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

PRINTED: 01/03/2021 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVI COMPLETED	(X3) DATE SURVEY COMPLETED	
		185283	B. WING_	<u> </u>	12/22/201	12/22/2020	
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 PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AI DEFICIENCY)		ION SHOULD BE COMPL THE APPROPRIATE DA	X5) PLETION ATE	
F 000	INITIAL COMME	NTS	F 00	00			
	was initiated on 1 12/22/2020. The compliance with 4 regulations and had Medicare & Medic Centers for Disea	used Infection Control Survey 2/21/2020 and concluded on facility was found to be in 42 CFR 483.80 infection control as implemented the Centers for caid Services (CMS) and se Control and Prevention aded practices to prepare for census 86.	3				
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			4				
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BORATORY	DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE	F	

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		185283	B. WING		12	12/22/2020	
NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME				STREET ADDRESS, CITY, STATE, Z 2000 SOUTH MAIN STREET PARIS, KY 40361	IP CODE	12/22/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION FE DATE	
E 000	Initial Comments		E 00	00			
	Survey was initiate concluded on 12/2	used Emergency Preparedness ed on 12/21/2020 and 22/2020. The facility was found be with 42 CFR 483.73 related					
			2				
17			3				
LABORATORY	DIRECTOR'S OR PROV	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE	

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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING 100024 12/22/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET **BOURBON HEIGHTS NURSING HOME PARIS, KY 40361** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A COVID-19 Focused Infection Control Survey was initiated on 12/21/2020 and concluded on 12/22/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80. Total census 86.

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

TITLE

(X6) DATE