

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

PRINTED: 01/14/2016  
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  R 01/14/2016
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NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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(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
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{F 000} INITIAL COMMENTS

{F 000}

An offsite revisit was conducted, and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance on 12/18/15 as alleged.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/14/2015

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

*Approved for 12/14/15*  
PRINTED: 11/12/2015  
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NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361	
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F 000 INITIAL COMMENTS

A Recertification Survey was initiated on 10/27/15 and concluded on 10/29/15, with deficiencies cited at the highest Scope and Severity of a "D".

F 278 483.20(g) - (j) ASSESSMENT  
SS=D ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced

F 000

This plan of correction constitutes our written plan of correction for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal law and does not constitute acceptance or agreement with any claim or statement herein.

F 278

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Charles Roberts*

Administrative

(X6) DATE  
12/14/15

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by:  
Based on observation, interview, record review and review of the "Resident Assessment Instrument User Manual Version 3.0" it was determined the facility failed to ensure the Minimum Data Set (MDS) Assessment accurately reflected the residents functional status for three (3) of fifteen (15) sampled residents (Residents #3, #10, and #12).

Review of Resident #3's Quarterly MDS Assessment dated 07/08/15, and Quarterly MDS Assessment dated 09/23/15, revealed the facility coded both MDS's as the resident requiring extensive assist of two (2) persons for eating; however, the resident was independent with feeding himself/herself.

Review of Resident #12's Annual MDS Assessment dated 09/22/15, revealed the facility coded the MDS as the resident requiring limited assist of one (1) person for eating; however, the resident was independent with feeding himself/herself.

Review of Resident #10's MDS Assessment dated 07/29/15, revealed the facility coded the MDS as the resident requiring extensive assistance of one (1) person for eating; however, the resident was NPO (nothing by mouth) and received all nutrition through the Gastric Tube requiring total assistance of staff. In addition, Resident #10's Quarterly MDS Assessment dated 10/21/15, revealed the facility coded the resident as requiring extensive assistance of two (2) persons for toileting; however, the resident was totally dependent on staff for toileting.

The findings include:

F 278 It is the policy of Bourbon Heights, Inc. to ensure the assessment accurately reflects the resident's status and that a registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. It is also the policy of Bourbon Heights, Inc. to have the registered nurse to sign and certify that the assessment is completed and that each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. No individual will willfully or knowingly certify a material or false statement in a resident assessment or cause another individual to willfully and knowingly certify a material false statement in a resident assessment.

1. Staff involved in the incorrect coding of the ADLs on the resident assessments identified were in-serviced by Tamara McCarty, LPN, MDS Assistant to educate on the correct coding on 10/29/15.
2. Tamara McCarty, LPN, MDS Assistant and Rebecca Highfield, LPN, MDS Assistant reviewed the RAI manual on 10/29/15 to ensure understanding of the correct way to document and code the assessments to accurately reflect the resident's status. Janet Caswell, RN, MDS Coordinator reviewed the RAI manual on 10/30/15.
3. All residents have the potential to be affected by the deficient practice.

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Review of the "Resident Assessment Instrument User Manual Version 3.0", Section G110, "Coding Instructions", revealed in order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance was received and clarifying the types of assistance provided such as verbal cueing and physical support

1. Review of Resident #3's clinical record revealed the facility admitted Resident #3 on 10/15/14 with diagnoses which included Diabetes, Anxiety, Anemia, Congested Heart failure, and Depression. Review of Resident #3's Quarterly MDS Assessment dated 07/08/15, and Annual MDS Assessment dated 09/23/15, revealed in section (G) Functional Status, the facility coded the MDS's as the resident requiring extensive assistance of two (2) persons for eating.

Review of Resident #3's Comprehensive Plan of Care, dated 10/07/15, revealed a problem of Resident #3 requiring extensive assistance with all Activities of Daily Living (ADL's) except eating after tray set up. The goal stated the resident would be maintained in a clean, well-groomed manner with assist of staff through next review. The interventions included; set up tray only-feeds self and prefers to eat in room.

Observation of Resident #3 on 10/27/15 at 12:30 PM, and 5:35 PM revealed the resident was eating his/her meal per self after tray set up with no difficulty. Further observation of Resident #3 on 10/28/15 at 8:10 AM revealed the resident was eating breakfast per self after tray set up with no difficulty observed. Observation on 10/28/15 at

- F 278
4. Posterboards with correct ADL coding information located in the breakroom on each unit were reviewed by Tamara McCarty, LPN, MDS Assistant for accuracy on 10/29/15 and are used as daily reminders for correct coding for all staff.
  5. Mandatory in-services will be completed every 3 months for 1 year for all nursing employees and continued annually on correct ADL coding. The first in-service was given on 12/3/15 by Tamara McCarty, LPN, MDS Assistant and Rebecca Highfield, LPN, MDS Assistant. Any employees unable to attend the in-service will be in-serviced either individually or in small groups by Tamara McCarty, LPN, MDS Assistant or Rebecca Highfield, LPN, MDS Assistant before 12/18/15.
  6. The in-service information on correct ADL coding will be added to the new employee orientation effective with the scheduled orientation of 12/11/15. Bourbon Heights, Inc. uses no agency staffing.
  7. When gathering information for assessment completion, the MDS staff will provide individual education to employees if discrepancies are identified effective 10/30/15.
  8. MDS Staff are documenting any discrepancies found from the ADL coding to the actual resident status in the resident record to ensure compliance with the RAI Manual effective 10/30/15.

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8:40 AM revealed the resident consumed seventy-five percent (75%) of the meal and drank two hundred and forty (240) milliliters of fluid. During this observation the resident stated no one had to assist him/her with eating during his/her stay at the facility.

2. Review of Resident #12's clinical record revealed the facility admitted Resident #12 on 10/03/14, with diagnoses which include Diabetes, Congested Heart failure, Lupus, and Alzheimer's Disease. Review of Resident #12's Annual MDS Assessment dated 09/22/15, revealed in section (G) Functional Status, the facility coded the MDS as the resident requiring limited assist of one (1) person for eating.

Review of Resident #12's Comprehensive Plan of Care, dated 09/23/15, revealed a problem of Resident #12 requiring extensive assistance with all ADL's except with eating after tray set up. The goal stated the resident would be maintained in a clean, well groomed manner with staff assist. The interventions included; set up tray only- feeds self and prefers to eat in room.

Observation of Resident #12, on 10/29/15 at 12:00 PM, revealed the resident was eating lunch per self without difficulty. When asked about assistance needed for eating, the resident stated, "I always feed myself, no one has ever had to help me or feed me".

Interview with State Registered Nurse Aide (SRNA) #2, on 10/28/15 at 10:00 AM, revealed she was assigned to care for Residents #3 and #12 at times and both were independent with dining after their trays were set up. She revealed, she didn't remember ever having to assist either

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9. The Director of Nursing will review at least one (1) assessment each month for accuracy to monitor the performance of the MDS staff and to ensure the solutions are sustained.
  10. If discrepancies are noted during the monitoring process, corrections will be made immediately by the MDS staff and they will be educated on the corrective process by the Director of Nursing.
  11. Results of the monitoring process will be submitted to the Quality Assurance (QA) Director as it is identified and the QA Director will present the information to the QA committee during the quarterly meetings.
  12. The QA Committee will consist of Charlotte Roberts, Administrator, Deanna Eads, Director of Nursing, Julie Dale, Business Office Manager, Dwana Tolbert-Dye, Social Services Director, Teresa Earlywine, Quality Assurance Director, Barbara Traylor, Housekeeping Director, Kim Mullins, Dining Services Director, Janet Caswell, MDS Coordinator, Lauren Biddle, Activities Director, Anthony Collier, Maintenance Director, and Dr. Nathan Moore, Medical Director. This committee meets at least quarterly.
  13. Compliance Date

12/18/15

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Resident #3 or Resident #12 to eat.

Interview with SRNA #3, on 10/28/15 at 10:30 AM, revealed she was often assigned to Resident #3 and Resident #12 and knew the residents very well. She stated, they required no staff assistance to eat their meals.

Interview with Registered Nurse (RN) #2, on 10/28/15 at 11:30 AM, revealed she was often assigned to Resident #3 and Resident #12 and they fed themselves at meal times and had not required staff assistance to eat.

Interview with Licensed Practical Nurse (LPN) #2 on 10/28/15 at 1:00 PM revealed she was the Unit Manager for Resident #3 and Resident #12's unit. She stated no concerns had been identified with Resident #3 or Resident #12 feeding themselves, and these residents had not required staff assistance to eat.

Interview with MDS Nurse #1, on 10/29/15 at 2:50 PM revealed she would review Resident #3 and #12's coding and documentation. Further interview with MDS Nurse #1, on 10/29/15 at 4:50 PM, revealed Resident #3 and #12's care plans were correct, both residents were independent with eating, and the MDS's were coded incorrectly. "I just missed it"

3. Review of Resident #10's clinical record revealed the facility admitted him/her on 02/26/10 with diagnoses which included Traumatic Brain Injury (TBI), Cauda Equina Syndrome (extreme pressure and swelling of the nerves at the end of the spinal cord resulting in paralysis of extremities), Spastic Quadriplegia due to a Motor Vehicle Accident, and Gastrostomy Tube

F 278 Bourbon Heights is an excellent nursing facility with a committed staff and dedicated board of directors. The facility remains committed to providing a delivery of high quality health care and will continue to make whatever changes and improvements necessary to satisfy that objective. Please do not consider the filing of this Plan of Correction to be an admission of the finding of deficient practice.

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(G-Tube) ( tube inserted through the abdomen that delivers nutrition directly to the stomach).

Review of the Annual MDS Assessment, dated 07/29/15, revealed the facility assessed Resident #10 as having a BIMS score of a three (3) indicating severe cognitive impairment. Further review of the MDS Assessment, Section (G), Functional Status, revealed the facility coded the MDS as the resident requiring extensive assist of one (1) staff member for eating.

Review of the Care Area Trigger worksheet (CAT) dated 07/29/15, revealed Resident #10 was to receive nothing by mouth and received one hundred percent (100%) nutrition through the feeding tube which was not a change for the resident.

Review of the October 2015 Monthly Physician's orders with an original order date of 01/15/15, revealed orders for nothing by mouth (NPO), and bolus feedings of Fibersource (tube feeding formula), 250 milliliters per G-tube, everyday at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM.

Continued Interview with MDS Nurse #1, on 10/29/15 at 2:50 PM, revealed Resident #10's Annual MDS dated 07/29/15 should have been coded to reflect Resident #10's total dependence on staff for eating as the resident received all nutrition per tube feeding.

4. Further review of Resident #10's clinical record, revealed a Care Area Trigger Worksheet (CAT), dated 07/29/15 which stated Resident #10 was totally dependent on staff for all areas of Activities of Daily Living (ADL's) including toileting.

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F 278 - Continued From page 6

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Review of Resident #10's Comprehensive Plan of Care, dated 08/05/15, revealed a problem of requiring assistance with ADL's and was incontinent of bowel and bladder. The goal stated the resident's appearance would be maintained in a clean, well - groomed manner, with all ADL's performed by staff. The interventions included checking and changing briefs every two (2) hours and providing pericare with the assistance of two (2).

Review of Resident #10's Quarterly MDS Assessment, dated 10/21/15, revealed the facility assessed Resident #10 as having a BIMS Score of three (3) indicating severe cognitive impairment. Further review of the MDS, Section (G), Functional Status, revealed the facility coded the MDS as the resident requiring extensive assistance of two (2) staff members to assist him/her with the toileting process.

Additional interview with MDS Nurse #1 on 10/29/15 at 2:50 PM revealed Resident #10's Quarterly MDS Assessment, dated 10/21/15 should have been coded as the resident requiring total dependence of staff for toileting in order to accurately reflect the resident's inability to assist with toileting related to diagnoses. MDS Nurse #1 stated, the MDS Assessment information was gathered from the resident, staff, medical record, and electronic record. She further stated the MDS Nurses reviewed the coding on the ADL Tracker (SRNA documentation of resident ADL's) for functional status when gathering MDS Assessment information; however, had coded functional status incorrectly for Resident #3, #10 and #12.

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 185283	(Y2) Multiple Construction A. Building 01 - MAIN BUILDING 01 B. Wing	(Y3) Date of Revisit 1/5/2016
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Name of Facility BOURBON HEIGHTS NURSING HOME	Street Address, City, State, Zip Code 2000 SOUTH MAIN STREET PARIS, KY 40361
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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. # NFPA 101 LSC K0025	Correction Completed 01/05/2016	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 10/30/2015	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	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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: <i>[Signature]</i>	Date: 1/5/2016
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/28/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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{K 000}	INITIAL COMMENTS  An offsite revisit was conducted, and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance on 01/05/16 as alleged.	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE 01/07/2016
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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  Building: 01  Plan Approval: 1965  Survey under: NFPA 101 (2000 Edition)  Facility type: SNF/NF  Type of structure: Type III (000) Unprotected  Smoke Compartments: Ten (10)  Fire Alarm: Complete Fire Alarm System  Sprinkler System: Complete Sprinkler System (Wet and Dry)  Generator: Type II Diesel  A Life Safety Code Survey was conducted on 10/28/15. The facility was found to not be in compliance with the requirements for participation in the Medicare and Medicaid Program. The census the day of the survey was sixty seven (67) with the facility being licensed for sixty seven (67) beds.  The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (life Safety from Fire) with the highest Scope and Severity at a "F" level.	K 000	This plan of correction constitutes our written plan of correction for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal law and does not constitute acceptance or agreement with any claim or statement herein.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Charles Roberts* -TITLE *Administrator* DATE *11/7/16*

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

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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  10/28/2015
NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361	
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K 025 Continued From page 1  
least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by:  
Based on observation and interview, the facility failed to maintain fire/smoke barriers with a half (1/2) hour fire resistance rating as required by National Fire Protection Agency (NFPA) standards. This deficient practice affected five (5) of ten (10) smoke compartments, staff and approximately forty (40) residents. The facility had the capacity for sixty-seven (67) beds with a census of sixty-seven (67) the day of survey.

The findings include:

During the Life Safety Code survey on 10/28/15, at 2:30 PM, with the Director of Maintenance (DOM), the fire/smoke barrier wall above the ceiling in the Unit 1 Break room was observed not to continue vertically to the floor level above as required. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility in a fire situation. Interview with the DOM on 10/28/15, at 2:30 PM revealed he was not aware the fire/smoke barrier wall did not extend to the second floor level as required. During the survey

K 025 It is the policy of Bourbon Heights to ensure the safety of all residents by complying to Life Safety Code Regulations and following the State Fire Marshall recommendations as they relate to our facility.

1. The deficiency identified has the potential to affect residents in the Unit 1 smoke compartment and residents in the Personal Care/Unit 3 smoke compartment.
2. Upon notification that there was an issue identified, signs were added to the smoke doors in question outside of the unit 1 breakroom and outside of Room 228 to state "This is not a smoke door".
3. An in-service was completed on 10/28/15 and distributed or given by Charlotte Roberts, Administrator for all staff to educate on the evacuation protocols due to the identified doors and the smoke compartments affected.
4. As of 12/12/15, 124 out of 155 staff have been educated on the smoke doors with signs stating "This is not a smoke door". Remaining staff are PRN or out on leave and will be educated prior to returning to work. Bourbon Heights utilizes no agency staff.

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NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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K 025 Continued From page 2  
a fire/smoke barrier wall located in room 228 was also observed not to extend to the roof deck above as required.

On 10/28/15 at 2:45 PM two (2) office doors located in a fire/smoke barrier wall near the front lobby were observed not to have door closing devices as required. Interview with the DOM, on 10/28/15 at 2:45 PM, revealed he was not aware the office doors were part of a smoke barrier wall and would require door closing devices.

The findings were revealed to the Administrator on exit.

Reference: NFPA 101 2000 edition

19.3.7.3  
Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.

8.3.2\* Continuity.  
Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.

Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.

K 025 5. Closures were added to the (2) two office doors located in a fire/smoke barrier wall near the front lobby.

6. Education will be added to the new employee orientation packet and all employees will be trained yearly during the annual fire in-service.

7. Contractor S.W. Reynolds Corporation will move existing fire doors from outside the breakroom to an existing fire wall section outside of Room 131, where the wall is continuous from the first floor to the second floor per proposal signed and accepted January 4, 2016 (see attached). Work to be completed by 1/15/16 or prior.

8. Compliance Date

1/05/2016

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K 025 Continued From page 3

K 025

8.3.4.2\*

Where a fire resistance rating for smoke barriers is specified elsewhere in the Code, openings shall be protected as follows:

(1) Door opening protectives shall have a fire protection rating of not less than twenty (20) minutes where tested in accordance with NFPA 252, Standard Methods of Fire Tests of Door Assemblies, without the hose stream test, unless otherwise specified by Chapters 12 through 42.

(2) Fire windows shall comply with 8.2.3.2.2.

Exception: Latching hardware shall not be required on doors in smoke barriers where so indicated by Chapters 12 through 42.

8.3.4.3\*

Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1.

7.2.1.8.1\*

A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.

7.2.1.8.2

In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met:

(1) Upon release of the hold-open mechanism, the door becomes self-closing.

(2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed.

(3) The automatic releasing mechanism or

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K 025 Continued From page 4  
medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®.  
(4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing.  
(5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.

K 050 SS=F NFPA 101 LIFE SAFETY CODE STANDARD  
Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:  
Based on interview and record review, the facility failed to conduct fire drills to ensure that staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness. This failure affected all residents and staff in the facility.  
The facility had the capacity for sixty-seven (67) beds with a census of sixty-seven (67) the day of survey.

K 025

K 050 It is the policy of Bourbon Heights, Inc. to hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9pm and 6am a coded announcement may be used instead of audible alarms.

1. All maintenance personnel were inserviced by Anthony Collier, Maintenance Director regarding the need to hold fire drills at unexpected times on 10/28/15.
2. All residents have the potential to be affected by the deficient practice.
3. Anthony Collier, Maintenance Director will be responsible for planning the fire drills completed within the facility and will ensure that fire drills are completed at unexpected times with varying conditions, including differing times on alternate shifts.

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K 050 Continued From page 5  
The findings include:

During the Life Safety Code survey on 10/28/15 at 12:20 PM, with the Director of Maintenance (DOM), a record review revealed the facility had not been performing fire drills at unexpected times and varying conditions on the second shift as follows: Three (3) fire drills on the second shift from 07/30/15 to 10/26/15, were conducted between 3:35 PM to 4:15 PM. An interview with the DOM revealed he was unaware the fire drills should be conducted at unexpected times and conditions and would lengthen the times between fire drills.

The findings were revealed to the Administrator on exit.

K 050

4. Anthony Collier, Maintenance Director will ensure these are completed at least quarterly.
5. Completed fire drills are maintained by the Quality Assurance Department, who will ensure that fire drills are completed at least quarterly at unexpected times under varying conditions.
6. The Quality Assurance Director and Maintenance Director will report on the fire drills and the times and dates of the fire drills during the quarterly QA Committee meeting, which consists of the Administrator, Medical Director, Director of Nursing, Quality Assurance Director, Business Office Manager, Maintenance Director, Housekeeping Director, Activity Director and Social Services Director.
7. Compliance Date 10/30/15

Bourbon Heights is an excellent nursing facility with a committed staff and dedicated board of directors. The facility remains committed to providing a delivery of high quality health care and will continue to make whatever changes and improvements necessary to satisfy that objective. Please do not consider the filing of this Plan of Correction to be an admission of the finding of deficient practice.