident had a medication cup with three antacids in it on the over-the-bed table. He stated the antacids were there (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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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when he gave the resident their medications that morning. He stated he did not think about removing them when he saw them, but he should have. RN #7 went to the nurses' station and confirmed that Resident #10 did not have an order to leave them at the bedside, and he was unable to locate a self-administration assessment for the resident. During an interview on 02/13/2026 at 1:21 PM, Licensed Practical Nurse (LPN) #2 stated that if a resident wanted to self-administer a medication, the resident would have to sign a consent. She stated she always stayed with the resident until they took all their medications and did not leave medications at the bedside. She stated she did know Resident #10 had antacids at the bedside before but did not know if they had been assessed and thought that it was okay. She stated that she thought Resident #10 was capable of self-administering the antacids. She stated she did not think they needed an order, just consent from the resident. She stated that if she found medications in a room, she would remove them and educate the resident. 2. Review of a Resident Face Sheet indicated the facility admitted Resident #69 on 02/05/2026. According to Resident Face Sheet, the resident had a medical history that included diagnoses of non-pressure chronic ulcers of the right and left calf with necrosis of the muscle, and age-related osteoporosis. Review of Resident #69's Care Plan revealed problem statement initiated 02/12/2026, that indicated the resident demonstrated forgetfulness and benefitted from cueing. The Care Plan revealed that it did not include information about the resident self-administering medications or leaving medications at the bedside. Review of Resident #69's [the facility's parent company name]-Self-Administration of Medications assessment, dated 02/06/2026, indicated the resident did not want to self-administer medications. The assessment indicated that the resident would not be self-administering medications. An observation on 02/09/2026 at 10:33 AM revealed Resident #69 had multiple bottles of medications in their windowsill, including collagen peptides (a dietary supplement), Florastor (an antidiarrheal probiotic), zinc (a mineral), and bone support (dietary supplement for bone health). There was also a bottle of loratadine (an antihistamine) and fluticasone (a nasal steroid) on the dresser. An observation on 02/10/2026 at 8:30 AM, 12:32 PM, and 2:03 PM revealed the bottles of medications in the windowsill and dresser remained. During an interview at the time of the observation, Resident #69 stated they tried to remember to take the medications but did not always. Resident #69 stated they did not recall having any type of assessment, but the staff never told them that they could not have the medication. An observation on 02/11/2026 at 9:31 AM revealed all the bottles of medications were removed from the windowsill and dresser but there was a bottle of fluticasone on the nightstand. An observation on 02/12/2026 at 10:00 AM revealed a bottle of fluticasone on the nightstand. Resident #69's Physician Order History, for the timeframe from 01/14/2026 through 02/14/2026, revealed an order, dated 02/05/2026, for fluticasone propionate 50 micrograms (mcg) per actuation, one spray in each nostril twice a day. The Order History revealed no orders for the other medications found in the resident's room. The Order History revealed no orders for the resident to keep medications at the bedside or to self-administer medications. During an interview on 02/12/2026 at 11:07 AM, Registered Nurse (RN) #12 stated medications should not be left at residents' bedside. He stated if a resident wanted to self-administer their own medications, they needed to be assessed, and it would have to be approved by the Interdisciplinary Team (IDT), and they would need a physician order. He stated they also needed a physician order to keep the medication at the bedside. RN #12 stated that Resident #69 did not have an order to keep medications at the bedside or to self-administer their medications. He also stated that Resident #69's self-administration assessment indicated the resident did not want to self-administer medications. During an interview on 02/13/2026 at 3:44 PM, the Infection Control Nurse (ICN) stated that if a resident was alert and oriented and wanted to self-administer their medications, they completed an assessment first, and if the resident was assessed to be able to administer their own medications, they called the physician to get an order to self-administer and leave at the bedside. She stated that the nurse would document the use of the medication. During an interview on 02/13/2026 at 4:36 PM, the Director of Nursing Services (DNS) stated a resident could self-administer their own medications (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if an assessment was completed to determine if they were able to, then they notified the physician and got an order. She stated that the medications could be left at the bedside with an order from the physician.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure staff provided respiratory care consistent with resident care policies related to cleaning and storage of equipment for 3 of 4 residents sampled for respiratory therapy out of a total sample of 17 residents (Residents (R) 30, 48, and 69). Observations revealed used respiratory equipment not cleaned and/or stored appropriately after use. The findings include:1. Review of facility policy, Respiratory Equipment, last reviewed 12/16/2026, revealed the Overview indicated, To provide infection control guidelines to help prevent infections associated with respiratory therapy equipment and to prevent transmission of infections to residents and staff. The policy also indicated, 2. Oxygen Administration included, j. Keep oxygen cannula and tubing used PRN [pro re nata; as needed] in a plastic bag when not in use. The policy revealed, Medication Nebulizers/Continuous Aerosol included, c. After completion of therapy, which included, i. Remove nebulizer container, ii. Rinse container with fresh tap water, iii. Allow to dry on clean paper towel or gauze sponge, and iv. Reconnect to administration 'set up.' The policy continued, e. Wipe mouthpiece with damp paper towel or gauze sponge. f. Store circuit in plastic bag, marked with date and resident's name, between uses. During an interview on 02/11/2026 at 2:20 PM, the Director of Nursing Services (DNS) stated that there was no specific policy for use of CPAP machines. Review of facility document Resident Face Sheet revealed the facility admitted Resident #69 on 02/05/2026. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of asthma. Review of Resident #69's Care Plan included a problem area initiated 02/11/2026, that indicated the resident had the potential for complications, functional and cognitive status decline related to respiratory disease. Interventions initiated 02/11/2026 directed staff to provide respiratory therapy per orders and provide medications as ordered. Review of Resident #69's physician's Order History, for the timeframe from 01/14/2026 through 02/14/2026, revealed an active order, dated 02/05/2026, for ipratropium-albuterol (a bronchodilator combination) solution for nebulization 0.5 milligrams (mg)-3 mg/3 milliliters (mL) one vial inhaled every four hours PRN for wheezing and shortness of air. An observation on 02/09/2026 at 10:33 AM revealed a nebulizer machine on Resident #69's nightstand with dried debris in the mask and fluid in the medication cannister. There was no bag to store the equipment in. Observations on 02/10/2026 at 8:30 AM and 12:32 PM revealed the nebulizer machine on Resident #69's nightstand with the mask and medication cannister in the top drawer with dried debris in the mask. The equipment was not stored in a bag. During an observation and interview on 02/10/2026 at 2:03 PM, Resident #69 stated they used the nebulizer machine when they were short of breath. The resident stated the staff laid the mask on top of the machine or in the drawer, and they had not seen staff rinse it out. The medication cannister and mask were lying on top of the nightstand and were not stored in a bag. There was fluid in the medication cannister. Review of Resident #69's Medication Administration History revealed staff documented the resident received an ipratropium-albuterol nebulizer treatment on 02/10/2026 at 8:12 PM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 02/11/2026 at 9:31 AM revealed Resident #69's nebulizer machine was on the nightstand with the tubing attached, with the mask and medication cannister lying on top of the nightstand. There was dried debris in the mask and liquid in the medication cannister, and it was not stored in a bag. An observation on 02/12/2026 at 10:00 AM revealed Resident #69's nebulizer machine on Resident #69's nightstand with the tubing attached, with the mask and medication cannister lying on top of the nightstand, with dried debris in the mask and a scant amount of liquid in the medication cannister. The mask and medication cannister were not stored in a bag. During an interview on 02/12/2026 at 11:07 AM, Registered Nurse (RN)#12 entered Resident #69's room and confirmed that the nebulizer mask was dirty and not stored in a bag. He opened the top drawer of the nightstand and there was a bag to store the equipment in. He stated the mask should be wiped out after use and the medication cannister rinsed, dried, and stored in the bag. RN #12 put Resident #69's name, room number and date on the bag and then set it next to the machine. He then removed the mask and tubing and threw them away and stated that he was going to get new equipment. During an interview on 02/13/2026 at 1:21 PM, Licensed Practical Nurse (LPN) #2 stated that after a nebulizer treatment, the mask should be wiped out and put in a plastic bag, and the medication cannister should be rinsed and allowed to air-dry then put in the bag. During a telephone interview on 02/13/2026 at 10:14 AM, RN #13 stated they were supposed to put the nebulizer mask in a bag after use. She stated that she had administered Resident #69 a nebulizer treatment on 02/10/2026, and once it was done, she placed the mask in the top drawer of the nightstand because the resident did not have a bag in their room at that time. She stated she meant to get one and put it in the room, but she got busy and forgot. 2. Review of Resident Face Sheet revealed the facility admitted Resident #48 on 03/31/2025. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure (CHF) and chronic pulmonary embolism. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/18/2025, revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated that the resident received oxygen therapy during the assessment timeframe. Review of Resident #48's Care Plan included a problem area initiated 04/07/2025, that indicated the resident had a potential for cardiovascular distress and complications related to CHF. Interventions directed staff to administer oxygen therapy per physician orders (initiated 04/07/2025). Review of Resident #48's physician's Order History, for the timeframe from 01/14/2026 through 02/14/2026, revealed an active order, dated 03/31/2025, for supplemental oxygen at 2 liters continuous per nasal cannula. The Order History indicated that the order was changed to PRN on 02/11/2026. An observation on 02/09/2026 at 9:54 AM revealed an oxygen concentrator in Resident #48's room with the oxygen tubing lying on the floor. A portable oxygen tank was under and behind a chair in the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room, with the tubing and nasal cannula touching the floor. At 11:49 AM, the oxygen tubing was wadded up on top of the concentrator. An observation on 02/10/2026 at 8:29 AM revealed the oxygen concentrator in Resident #48's room was on, and the tubing was hanging over the open drawer of the nightstand, with the cannula touching the side of the nightstand. The portable oxygen tank remained on its side under and behind the chair, with the cannula and the tubing touching the floor. An observation on 02/11/2026 at 9:30 AM revealed the oxygen concentrator in Resident #48's room was on. The tubing was not plugged in but was wadded up on top of the machine. The portable oxygen tank remained on its side under and behind the chair, with the cannula and the tubing touching the floor. An observation on 02/11/2026 at 10:01 AM revealed the oxygen concentrator in Resident #48's room was off, and the tubing was lying across the resident's bed. The portable oxygen tank remained on its side under and behind the chair, with the cannula and the tubing touching the floor. During an interview on 02/12/2026 at 11:09 AM, Registered Nurse (RN) #12 stated that when oxygen tubing was not in use, it should be stored in a plastic bag. Upon entering Resident #48's room, RN #12 noticed the portable tank lying under and behind the chair. He set it up, removed the tubing, and threw it away. He stated the tubing on the bed should be stored in a plastic bag, and he was going to have to get a bag to store the equipment in. He removed the tubing from the concentrator and threw it away and stated he was going to replace it. During an interview on 02/13/2026 at 1:21 PM, Licensed Practical Nurse (LPN) #2 stated oxygen tubing should be stored in a bag when not in use, and if it fell on the floor, it should be thrown away and replaced. During an interview on 02/13/2026 at 3:44 PM, the Infection Control Nurse (ICN) stated that oxygen tubing should be stored in a bag when not in use. He stated the bag was dated and had the resident's name on it. He stated that if it touched the floor, then it should be replaced. He stated that the nebulizer mask and medication cannister should be rinsed out and stored in a plastic bag after use. During an interview on 02/13/2026 at 4:36 PM, the Director of Nursing Services (DNS) stated oxygen tubing should be stored in a bag when not in use, and if it fell on the floor, it should be thrown away and a new one obtained. She stated that per the facility policy, nebulizer equipment should be washed with soap and water, air-dried, and stored in a bag. During an interview on 02/13/2026 at 4:36 PM, the Executive Director stated staff should follow the facility policy related to respiratory equipment. 3. Review of facility document Resident Face Sheet indicated the facility admitted Resident #30 on 01/30/2026 with diagnoses including obstructive sleep apnea. Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date of 02/02/2026, indicated the facility assessed Resident #30 with a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #30 received non-invasive mechanical ventilator respiratory treatments while a resident. Review of Resident 30's Care Plan, included a problem statement initiated 02/03/2026, that indicated the resident had the potential for shortness of breath (SOB) while lying flat related to obstructive sleep apnea (OSA). Interventions (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directed staff to administer oxygen per the physician's order and as needed (started 02/03/2026). Resident 30's Care Plan, included a problem statement initiated 02/03/2026, that indicated the resident required the use of home continuous positive airway pressure (CPAP) due to OSA. Interventions directed staff to provide CPAP treatments per the physician's orders (started 02/03/2026). An observation on 02/09/2026 at 3:36 PM of Resident #30's room revealed a CPAP mask on the top of a side table, not stored in a receptacle bag. An observation on 02/10/2026 at 10:43 AM of Resident #30's room revealed the CPAP mask on the top of the side table, not stored in a receptacle bag. During an interview on 02/11/2026 at 12:58 PM, Licensed Practical Nurse (LPN) #10 stated that Resident 30's CPAP mask should be stored in a respiratory bag when not in use. During an interview on 02/11/2026 at 1:21 PM, the acting Director of Nursing Services (DNS) stated licensed nurses were responsible for CPAP device care, including storing masks in clean plastic bags. During a concurrent observation and interview on 02/11/2026 at 1:40 PM, the DNS confirmed that upon entering Resident #30's room, the CPAP mask was observed on the top of the resident's side table, not stored in a plastic bag.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review and interviews the facility failed to ensure medication error rates were less than five percent (5%). Observations during medication administration revealed three medication errors during administration of 27 medication events resulting in a medication error rate of 11.11%. The findings include:Review of facility policy, Medication Administration - General Guidelines, revised 01/2018, indicated the Procedures included, 4) Five Rights - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. The policy continued, a. Check #1: Select the Medication - label, container and contents are checked for integrity and compared against the medication administration record (MAR) by reviewing the 5 Rights. b. Check #2: Prepare the dose - the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. c. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights when putting the medication away. The policy also indicated, D. Documentation included, 6. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, (e.g. [exempli gratia, for example], the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), it is documented on MAR or in the EHR [electronic health record]. An explanatory note is also entered. 1. Review of facility document, Resident Face Sheet, indicated the facility admitted Resident #59 on 12/02/2021. According to the Resident Face Sheet, the resident had diagnoses including irritable bowel syndrome and constipation. Review of the facility quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/2025, revealed the facility assessed Resident #59 with a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Review of Resident #59's physician Order History for the timeframe from 01/01/2026 to 02/14/2026, included an active order, dated 12/15/2025, for polyethylene glycol (a laxative) 17 grams mixed in 8 ounces of liquid orally once a day. During a medication administration observation on 02/11/2026 at 8:11 AM, Certified Resident Medication Assistant (CRMA) #3 prepared and administered medication to Resident #59. However, CRMA #3 omitted administering the polyethylene glycol to the resident. During an interview on 02/11/2026 at 2:34 PM, CRMA #3 stated that he did not give Resident #59 their polyethylene glycol because the resident had diarrhea. He stated that he should have documented why it was not given. 2. Review of Basaglar [a type of insulin] KwikPen Instruction for Use specified, Prime before each injection. Priming means removing the air from the Needle and Cartridge that may collect during normal use. It is important to prime your Pen before each injection so that it will work correctly. If you do not prime before each injection, you may get too much or too little insulin. The instructions continued, Step 6, To prime your Pen, turn the Dose Knob to select 2 units. The instructions continued, Step 7, Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. The instructions revealed, Step 8, Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and ?0' is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat the priming steps, but not more than 4 times. If you still do not see insulin, change the needle and repeat the priming steps. Review of a Resident Face Sheet indicated the facility admitted Resident #39 on 12/28/2018. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of diabetes mellitus and constipation. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/25/2025, revealed the facility assessed Resident #39 with a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Review of Resident #39's physician Order History, for the timeframe from 01/01/2026 through (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/14/2026, included an active order, dated 12/17/2025, for Basaglar KwikPen insulin 100 units/milliliter (ml) 40 units subcutaneous once a day. The Order History also included an active order, dated 11/24/2025, for polyethylene glycol (a laxative) 17 grams by mouth twice a day. During a medication administration observation on 02/11/2026 at 8:39 AM, Licensed Practical Nurse (LPN) #2 prepared and administered medication to Resident #39. LPN #39 omitted administering the polyethylene glycol to the resident and failed to prime the Basaglar KwikPen insulin pen needle prior to turning the dose knob to 40 units. During an interview on 02/11/2026 at 12:20 PM, LPN #2 stated that she forgot to give the polyethylene glycol to Resident #39. She stated she was nervous, but she should have double and triple checked the orders to ensure she administered everything that was ordered to be given at that time. LPN #2 stated she had never been educated to prime an insulin pen needle. During an interview on 02/13/2026 at 3:44 PM, the Infection Control Nurse (ICN) stated that when administering medications, staff should follow the five rights. She stated they should move the medication cart in front of the room to verify the room number and the resident with a picture, then they should double check the medication with the MAR to ensure the right medication, right dose, right time, and right route for the right resident. He stated they should check the orders against the pharmacy packet. He stated they had to have a reason if a medication was not given, and it must be documented. He stated that insulin pen needles should be primed with two units. During an interview on 02/13/2026 at 4:36 PM, the acting Director of Nursing Services (DNS) stated staff should follow the five rights of medication administration, the right resident, medication, dose, route, and time. The DNS stated that insulin pen needles should be primed with two units or until the insulin was seen coming out of the needle. During an interview on 02/13/2026 at 4:36 PM, the Executive Director (ED) stated the staff