

PRINTED: 09/13/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2011
NAME OF PROVIDER OR SUPPLIER BOURON 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 000	INITIAL COMMENTS An Abbreviated Survey Investigating ARO #KY00017042 was initiated on 08/24/11 and concluded on 8/29/11. The allegation was substantiated with deficiencies cited. The highest scope and severity was a "D".	F 000	This plan of correction constitutes our written allegation of compliance 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 280 SS-D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the Comprehensive Plan of Care was revised for one (1) of three (3) sampled residents (Resident #1). Resident #1 sustained a bruise to the left breast during a whirlpool bath; however, there was no documented evidence the Plan of Care was revised to include interventions to prevent reoccurrence.	F 280	F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP This plan of correction constitutes our written allegation of compliance 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. It is the policy of Bourbon Heights Nursing Home ("Bourbon Heights") to ensure that residents and their families participate in the planning care and treatment or changes in their care and treatment and to develop interventions after incidents to prevent further reoccurrences. Policies were reviewed and updated on 9/23/11 regarding comprehensive care plans and interventions after incidents. Facility policy requires that a comprehensive care plan will be developed within 7 days after the completion of the comprehensive assessment. This is prepared by an interdisciplinary team that includes the attending physician, and a

RECEIVED
SEP 28 2011

Angela Burge, Administrator

1
9-26-11

PRINTED: 09/13/2011

FORM APPROVED

OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2011	
NAME OF PROVIDER OR SUPPLIER BOURON 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	

	<p>The findings include:</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident with diagnoses which included Osteopenia, Osteoporosis, Degenerative Osteoarthritis, and Dizziness. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 06/03/10 revealed the facility assessed the resident as having no cognitive impairment, and as requiring no assistance with transfers.</p> <p>Review of the Comprehensive Plan of Care dated 12/31/09 revealed the resident was at risk for falls/injury due to an unsteady gait, and a diagnoses of Chronic Vertigo, Panic attacks, and Anxiety. The approaches included assessing for safety alternatives.</p> <p>Review of the Nursing Assistant Care Plan dated 07/10 revealed the resident required the assistance of one (1) for baths.</p> <p>Review of the facility Variance Report dated 07/11/10 revealed Resident #1 showed Licensed Practice Nurse (LPN) #1 her/his left breast and there was purple bruising noted. Further review revealed the resident complained she/he had received a whirlpool on Friday (07/09/10) by Certified Nursing Assistant (CNA) #6, and CNA #8 had turned the whirlpool chair around too close to the whirlpool tub pole which caused the pole to strike the resident's breast. The Report stated there was limited range of motion (ROM) to the resident's shoulder and no swelling or deformities were noted. Further review revealed the section which stated; additional comments and/or steps to prevent recurrence was not completed.</p> <p>Review of the Physician's Progress Notes dated 07/16/10 revealed the X-Ray (completed 07/12/10 of the right shoulder) showed remote rib fractures, and a Grade 2 AC separation with no fractures. Further review revealed the Note stated the resident had a hematoma to the left breast secondary to trauma from the whirlpool. However,</p>		<p>registered nurse with responsibility for the resident among others. The DON will monitor compliance with this policy by reviewing sample charts on a weekly basis. After an incident occurs, interventions will be prepared on an individual basis by the Director of Nursing/Designee, Quality Assurance Director, MDS/Care Plan Coordinator and the Unit Coordinator, which will trigger the review of a patient's comprehensive plan for necessary updates.</p> <p>In addition, on 9/26/11 an in-service was conducted regarding the updated policy for care plans for clinical staff.</p> <p>As to Resident #1:</p> <p>Resident #1's bruise is healed. Because Resident #1 required the assistance of only one nursing assistant at the time of the event, training one-on-one of the nursing assistant involved occurred on 7/13/10. Training included review of the proper techniques for transfer as well as a review of the scenario and the available proper alternatives related to the care of Resident #1. The comprehensive care plan was updated on 1/13/11 to reflect assistance of two aides for transfers of Resident #1.</p> <p>All nursing assistant care plans and comprehensive care plans will be reviewed by 9/30/11 to determine if the plans were consistent for required staff specifically for one and two person assist.</p> <p>Our facility changed to a three-part physician order sheet on March 15, 2011 that includes: change of condition, care plan updates, and</p>	
--	---	--	--	--

PRINTED: 09/13/2011

FORM APPROVED

OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 168283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/28/2011
NAME OF PROVIDER OR SUPPLIER BOURON 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

<p>the Physician did not think the shoulder injury was secondary to the whirlpool accident and was unsure of the etiology.</p> <p>Further review of the Comprehensive Plan of Care dated 12/31/09 revealed there was no documented evidence of the whirlpool injury and no new approaches to prevent further injury while the resident was in the whirlpool bath.</p> <p>Interview on 08/25/11 at 4:00 PM with the DON and the Administrator revealed they remembered investigating what happened with the whirlpool chair and had spoken to CNA #6 about the incident. They stated CNA #6 explained the resident slipped while strapped in the chair and CNA #6 left the room to get help instead of using the call bell. Further interview revealed CNA was disciplined for leaving the resident alone instead of using the call bell for help.</p> <p>Interview on 08/28/11 at 12:40 PM with LPN #2 revealed she was the Unit Coordinator and she and the Director of Nursing (DON) had come to the whirlpool room after the incident and noted the whirlpool chair was in close proximity to the pole which held the chair when the chair was swiveled to the side. She stated the resident's breast could have hit the pole during transfer of the chair into or out of the tub if the chair swiveled next to the pole. Further interview revealed in 07/10 any nurse could have updated the Plan of Care as needed. She stated residents only needed one assist with bathing unless they had the tendency to slide.</p> <p>Continued interview on 08/29/11 at 1:45 PM and 2:45 PM with the Administrator revealed the facility did not implement any interventions after the incident to prevent further reoccurrence such as having two (2) aides to assist with a whirlpool bath. She further stated an investigation was done only to the extent of finding out what happened from the interview with CNA #6.</p> <p>Further interview on 08/29/11 at 3:00 PM with the DON, revealed she had gone to the whirlpool</p>	<p>physicians orders. This change has enabled Unit Coordinators, the Quality Assurance Department, the Director of Nursing, and the MDS Coordinator to have appropriate and timely information about the changes and updates to all aspects of patient care. The procedure was reviewed to assure that the proper physician order sheets were being used on 9/30/11.</p> <p>As of 3/15/11 every new order is received and reviewed daily by the Director of Nursing/Designee, Quality Assurance Director, MDS/Care Plan Coordinator and the Unit Coordinator. Care Plans are updated with each new order by the nurse daily and quarterly by the MDS Coordinator/Care Plan Coordinator as needed. The Administrator interviewed staff to assure that the process is being followed on 9/30/11.</p> <p>All other Residents: A comprehensive care plan will be developed within 7 days after the completion of the comprehensive assessment. This will be prepared by an interdisciplinary team that includes the attending physician, and a registered nurse with responsibility for the resident among others. The DON will monitor compliance with this policy by reviewing sample charts on a weekly basis. After an incident occurs, interventions will be prepared on an individual basis by the Director of Nursing/Designee, Quality Assurance Director, MDS/Care Plan Coordinator and the Unit Coordinator, which will trigger the review of a patient's comprehensive plan for necessary updates.</p> <p>Substantial compliance will be achieved 9/30/11.</p>
---	--

PRINTED: 09/13/2011

FORM APPROVED

OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/28/2011	
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	

	room with CNA #8 and asked her to demonstrate the process of transferring a resident into and out of the tub with the whirlpool chair. She stated she did not see anything wrong with the process. Continued interview revealed she did not remember if interventions were placed to prevent further occurrence. After reviewing the record, she stated she could find no evidence of any interventions to prevent reoccurrences except for the disciplinary action with CNA #8 related to leaving the resident alone in the whirlpool room.			
F282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</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:</p> <p>Based on interview and record review it was determined the facility failed to ensure care was provided in accordance with the resident's written Comprehensive Plan of Care for one (1) of three (3) sampled residents (Resident #2). The facility failed to implement the Comprehensive Plan of Care related to transfer technique for Resident #2 resulting in a fall.</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #2 to the facility with diagnoses which included a History of a Cerebral Vascular</p>	F 282	<p>F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>This plan of correction constitutes our written allegation of compliance 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.</p> <p>It is the policy of Bourbon Heights to ensure residents are provided services in accordance with each resident's written care plan.</p> <p>Resident #2's Nursing Care Plan already reflected a two-person assist. The comprehensive care plan was updated to reflect two-person assist</p>	

PRINTED: 09/13/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/28/2011	
NAME OF PROVIDER OR SUPPLIER BOURON 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

Accident (CVA) and Parkinson's Disease.
Review of the Quarterly MDS Assessment dated 04/12/11 revealed the facility assessed the resident as having no impairment with cognitive skills for decision making. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) persons for transfers and as ambulating not occurring.

Review of the Comprehensive Plan of Care dated 01/18/11 revealed the resident was at risk for injury related to falls secondary to diagnoses of CVA with Hemiplegia and Parkinson's Disease. The approaches included; using a gait belt with the assist of one (1) to two (2) when assisting with transfers and ambulation.

Review of the Nursing Assistant Care Plan dated 05/11 revealed an intervention for the assistance of two (2) and a gait belt to transfer.

Review of the Resident Fall Variance Notes revealed the resident fell on 05/04/11 at 7:15 PM. Further review revealed, upon transfer the CNA did not have a gait belt on and the resident became weak and had to be eased to the floor. The approaches included an inservice regarding gait belt use and two (2) assist.

Interview on 08/29/11 at 3:00 PM with CNA #5 revealed she transferred the resident on 05/04/11 due to the residents request to go to the bathroom. She stated she checked the Nurse Aide Care Plan at the beginning of the shift and was aware the resident required a two (2) person transfer; however, it was very hectic on the unit, and the resident stated her/his legs were feeling good. She further stated she did not think to get a gait belt prior to transfer and the resident started to go down during the transfer and was eased to the floor.

Interview on 8/29/11 at 2:30 PM with LPN #3 who was assigned to the resident at the time of the fall on 08/29/11, revealed she did rounds during the shift to ensure care was provided which

on 9-15-11. An in-service was conducted on 8-24-11 for all aides regarding nursing basics that included transfer techniques and gait belt use.

All nursing assistant care plans and comprehensive care plans will be reviewed by 9/30/11 to assure that the plans were consistent for the number of staff required for assists, for gait belt use, Plans were also checked to assure they were consistent in regards to one and two person assist. Gait belts are required to be used.

All Employees are checked for gait belt possession and usage on weekly walk through of the facility by Quality Assurance Committee staff. "Check offs" of all nursing assistants were conducted on August 22nd, 2011 and August 23rd, 2011 as to proper transfer technique and care lift usage. Nursing Assistant Care plans will be reviewed and updated by the care plan team during quarterly care plan meetings along with the Comprehensive Care Plan. Nursing Assistant Care plans will be updated daily as changes occur by the Unit Nurse.

To ensure continued compliance, the Nursing Assistant Care Plan will be reviewed by the unit coordinator nurse monthly for accuracy and consistency with the Comprehensive Care Plan.

As to Resident #2, when her legs became weak, resident was lowered to floor. Staff was re-educated regarding use of gait belts on 8/29/11 and consistency with the Comprehensive Care Plan.

PRINTED: 09/13/2011

FORM APPROVED

OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2011	
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	

	<p>included observing for transfer technique. She stated it was a busy night when CNA #5 incorrectly transferred Resident #2; however, the aide should have used the appropriate technique as per the Nurse Aide Care Plan.</p>		<p>All other Residents:</p> <p>Bourbon Heights will ensure residents are provided services in accordance with each resident's written care plan. The Nursing Assistant Care Plan will be reviewed by the unit coordinator nurse monthly for accuracy and consistency with the Comprehensive Care Plan.</p> <p>Substantial compliance will be achieved 9/30/11.</p>	
--	---	--	---	--

PRINTED: 09/13/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2011
NAME OF PROVIDER OR SUPPLIER BOURON 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 323	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F323	<p>F323 FREE OF ACCIDENT/HAZARDS/SUPERVISION/ DEVICES</p> <p>This plan of correction constitutes our written allegation of compliance 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.</p>	
	<p>Based on interview and record review it was determined the facility failed to ensure each resident received adequate supervision to prevent accidents for two (2) of three (3) sampled residents (Resident #1 and #2).</p> <p>Resident #1 sustained a bruise to the left breast during a whirlpool bath. There was no documented evidence of a thorough investigation to identify the causative factor for the injury, in order to implement interventions to prevent further injuries.</p> <p>Resident #2 sustained a fall related to improper transfer technique.</p> <p>The findings include:</p> <p>Review of the Accident/Incident Investigation Policy dated 03/04 revealed a Variance Report was to be completed on all accidents or incidents where there was an injury or the potential to result in injury to include bruises. Further review revealed an investigation was to be conducted to ensure that the resident's safety was not jeopardized. Continued review revealed the licensed nurse's were to initiate and complete Variance Reports and the Director of Nursing (DON) was to review each case and bring to the daily Quality Assurance (QA) committee meetings</p>		<p>It is the policy of Bourbon Heights to ensure that all residents remain as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Resident #1's bruise is healed. The Staff member received one on one education on proper use of whirlpool and chair.</p> <p>On 7/13/11 staff were educated on proper transfer technique for Resident #1 on day of event.</p> <p>All Nursing Assistant Care Plans and Comprehensive Care Plans were reviewed on 9/30/11 for accuracy and consistency regarding interventions and changes to the Resident's current status.</p> <p>In service training was conducted by Quality Assurance Director and her assistant for all direct care staff. All staff were evaluated using a check-off skill tool on August 22nd, 2011 and August 23rd, 2011.</p>	

PRINTED: 09/13/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/28/2011	
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2900 SOUTH MAIN STREET PARIS, KY 40381		
(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

	<p>to assess and identify any trends and establish methods to prevent future occurrences.</p> <p>1. Record review revealed the facility admitted Resident #1, on 10/02/09, with diagnoses which included Osteopenia, Osteoporosis, Degenerative Osteoarthritis, Dizziness, and Arteriosclerotic Heart Disease (ASHD). Review of the Quarterly Minimum Data Set (MDS) Assessment dated 05/03/10 revealed the facility assessed the resident as having no impairment in cognitive skills for decision making, and as requiring no assistance with transfers.</p> <p>Review of the Comprehensive Plan of Care dated 12/31/09 revealed the resident was at risk for falls/injury due to unsteady gait, and diagnoses of Chronic Vertigo, Panic attacks, and Anxiety. The interventions included assessing for safety alternatives.</p> <p>Review of the Nursing Assistant Care Plan dated 07/10 revealed the resident was to have the assistance of one (1) for baths.</p> <p>Review of the facility Variance Report dated 07/11/10 revealed Resident #1 showed Licensed Practical Nurse (LPN) #1 her/his left breast and purple bruising was noted. The Report stated the resident complained she/he had received a whirlpool on Friday 07/09/10 by Certified Nursing Assistant (CNA) #6, and CNA #6 had turned the whirlpool chair around too close to the whirlpool tub pole causing the pole to strike the resident's breast. Further review revealed there was limited range of motion (ROM) to the shoulder and no swelling or deformities were noted. Continued review revealed the section which stated; additional comments and/or steps to prevent recurrence was not completed.</p> <p>Review of the Nurse's Note dated 7/11/10 at 9:30 AM revealed the resident's left breast was bruised purple with surrounding green, and the resident complained of right shoulder pain.</p> <p>Review of the X-Ray Report dated 07/12/10</p>		<p>The Comprehensive Care Plans and the Nursing Assistant Care Plans were updated on 8/30/11 to reflect increased assist upon resident decline.</p> <p>To ensure continued compliance, variance reports will be completed and investigated on all injuries and bruising per facility policy.</p> <p>Our facility changed to a three-part physician order sheet on March 15, 2011 that includes: change of condition, care plan updates, and physicians orders. This change has enabled unit coordinators, the quality assurance department, Director of Nursing, and the MDS Coordinator to have appropriate and timely information about the knowledge of changes and updates to all aspects of patient care.</p> <p>All nurses were educated on completing variance reports and given guidelines to follow in an in-service training on 8-18-11.</p> <p>All variance reports will be formally investigated as to the causative factors by QA director, Director of Nursing/designee, and Administrator. Appropriate interventions will be put into place on 8/30/11.</p> <p>All other Residents:</p> <p>Variance reports will be completed and investigated on all injuries and bruising per facility policy.</p> <p>Our facility changed to a three-part physician order sheet on March 15, 2011 that includes: change of condition, care plan updates, and physicians orders. This change has</p>	
--	---	--	---	--

PRINTED: 09/13/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2011
NAME OF PROVIDER OR SUPPLIER BOURON 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

	<p>revealed; Impressions: Grade two (2) Acromio Claviocular (AC) separation with Degenerative Joint Disease changes and Multiple Right Rib fractures which were age indeterminate.</p> <p>Review of the Physician's Progress Notes dated 07/16/10 revealed the X-Ray showed remote rib fractures, and a Grade 2 AC separation with no fractures. Further review revealed the Note stated the resident had a hematoma to the left breast secondary to trauma from the whirlpool. Continued review revealed the Physician stated he did not think the shoulder injury was secondary to the whirlpool accident and was unsure of the etiology.</p> <p>Further review of the Plan of Care, dated 12/31/09, revealed there was no documented evidence of the whirlpool injury and no new interventions to prevent further injury while the resident was in the whirlpool bath.</p> <p>Review of a Disciplinary Warning Notice for CNA #6 revealed CNA #6 left the resident in the whirlpool room unattended which could have led to a serious accident. Further review revealed the CNA was suspended for three days and would be placed back in orientation for a week.</p> <p>Interview was attempted with CNA #6 who no longer worked at the facility; however, was unsuccessful.</p> <p>Interview, on 08/25/11 at 4:00 PM, with the Director of Nursing (DON) and the Administrator revealed they remembered investigating what happened with the whirlpool chair and had spoken to CNA #6 who no longer worked there. They stated the CNA explained the resident slipped while strapped in the chair. Further interview revealed CNA #6 left the room to get help when the resident started to slide instead of using the call bell. Continued interview revealed CNA #6 was disciplined for leaving the resident alone instead of using the call bell for help.</p> <p>Interview, on 08/28/11 at 2:30 PM, with LPN #1</p>		<p>enabled unit coordinators, the quality assurance department, Director of Nursing, and the MDS Coordinator to have appropriate and timely information about the knowledge of changes and updates to all aspects of patient care.</p> <p>Substantial compliance will be achieved 9/30/11.</p>	
--	--	--	--	--

PRINTED: 09/13/2011
 FORM APPROVED
 OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER: 166283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2011
NAME OF PROVIDER OR SUPPLIER BOURON 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

who was assigned to Resident #1, revealed staff was to stay with residents while they were in the whirlpool bath, and one person could assist the residents once they were transferred to the whirlpool chair with the strap around the waist. She stated she was unaware of how Resident #1 became injured during the whirlpool bath.

Interview, on 08/29/11 at 12:40 PM, with LPN #2 revealed she was the Unit Coordinator and had come to the whirlpool room with the Director of Nursing (DON) after the incident and noted the whirlpool chair was in close proximity to the pole which held the chair when the chair was swiveled to the side. She stated the resident's breast could have possibly hit the pole during transfer of the chair into or out of the tub if the chair swiveled next to the pole. Continued interview revealed in 07/10 any nurse could have updated the Plan of Care as needed.

Further interview, on 08/29/11 at 1:45 PM and 2:45 PM, with the Administrator revealed the facility did not do anything different after the incident to prevent further reoccurrence such as having two (2) aides to assist with a whirlpool bath. She stated an investigation was done only to the extent of finding out what happened from the interview with CNA #6. Further interview revealed she had no documented evidence of a statement or interview from CNA #6 and no documented evidence administration had interviewed the resident related to the incident.

Further interview, on 08/29/11 at 3:00 PM, with the DON revealed she had gone to the whirlpool room with CNA #6 and asked her to demonstrate the process of transferring a resident into and out of the tub with the whirlpool chair. She stated she did not see anything wrong with the process except for leaving the resident alone in the whirlpool room. Continued interview revealed she did not remember if interventions were placed to prevent further occurrence. After reviewing the record, she stated she could find no evidence of any interventions to prevent reoccurrence except for the disciplinary action with CNA #6.

PRINTED: 09/13/2011
 FORM APPROVED
 OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2011	
NAME OF PROVIDER OR SUPPLIER BOURON 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

	<p>2. Record review revealed the facility admitted Resident #2 to the facility with diagnoses which included a History of a Cerebral Vascular Accident (CVA) and Parkinson's Disease. Review of the Quarterly MDS Assessment dated 04/12/11 revealed the facility assessed the resident as having no impairment with cognitive skills for decision making. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) persons for transfers and as being non-ambulatory.</p> <p>Review of the Comprehensive Plan of Care, dated 01/18/11, revealed the resident was at risk for injury related to falls. The interventions included one (1) to two (2) persons and a gait belt when assisting with transfers and ambulation.</p> <p>Review of the Nursing Assistant Care Plan dated 05/11 revealed the resident required the assistance of two (2) and a gait belt to transfer.</p> <p>Review of the Nurse's Notes dated 05/04/11 at 7:15 PM revealed, upon transfer from the recliner to the bed, the CNA assisted the resident to the floor due to weakness with no injury noted.</p> <p>Review of the Resident Fall Variance Notes revealed the resident sustained a fall on 05/04/11 at 7:15 PM. The description of the incident (cause of the fall) revealed, upon transfer the CNA did not have a gait belt on and the resident became weak and had to be eased to the floor. The interventions included an inservice regarding gait belt use and two (2) assist.</p> <p>Interview, on 08/28/11 at 3:00 PM, with CNA #5 revealed she had transferred the resident on 5/04/11 when the resident was needing to go to the bathroom. She stated she checked the Nurse Aide Care Plan at the beginning of the shift for a reference and was aware the resident required a two (2) person transfer; however, it was very hectic on the unit, and the resident stated her/his legs were feeling good. She stated she did not think to get a gait belt prior to transfer and the</p>			
--	--	--	--	--

PRINTED: 09/13/2011
 FORM APPROVED
 OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/29/2011	
NAME OF PROVIDER OR SUPPLIER BOURON 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

	<p>resident started to go down during the transfer and was eased to the floor.</p> <p>Interview, on 08/29/11 at 2:30 PM, with LPN #3 who was assigned to the resident at the time of the fall on 08/29/11, revealed she did rounds during the shift to ensure care was provided which included observing for transfer technique as per the Nurse Aide Care Plan.</p>			
--	--	--	--	--