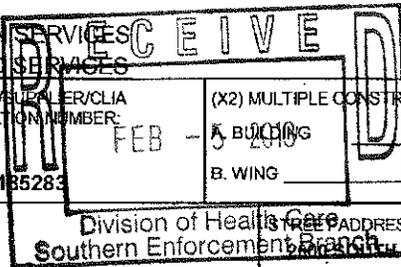


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/17/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME	ADDRESS, CITY, STATE, ZIP CODE Division of Health Care Southern Enforcement Branch MAIN STREET PARIS, KY 40361
--	--

(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 standard health survey was conducted on 01/15-17/13. Deficient practice was identified with the highest scope and severity at 'D' level.	F 000	1. Resident's #10 and #13 were care planned to address the residents positive PPD status and to observe for signs and symptoms. Review of the record noted no signs and symptoms present.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to develop a comprehensive plan of care for two of fifteen sampled residents (Residents #10 and #13). Residents #10 and #13 were identified by the facility to have a history of past positive tuberculin skin testing; however, the facility failed to develop	F 279	2. There are 8 residents in the facility with positive PPD's. Any new admits with positive PPD's will follow the new guidelines and policy which is to appropriately care plan for observations of signs and symptoms of active TB. 3. The TB policy was updated (see attachment) to reflect the addition of care planning for signs and symptoms of active TB. The new policy was distributed to all nursing staff on 2-8-13 by the department clerk to ensure everyone was aware of the update. Education of all nursing staff will be conducted by the Director of Nursing regarding the new policy and on F tag 279 and overview of all care planning on 2-15-13. A list of signs and symptoms was added to the care plan that included: fever, weight loss, chronic fatigue, heavy sweating especially at night, cough with thick, yellow or bloody sputum's, chest pain, shortness of breath and reddish, cloudy urine. The Quality Assurance and care plan team met to discuss all aspects of F279 to identify other areas on the comprehensive care plan that could affect the residents physical, mental, and psychosocial well being. Nail care and shaving were added	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Cynthia B. Ferguson* TITLE: *Administrator* (X5) DATE: *2-5-13*

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.

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/17/2013
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
(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 279	<p>Continued From page 1</p> <p>a plan of care to ensure these residents were monitored for signs/symptoms of active tuberculin disease.</p> <p>The findings include:</p> <p>A review of the facility's Care Management policy (no date) revealed an individualized plan of care would be developed for each resident by the Interdisciplinary Team (IDT). Per the policy, the IDT would use five steps of the nursing process to complete the resident's plan of care. These five steps were noted to be assessment, diagnoses, goal setting, implementation, and evaluation. The policy further noted the plan of care would be developed and implemented within seven days of admission to the facility and would be continually updated to reflect current resident needs at all times.</p> <p>Review of the "TB Control Plan" policy (no date) revealed a risk assessment would be completed annually for residents with a past positive PPD history. The policy noted a reassessment would be conducted more frequently if there was a documented increase in employee or resident PPD skin test conversion for any time less than one year.</p> <p>1. A review of the Medical Record for Resident #10 revealed the facility admitted the resident on 01/04/08 with diagnoses including Chronic Kidney Disease and a Positive Purified Protein Derivative (PPD) test (a test used to identify exposure to Tuberculosis).</p> <p>A review of the plan of care developed for Resident #10 with a revision date of 12/27/12,</p>	F 279	<p>to the Nursing Assistant care plan. (see attachment).</p> <p>4. All new hires will be trained on the use of the comprehensive care plan as a directive for monitoring of many diagnoses in the well being of the resident. Quality assurance team will review the comprehensive care plans quarterly during chart audits for completeness and updates. Quality Assurance department monitors all positive TB reactors in the facility to ensure that the Physician has reviewed each resident annually.</p> <p>5.</p>	2-28-13	

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/17/2013
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
(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 279	Continued From page 2 revealed no evidence of a plan of care to address the resident's positive PPD status. Interview conducted with the Minimum Data Set (MDS) Nurse, Licensed Practical Nurse (LPN) #1, revealed a care plan had not been developed because the MDS Nurse was not aware a care plan was required when a resident was PPD positive. 2. Review of the medical record revealed the facility admitted Resident #13 on 08/21/09 with diagnoses including Cerebral Vascular Accident, Hyperlipidemia, Hypertension, Osteoarthritis, and Parkinson's Disease. Further record review revealed the resident's chart was flagged "Positive PPD." However, a review of the comprehensive care plan for Resident #13 revealed there was no evidence the facility developed a plan of care to address the resident's history of positive tuberculin skin testing (PPD) to include monitoring for the development of signs/symptoms of active tuberculosis. Interview conducted with the MDS/Care Plan (CP) Coordinator on 01/17/13, at 1:40 PM, revealed she had not developed a care plan to address the resident's positive PPD history with interventions to include monitoring the resident for the development of signs/symptoms of active pulmonary disease. The MDS/CP nurse stated she had never been directed to complete a care plan to address a resident's history of positive PPD.	F 279			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/17/2013
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
(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 282	<p>Continued From page 3</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure services were provided in accordance with the plan of care for two of fifteen sampled residents (Residents #2 and #8). Resident #2's care plan directed staff to assist the resident with personal hygiene tasks as needed due to the resident's impaired functional ability to complete activities of daily living (ADLs). However, Resident #2 was observed to have a dark brown substance underneath the resident's fingernails on two consecutive days of the survey conducted on 01/15-17/13. Resident #8's plan of care directed staff to report behavior changes if a resident became agitated or resistive to care. There was no evidence the behavior was reported to the nurse or physician as directed by the plan of care.</p> <p>The findings include:</p> <p>A review of the facility's Care Management policy (no date) revealed an individualized plan of care would be developed for each resident by the Interdisciplinary Team (IDT). Per the policy, the IDT would use five steps of the nursing process to complete the resident's plan of care. These</p>	F 282	<ol style="list-style-type: none"> Nails were cleaned and cut for residents #2 & #8 by nursing assistants on the unit on 1-17-13. The comprehensive care plan and nursing assistant care plan were updated for Resident #8 to list interventions with nail care while difficult behaviors are present. All residents have the potential to be affected by the Activities of Daily Living not being care planned. However, all comprehensive care plans and Nursing Assistant care plans were reviewed by the Care plan coordinator and her assistant for ADL interventions where needed by 2-28-13. All comprehensive care plans were updated to reflect resident ADL concerns by the care plan coordinator and her assistant. The nursing assistant care plan was revised to include a specific nail care section to address resident needs. The comprehensive care plan and nursing assistant care plan were updated for Resident #8 to list interventions with nail care while difficult behaviors are present. The nail care policy was updated (see attachment) and staff educated by the Director of Nursing on 1-23-13. Education and training on all Activities of daily living and F tag 282 and F tag 312 will be conducted on February 15, 2013, by the Director of Nursing. 		

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/17/2013
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
(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 282	<p>Continued From page 4</p> <p>five steps were noted to be assessment, diagnosis, goal setting, implementation, and evaluation.</p> <p>Review of the facility Nail Care policy (no date) revealed nail care would be provided to all residents to enhance the resident's general appearance and to prevent infections, injury, and odors.</p> <p>Interview conducted with the Director of Nurses (DON) on 01/17/13, at 11:30 AM, revealed the facility did not have a written policy/procedure to ensure care plan interventions were implemented. The DON stated resident care needs were monitored through quality assurance and utilization of multi-disciplinary staff assigned to monitor areas of resident concern.</p> <p>1. Review of the medical record revealed the facility admitted Resident #2 on 02/13/09 with diagnoses including Hypertension, Hiatal Hernia, Atrial Fibrillation, Parkinson's Disease, Osteoarthritis, Chronic Obstructive Pulmonary Disease, and Osteopenia.</p> <p>Review of the annual comprehensive assessment dated 10/31/12, revealed the facility assessed Resident #2 to require limited assistance of one staff person for personal hygiene and extensive assistance of two for bathing needs. The resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 10.</p> <p>Review of the comprehensive care plan dated 11/06/12, revealed the facility identified Resident #2 to have impairment with ADL functioning due to diagnoses of Parkinson's Disease, Anxiety,</p>	F 282	<p>4. An in-service will be held on 2-15-13 for all nursing staff to educate on the use of the comprehensive care plan and the Nursing Assistant Care plan as an effective tool for direction for resident ADL's. The quality Assurance Team will review the comprehensive care plan and Nursing Assistant care plan quarterly during chart audits for completeness and updates. Also, the Quality assurance department will monitor nail care and nursing assistant care plans on weekly walk through's conducted by the Quality Assurance Team.</p> <p>5.</p>	2-28-13	

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/17/2013
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
(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 282	<p>Continued From page 5</p> <p>Hypertension, Atrial Fibrillation, and a history of Total Right Knee Replacement. The care plan interventions included to shower the resident weekly, to assist the resident with setup of grooming articles, and to provide assistance with personal hygiene tasks as needed.</p> <p>Resident #2 was observed on 01/15/13, at 11:30 AM to be sitting in a personal recliner in the resident's room. The resident was observed to have long fingernails with a dark brown substance underneath the resident's nails. The resident was observed on 01/15/13, at 4:15 PM, to be sitting in a wheelchair in the resident's room. The resident's fingernails continued to have a dark brown substance under the nails. The resident stated he/she preferred to have long fingernails but would like to have "that stuff" cleaned from underneath his/her fingernails. Observation of Resident #2 during the evening meal on 01/15/13, at 5:25 PM revealed the resident picked up the hash brown potatoes with his/her fingers and placed them into the resident's mouth. The dark brown substance was still noted to be under the resident's fingernails. Further observation conducted on 01/16/13, at 9:05 AM revealed the facility State Registered Nurse Aide (SRNA) provided Resident #2 with a bed bath. During the bed bath, the SRNA told the resident she would "try to soak your fingernails today." Additional observations conducted on 01/16/13 at 10:15 AM, at 12:45 PM, and at 2:25 PM, revealed the resident continued to have the dark brown substance underneath his/her fingernails.</p> <p>Interview with the Unit Coordinator (UC) on 01/17/13, at 10:00 AM, revealed the UC was responsible to monitor the nursing staff to ensure</p>	F 282			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/17/2013
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
(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 282	<p>Continued From page 6</p> <p>resident care needs were provided according to the plan of care. The UC stated she observed residents when she conducted her assigned tasks and when doing the weekly skin assessments for the residents. The UC stated staff was responsible to clean the residents' nails whenever soiling was observed.</p> <p>An interview conducted with the DON on 01/7/13, at 2:00 PM, revealed the nurses were responsible to monitor resident care needs to ensure care plan interventions were provided. The DON stated the nurses should be monitoring the resident's nails when performing weekly skin assessments.</p> <p>2. Record review for Resident #8 revealed the facility admitted the resident on 02/22/12 with diagnoses of Alzheimer's Dementia, Delusional Disorder, and Anxiety. A review of the Comprehensive Minimum Data Set (MDS) assessment for Resident #8, with an assessment reference date of 05/07/12, revealed Resident #8 was assessed to have physical behavior directed toward others and rejected care. A review of the plan of care developed for Resident #8 revealed interventions for staff to report behavior and mood changes. Additional review of the plan of care revealed the resident's fingernails were required to be trimmed as needed.</p> <p>Observation of a skin assessment conducted for Resident #8 on 01/16/13 at 3:50 PM revealed the resident's fingernails and toenails were long and had not been recently trimmed.</p> <p>An interview conducted with RN#1, who conducted the skin assessment, on 01/16/13 at</p>	F 282			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/17/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
--	--

(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 282	<p>Continued From page 7</p> <p>3:50 PM, revealed the resident's nails were long and should have been trimmed when the resident received a shower during the 11:00 PM to 7:00 AM shift on 01/11/13.</p> <p>An interview conducted with State Registered Nurse Aide (SRNA) #1 on 01/16/13 at 5:00 PM, revealed SRNA #1 had attempted to trim the resident's nails during a shower conducted on 01/11/13; however, the resident was resistive and the SRNA could not trim the resident's nails. According to SRNA #1, she reported to the next shift that nail care had not been done for Resident #8.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #2 on 01/17/13 at 11:00 AM, revealed LPN #2 was assigned to Resident #8 for the 11:00 PM to 7:00 AM shift on 01/11/13. According to LPN #2, she was not aware of any behaviors exhibited by Resident #8 during a bath conducted on 01/11/13 and was not aware the resident had refused nail care. According to LPN #2, if the resident had refused nail care, SRNA #1 should have reported the behavior to LPN #2 so the information could have been documented on the shift report and reported to the oncoming shift on 01/12/13 to trim the resident's nails.</p> <p>A review of the 24-hour shift reports for 01/11-12/13 revealed no evidence Resident #8 refused nail care. In addition, a review of care comments documented by SRNA #1 for the 11:00 PM to 7:00 AM shift on 01/11-12/13 revealed Resident #8 "slept good and AM care was given."</p> <p>An interview conducted with The Director of Nursing (DON) on 01/17/13 at 2:10 PM, revealed</p>	F 282		
-------	---	-------	--	--

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/17/2013
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
(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 282	Continued From page 8 resident nail care was completed weekly during bathing and nurses were required to monitor SRNAs to ensure care was provided. According to the DON, if care could not be completed or a resident refused, it was required to be documented in the record and reported to the next shift.	F 282			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure two of fifteen sampled residents (Residents #2 and #8) who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and personal hygiene. The facility failed to provide nail care for Residents #2 and #8. Resident #2 was observed to have a dark brown substance underneath the resident's fingernails on two consecutive days of the survey conducted on 01/15-17/13. Resident #8 was observed to have long fingernails and toenails during a skin assessment conducted on 01/16/13. The findings include: Review of the facility Nail Care policy (no date) revealed nail care would be provided to all	F 312			

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/17/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
--	--

(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 312	<p>Continued From page 9</p> <p>residents to enhance the resident's general appearance and to prevent infections, injury, and odors. The policy further noted nail care was the responsibility of all nursing staff and would be provided during bathing and/or as needed.</p> <p>An interview conducted with the DON on 01/17/13, at 2:00 PM, revealed the nurses were responsible to monitor resident care needs to ensure care plan interventions were provided. The DON further stated residents' nails should be cleaned when staff observed the resident's nails to be soiled as well as during bathing weekly. According to the DON if care could not be completed or a resident refused it was required to be documented in the record and reported to the next shift.</p> <p>1. Resident #2 was observed during the initial facility tour conducted on 01/15/13, at 11:30 AM to be sitting in a personal recliner in the resident's room. The resident was observed to have long fingernails with a dark brown substance underneath the resident's nails. The resident was observed on 01/15/13, at 4:15 PM, to be sitting in a wheelchair in the resident's room and the dark brown substance was noted to be present under the resident's fingernails. The resident stated he/she preferred to have long fingernails but would like to have "that stuff" cleaned from underneath his/her fingernails. The resident stated he/she used to be able to clean his/her own nails, but was no longer able to keep them clean. Further observation conducted during the evening meal on 01/15/13, at 5:25 PM, revealed Resident #2 was eating dinner in the activity dining room. The resident was observed to feed him/herself and to pick up hash brown potatoes</p>	F 312	<ol style="list-style-type: none"> The Nails of residents #2 and #8 were cleaned and cut by nursing assistants on the unit on 1-17-13. All residents in the facility received nail care by a clinical staff member during a complete sweep of the facility on 1-16 and 1-17-13. Nails were cut and cleaned. The nail care policy (<i>see attachment</i>) was updated and given to all nursing staff on 2-8-13 and again on 2-15-13 during the in-service. Education of all nursing staff will be conducted by the Director of Nursing to educate on all Activities of daily living including nail care. All aspects of F tag 282 and F tag 312 will be discussed with all nursing staff on 2-15-13. Nail clippers were purchased for every resident and put in their rooms on 1-23-13 to be used during showers and as needed. The Nursing assistant care plan was revised to include nail care and shaving guidance. <i>See attachment.</i> 	
-------	--	-------	---	--

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/17/2013
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
(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 312	<p>Continued From page 10</p> <p>with his/her fingers with the dark brown substance still present under the resident's fingernails. Additional observation revealed Resident #2 was given a bed bath by a facility State Registered Nurse Aide (SRNA #4) on 01/16/13, at 9:05 AM. The SRNA told the resident, "I will try to soak your fingernails today," during the bath. However, further observations conducted on 01/16/13 at 10:15 AM, at 12:45 PM, and at 2:25 PM, revealed the resident continued to have the dark brown substance underneath his/her fingernails.</p> <p>Review of the medical record revealed the facility admitted Resident #2 on 02/13/09 with diagnoses including Hypertension, Hiatal Hernia, Atrial Fibrillation, Parkinson's Disease, Osteoarthritis, Chronic Obstructive Pulmonary Disease, and Osteopenia.</p> <p>Review of the annual comprehensive assessment dated 10/31/12, revealed the facility assessed Resident #2 to require limited assistance of one staff person for personal hygiene and extensive assistance of two for bathing needs. The resident was assessed to have a BIMS score of 10. The comprehensive care plan dated 11/06/12, revealed the facility identified Resident #2 to have impairment with ADL functioning with interventions to include to shower the resident weekly, to assist the resident with setup of grooming articles, and to provide assistance with personal hygiene tasks as needed.</p> <p>An interview conducted with SRNA # 2 on 01/15/13, at 4:25 PM, revealed the resident required assistance with personal hygiene, nail care, hair care, and oral care. SRNA #2 stated</p>	F 312	<p>4. Weekly ADL observations will be conducted by the Quality Assurance team of a selected number of residents per unit and will be monitored by the QA director, Infection Control nurse, Director of Nursing and the Administrator. Tracking and trending will be presented to the medical director each quarter at the Quality Assurance meetings. On-the-spot education will be done for any staff found to be non-compliant with ADL's for residents. Quarterly chart audits of the Comprehensive care plans and the Nursing assistant care plans will be done by the Quality assurance department.</p> <p>5.</p>	2-28-13	

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/17/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
--	--

(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 312	<p>Continued From page 11</p> <p>she was responsible to check the residents' fingernails daily, to trim the residents' nails when needed, and to clean the nails whenever they were noted to be soiled.</p> <p>Interview with SRNA #3 on 01/15/13, at 6:00 PM, revealed the SRNA was responsible to provide resident nail care when needed. The SRNA stated nail care was usually provided during the resident's bath; however, staff was responsible to clean the resident's nails whenever soiling was observed.</p> <p>Interview with SRNA #4 conducted on 01/16/13, at 2:30 PM, revealed she had completed the bed bath for Resident #2 on 01/16/13. SRNA #4 stated nail care was routinely provided during the resident's shower/bed bath. SRNA #4 stated she observed Resident #2's fingernails to be soiled during the bed bath, but she had not had time to get back to the resident. SRNA #4 stated she did not clean the resident's fingernails during the bath because another resident was requesting to use the bathroom.</p> <p>Interview with the Unit Coordinator (UC) on 01/17/13, at 10:00 AM, revealed the UC was responsible to monitor the nursing staff to ensure resident care needs were provided according to the plan of care. The UC stated she monitored the residents' care when she conducted her assigned tasks and when doing the weekly skin assessments for the residents. The UC stated residents' nails should be cleaned when staff observed the resident's nails/hands to be soiled.</p> <p>An interview conducted with the DON on 01/07/13, at 2:00 PM, revealed the nurses were</p>	F 312		
-------	---	-------	--	--

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/17/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
--	--

(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 312	<p>Continued From page 12</p> <p>responsible to monitor resident care needs to ensure care plan interventions were provided. The DON further stated residents' nails should be cleaned when staff observed the resident's nails to be soiled as well as during bathing weekly. According to the DON if care could not be completed or a resident refused it was required to be documented in the record and reported to the next shift.</p> <p>2. Observation conducted for Resident #8 during a skin assessment on 01/16/13 at 3:50 PM revealed the resident's fingernails and toenails were long.</p> <p>An interview conducted with RN #1, who conducted the skin assessment, on 01/16/13 at 3:50 PM, revealed the resident's nails were long and should have been trimmed when the resident received a shower on the 11:00 PM to 7:00 AM shift on 01/11/13.</p> <p>An interview conducted with State Registered Nurse Aide (SRNA) #1 on 01/16/13 at 5:00 PM, revealed SRNA #1 had attempted to trim the resident's nails during a shower conducted on 01/11/13; however, the resident would not allow the SRNA to trim the resident's nails. According to SRNA #1, she reported to the next shift that the nail care had not been done.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #2 revealed LPN #2 was assigned to Resident #8 for the 11:00 PM to 7:00 AM shift on 01/11/13. According to LPN #2, she was not aware of any behaviors exhibited by Resident #8. According to LPN #2, if the resident had refused nail care, SRNA #1 should have reported the</p>	F 312		
-------	--	-------	--	--

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/17/2013
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
(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 312	Continued From page 13 behavior to LPN #2 so the information could have been documented on the shift report and reported to the oncoming shift on 01/12/13 to trim the resident's nails. A review of the 24-hour shift reports for 01/11-12/13 revealed no evidence Resident #8 refused nail care. In addition, a review of care comments documented by SRNA #1 for the 11:00 PM to 7:00 AM shift on 01/11-12/13 revealed Resident #8 "slept good and AM care was given."	F 312			

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

PRINTED: 05/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 1965</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type III (000) Unprotected</p> <p>Smoke Compartments: Ten</p> <p>Fire Alarm: Complete Fire alarm System</p> <p>Sprinkler System: Complete Sprinkler System (Wet and Dry)</p> <p>Generator: Type II Diesel</p> <p>A standard Life Safety Code survey was conducted on 01/16/13. The findings that follow demonstrate compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Bourbon Heights Nursing Home was found to be in compliance with the requirements for participation in the Medicare and Medicaid program.</p>	K 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.

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

PRINTED: 04/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 1965</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type III (000) Unprotected</p> <p>Smoke Compartments: Ten</p> <p>Fire Alarm: Complete Fire alarm System</p> <p>Sprinkler System: Complete Sprinkler System (Wet and Dry)</p> <p>Generator: Type II Diesel</p> <p>A standard Life Safety Code survey was conducted on 01/16/13. The findings that follow demonstrate compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Bourbon Heights Nursing Home was found to be in compliance with the requirements for participation in the Medicare and Medicaid program.</p>	K 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.