

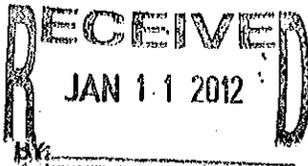
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/05/2012  
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  12/16/2011
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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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<p>F 000</p> <p>F 441 SS=D</p>	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was initiated on 12/12/11 and concluded on 12/16/11. Deficiencies were cited with the highest scope and severity of a "D".</p> <p>483.85 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p>	<p>F 000</p> <p>F 441</p>	<p>The Infection Control Program is currently under revision. Revisions will include: assessment of risks; assessment of services provided; assessment of population served; strategies to decrease risks; and a surveillance plan (logs) based on analysis of previous data. All of these revisions will guide the activities of the infection control department. The Infection Control plan will be updated at least annually by the Administrator, Director of Nursing and Quality Assurance Director if needs arise.</p> <div style="text-align: center;">  </div>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>[Signature]</i>	Administrator	1-10-12

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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F 441	<p>Continued From page 1</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility failed to ensure staff washed their hands after a skin assessment. In addition the facility failed to ensure infection control practices were followed for a dressing change for Resident #4.</p> <p>The findings include:</p> <p>Observation of a skin assessment, on 12/14/11 at 1:30 PM, revealed the Wound Care Nurse failed to wash his hands after completing the skin assessment. Further observation revealed, after completion of the skin assessment he did remove his gloves before exiting the room.</p> <p>Interview with the Wound Care Nurse, on 12/14/11 at 1:40 PM, revealed he should have removed his gloves and washed his hands before exiting the room. Further interview revealed he normally had an alcohol base sanitizing solution in his pocket but did not on this particular day.</p> <p>Observation of a skin assessment, on 12/14/11,</p>	F 441	<p>The Infection Control Nurse did the proper treatment and dressing change on resident #4 immediately in the afternoon of 12-14-11.</p> <p>The Director of Nursing educated the Infection Control nurse on the proper protocol of wound care that included gloving, hand washing, and proper dressing change. The D.O.N. observed I/C nurse while he performed wound care on 2 residents. He did well.</p> <p>The Director of Nursing and Unit Coordinators checked all wounds for proper dressing change techniques and to ensure timeliness of dressing change. All wounds were checked for proper infection control protocol, as well.</p> <p>The Infection Control Program is currently under revision. Revisions will include: assessment of risks; assessment of services provided; assessment of population served; strategies to decrease risks; and a surveillance plan (logs) based on analysis of previous data. All of these revisions will guide the activities of the infection control department. The Infection Control plan will be updated at least annually by the Administrator, Director of Nursing and Quality Assurance Director if needs arise.</p>	

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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  12/16/2011
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 441	<p>Continued From page 2</p> <p>at 3:30 PM, revealed the Wound Care Nurse failed to change a dressing on Resident # 4 after the completion of the skin assessment. The Wound Care Nurse pulled back the old dressing (dated 12/13/11) to measure the wound and then replaced the old dressing back onto the wound bed. No new dressing was placed on the wound.</p> <p>Review of Resident # 4 's Treatment Administration Record (TAR) for December 2011, revealed the dressing for his/her wound was to be completed daily. Further review of the TAR indicated the dressing had been changed on 12/13/11.</p> <p>Interview with the Wound Care Nurse and Director of Nursing, on 12/15/11 at 10:00 AM, revealed the Wound Care Nurse did not change the dressing on the wound and replaced the old one when he was finished with the skin assessment. Further interview revealed the dressing should have been removed when the skin assessment was completed and a new dressing applied to the wound.</p>	F 441	<p>Director of Nursing will observe the Infection Control nurse monthly for proper protocol regarding wound care, hand washing, and gloving. This will be conducted for three months during a probationary period of the employee.</p> <p>An in-service was conducted on January 6, 2012 addressing all infection control issues for all staff. Topics included specifically hand washing, gloving and un-gloving, dressing change protocol, and LINEN handling (to prevent the spread of infection).</p>	Jan. 20, 2012	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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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  12/15/2011
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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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 1985</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 Compartment: Ten (10)</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 12/15/11. Bourbon Heights was found to be in compliance with the requirements for participation in Medicare and Medicaid.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angela R. [Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1-10-12</i>
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