STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185283	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bourbon Heights Nursing Home	2000 South Main Street Paris, KY 40361

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on interview, record review, and review of the facility's policy, the facility failed to treat each resident with respect and dignity, and care for each resident in a manner and environment that promoted maintenance or enhancement of his/her quality of life, recognizing each resident's individuality for the total census of 74 residents, which included (Resident (R)3, R6, R9, R21, R41, R55, and R67).

On 08/29/2024, and 09/04/2024, the sample result for the Unit 2 shower showed legionella non-pneumophila at poorly controlled growth levels. Staff interviews revealed the facility failed to provide showers for residents starting in early September 2024, due to the showers on Unit 1, Unit 2, and Unit 3 being closed. During that timeframe residents were only offered bed baths.

Recommendations were made by the independent water systems company (IWSC) and the certified water safety and management expert (CLWSE) to bring in portable showers as a temporary measure in order for residents to have the opportunity to shower; however, the facility declined to do that.

Review of an electronic mail (e-mail) sent on 09/18/2024, from the facility's Infection Preventionist (IP) to the Director of the Local Health Department (LHD), revealed the facility inquired about reopening the showers on Units 1 and Unit 3 for resident use as those showers no longer showed detectable levels of Legionella pneumophilia bacteria. Per the email, the LHD Director noted if there was no detection of legionella in those showers, there was no reason residents could not use them. However, the showers on Units 1 and Unit 3 were not opened for resident use until October 2024. Resident interviews revealed they were not sure why they could not take showers as they had not been informed of any water concerns. The resident interviews revealed they missed taking their showers as bed baths only made them feel partially clean.

Refer to F880

The findings include:

Review of the facility's policy titled, Resident Rights, undated, revealed the resident had a right to a dignified existence with access to services inside the facility. Per review, the resident had the right to receive care in a manner and in an environment that promoted the maintenance or enhancement of his or her quality of life. Further policy review revealed the resident had the right to receive services in the facility with reasonable accommodation of resident needs and preferences.

Review of the facility's policy titled, Complete and Partial Bed Bath, undated, revealed all residents were bathed as often as necessary to maintain cleanliness, refresh, stimulate circulation, and

(continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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 11/22/2024
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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	prevent disease and infection. Continued review revealed a bed bath was to be given to residents who were unable to bathe themselves. Further review revealed a bed bath was given daily and/or as needed depending upon the condition and desires of the resident. Review of the microbiology analysis report dated 08/29/2024, performed by a third party IWSC to test for legionella, revealed the Unit 2 shower showed legionella non-pneumophila at 1.0 colony forming units per milliliter (CFUs/ml) with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Continued review of the microbiology report dated 09/04/2024, revealed the sample result from the Unit 2 shower showed legionella non-pneumophila at 1.0 CFUs/ml with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. 1. Review of R55's Face Sheet located in the resident's electronic medical record (EMR) revealed the facility admitted the resident on 12/16/2022 with diagnoses to chronic obstructive pulmonary disease (COPD), acute respiratory failure, and unspecified osteoarthritis. Review of the Annual Minimum Data Set (MDS) Assessment for R55, with an Assessment Reference Date (ARD), of 09/13/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated moderate cognitive impairment. Continued review revealed the facility also assessed R55 to require partial to moderate assistance (helper doing less than half the effort) with bed baths/showers. Review of R55's Comprehensive Care Plan (CCP), dated 08/20/2024, revealed the facility identified the resident as having an activities of daily living (ADL) self-care performance deficit. Per review, interventions included R55 needed a weekly shower and partial bed baths all other days with the assistance of one staff. Further review revealed interventions initiated on 11/14/2022, included R55 was able to specify her preference for bathing or showering. During interview with R55's Family (F)1, on 10/03/2024 at 10:32 AM, he stated there had been ongoing water contamination at the facility for at least four weeks. He stated however, he had not been notified of the water situation and only became aware of it after asking the Administrator about it directly. F1 stated showers were not available, and the Administrator told him the Local Health Department (LHD) and the Kentucky Department for Public Health (KDPH) had been discussing when the facility could resume shower usage for residents. He stated the Administrator informed him legionella bacteria had been detected in Unit 2's shower during a test. He reported the Administrator told him the issue of whether there was a risk to residents if they used the shower on the second floor was being discussed. F1 stated according to what the Administrator told him, neither the LHD nor the KDPH had provided the facility with a clear answer on whether to open the showers. He further stated he purchased water for R55, so she would have clean water to wash her hands and face and use it to brush her teeth, as the facility only provided water for drinking. During interview on 10/09/2024 at 3:43 PM, R55 stated she did not realize how mentally and physically refreshing a shower was and how much she missed getting her showers over the past month. She stated, I had my shower on Sunday, and it was wonderful. Additionally, R55 stated the bed baths had never made her feel completely clean. 2. Review of R41's Face Sheet located in the EMR, revealed the facility admitted the resident on 05/26/2023, with diagnoses to include chronic obstructive pulmonary disease, anxiety disorder, and other specified depressive episodes. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Quarterly MDS Assessment for R41, with an ARD of 09/18/2024, revealed the resident had not been assessed for mental status. Continued review revealed the facility assessed R41 to require partial to moderate assistance with bed baths/showers. Review of R41's CCP, dated 09/12/2024, revealed the facility identified R2 as having an Activities of Daily Living (ADL) self-care performance deficit and to require the assist of one staff for help with bathing/showering. Further review revealed no documented evidence of interventions in place related to the resident's preference for bathing or showering. During interview on 10/03/2024 at 1:20 PM, with R41's F2, she stated she was not aware the resident had not received showers in over a month. She stated the facility should have contacted her about the resident not getting showers. F2 further stated, It makes me upset that they did not communicate that to me. Additionally, F2 stated, it was not right that the residents were not provided showers for weeks. 3. Review of R9's Face Sheet located in the EMR revealed the facility admitted the resident on 11/19/2014, with diagnoses to include cerebral infarction, type 2 diabetes mellitus, and frequency of micturition (process of expelling urine from the bladder). Review of the Quarterly MDS Assessment for R9, with an ARD of 09/18/2024, revealed the facility assessed the resident to have a BIMS score of 11 out of 15, which indicated moderate cognitive impairment. Continued review revealed the facility also assessed R9 to require partial to moderate assistance with bed baths/showers. Review of R9's CCP, dated 08/20/2024, revealed the facility identified R9 as having ADL self-care performance deficit, and was totally dependent on one staff to provide showers weekly and bed baths all other days. Further review revealed no documented evidence of interventions in place related to the resident's preference for bathing or showering. During interview on 10/03/2024 at 12:11 PM, R9 stated it had been a while since she had received a shower. She stated, They have had trouble with the showers and the water isn't okay. R9 stated staff currently assisted her with a partial bed bath. The resident said she missed taking her showers and, You just don't get clean [with a bed bath]. Additionally, R9 stated she had been told the facility was not to blame, but the Local Health Department (LHD), was the cause of the resident's shower closure. 4. Review of R21's Face Sheet located in the EMR revealed the facility admitted the resident on 09/12/2024, with diagnoses to include sciatica, morbid obesity, and type 2 diabetes mellitus. Review of the admission MDS Assessment, with an ARD of 09/18/2024, revealed the facility assessed the resident as having a BIMS score of 12 out of 15, which indicated moderate cognitive impairment. Continued review revealed the facility additionally assessed R21 to require substantial/maximal assistance (helper doing more than half the effort) with bed baths/showers. Review of R21's CCP, dated 09/13/2024, revealed the facility identified the resident as having an ADL self-care performance deficit and required assistance of one staff for bathing/showering. Further review revealed no documented evidence of interventions in place related to the resident's preference for bathing or showering. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 10/03/2024 at 11:58 AM, R21 stated she had no idea what was wrong with the facility's water. R21 stated someone had mentioned weeks ago residents could not use the showers, and they had to start getting bed baths. She stated staff assisted her with her bed baths; however, she did not like taking bed baths. R21 stated she missed taking showers, and You just don't get clean with a bed bath. I felt like I smelled. Additionally, R21 stated she had been informed the facility was not to blame for the shower closures; rather, it was the LHD that was responsible. 5. Review of R67's Face Sheet located in the EMR revealed the facility admitted the resident on 04/28/2024, with diagnoses to include type 2 diabetes mellitus, dementia, and personal history of urinary tract infections. Review of the Quarterly MDS Assessment for R67, with an ARD of 09/11/2024, revealed the facility assessed the resident to have a BIMS score of six out of 15, which indicated severe cognitive impairment. Continued review revealed the facility also assessed R67 as independent with bed baths/showers. Review of R67's CCP, dated 08/20/2024, revealed the facility identified R67 as having an ADL self-care performance deficit and required the assistance of one staff for bathing/showering. Review further revealed no documented evidence of interventions in place related to the resident's preference for bathing or showering. During interview on 10/09/2024 at 3:21 PM, R67 stated, the facility's shower system was down and she was not sure why she could not take a shower. Additionally, R67 stated she liked her showers and bed baths only made her feel partially clean and not refreshed. 6. Review of R3's Face Sheet located in the resident's EMR, revealed the facility admitted the resident on 11/21/2022, with diagnoses to include type 2 diabetes mellitus, Alzheimer's disease, and paroxysmal atrial fibrillation. Review of the Quarterly MDS Assessment for R3, with an ARD of 08/22/2024, revealed the facility assessed the resident as having a BIMS score of eight out of 15, which indicated moderate cognitive impairment. Further review revealed the facility also assessed R3 as requiring substantial/maximal assistance with bed baths/showers. Review of R3's CCP, dated 07/15/2024, revealed the facility identified the resident as having an ADL self-care performance deficit, and as totally dependent on one staff to provide a shower at least weekly with partial bed baths all other days as necessary. Further review revealed no documented evidence of interventions in place related to the resident's preference for bathing or showering. During interview on 10/09/2024 at 3:30 PM, R3 stated he was not sure why he could not take a shower, and he had gone a long time without one. Additionally, R3 stated he missed taking showers, and said, I just feel dirty without a shower. 7. Review of R6's Face Sheet located in the resident's EMR, revealed the facility admitted the resident on 03/15/2023, with diagnoses to include cerebral palsy, Hemiplegia right side, and type 2 diabetes mellitus. Review of the Quarterly MDS Assessment with an ARD of 09/09/2024, revealed the facility assessed the resident as having a BIMS score of nine out of 15, which indicated moderate cognitive impairment. Continued review revealed the facility also assessed R6 as dependent (helper doing all of the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	effort) with bed baths/showers. Review of R6's CCP, dated 08/20/2024, revealed the facility identified the resident as having an ADL self-care performance deficit, and to require the assistance of one staff to provide a shower at least weekly with partial bed baths all other days as necessary. Continued review revealed no documented evidence of interventions in place related to the resident's preference for bathing or showering. During interview on 10/09/2024 at 3:50 PM, R6 stated she did not know what was wrong with the facility's water, but residents had been told they could not use the showers and had to receive bed baths, which she disliked. R6 stated she missed taking showers, and said, You just don't get clean with a bed bath, and I miss getting my hair washed in the shower. I felt dirty. She further stated she had been told the LHD, not the facility, was responsible for the shower closures. Review of an e-mail sent on 09/18/2024 at 7:18 AM, from the facility's Infection Preventionist (IP) to the Director of the LHD, revealed the facility was inquiring about reopening the showers in Units 1 and Unit 3 for resident use as those showers showed no detectable levels of Legionella pneumophilia bacteria. Per review of the email, the LHD Director replied to the facility's IP: if there was no detection of legionella in those showers, there was no reason the residents could not use them. During interview with Licensed Practical Nurse (LPN) 1, on 10/03/2024 at 10:15 AM, she stated there had been no showers for residents for a while. She stated staff used spring water from gallon jugs for both hydration and medication administration. She additionally stated residents and staff were allowed to use water from the faucets for ADL care, such as bed baths, handwashing, and oral care. During interview with Kentucky Medication Aide (KMA) 1, on 10/03/2024 at 11:10 AM, she stated there had been no showers available for residents since September 2024. She stated the facility supplied jugs of spring water for drinking and medication administration. KMA 1 further stated staff used water from the faucets in resident rooms to provide bed baths, washing hands, and oral care. During interview with Registered Nurse (RN) 1 (an agency nurse), on 10/03/2024 at 11:35 AM, he stated he wasn't quite sure why there had been no showers for residents in over a month. He stated he believed the facility provided water for drinking and medication administration. RN1 further stated residents could use water from the faucets in their rooms for bed baths, handwashing, and oral care. During interview, with State Registered Nurse Aide (SRNA) 1, on 10/03/2024 at 11:45 AM, she stated the facility had closed the showers on all units sometime in September 2024. She stated since then residents had not been allowed to take showers, and staff had been providing them bed baths. She further stated the residents were upset they did not get showers. During interview with SRNA5, on 10/03/2024 at 11:49 AM, she stated there had been no showers available for residents since September 2024 due to legionella being in the water. She stated the facility provided water for drinking and medication administration. SRNA5 further stated residents and staff used water from the faucets for bed baths, washing hands, and oral care. During interview with the Quality Assurance (QA) Nurse, on 10/09/2024 at 10:59 AM, she stated she was a member of the facility's water management plan (WMP) team and attended those meetings regularly. She stated the WMP team discussed the water contamination issues and shower use. The QA nurse reported Unit 2's shower was closed and had been closed for about a month to keep residents safe due to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the legionella bacteria in the water supply for that shower. She further stated however, she did not know why the Unit 1 and Unit 3 showers were not being used. The QA Nurse additionally stated the showers on Unit 1 and Unit 3 were now open, and residents residing on Unit 2 could use either shower. During interview with the Infection Preventionist (IP), on 10/03/2024 at 3:16 PM, she stated the control measures the facility was taking to protect the residents included providing bed baths instead of showers. She stated since February 2024, the facility had intermittently stopped and started using the showers due to the increased risk to residents. The IP said however, she could not explain why the facility did not utilize the showers on Unit 1 and Unit 3, as those units had no detectable bacteria. She stated recommendations the facility received from the LHD and the KDPH included closing Unit 2's shower while continuing testing and flushing. The IP reported the water was safe to drink, but out of an abundance of caution the facility provided gallon jugs of spring water to use for hydration and medication administration on all units. She said residents, and their families were frequently being updated on the results of the legionella testing, although she could not recall when the facility last notified them of the results. The IP further stated the last communication to staff on the results of legionella testing occurred through a telephone notification in June 2024. During telephone interview with an independent water systems company (IWSC) representative, on 10/11/2024 at 9:58 AM, he stated he had provided third-party water testing and treatment services for the facility. The IWSC representative stated the facility had been seeking guidance from the various health departments to make decisions for them. He stated, after the CLWSE's onsite assessment in September 2024, the facility awaited recommendations and repeatedly inquired about reopening the showers. The IWSC stated the CLWSE sent recommendations to the facility on [DATE], which stated it was the facility's responsibility to make decisions based on their own due diligence. The IWSC said he had suggested the facility bring in portable showers, but the facility opted not to do that. He stated not doing that he believed was detrimental to their situation, as it demonstrated a lack of responsibility for a temporary solution to the problem. The IWSC representative further stated, You can't have a nursing home without showers. During telephone interview with the CLWSE, on 10/04/2024 at 2:42 PM, he stated he had discussed the possibility of using temporary showers; however, the facility opted not to implement that solution. The CLWSE further stated he was unaware of any plans by the facility to manage the future use of its showers. He additionally stated there was no scientific reason not to use the showers based on the recent test results, but the facility still chose not to use the showers. During interview with the Director of Nursing (DON), on 10/08/2024 at 9:21 AM, she stated residents last received showers at the beginning of September 2024, and had since been receiving bed baths. The DON said the facility had waited for confirmation from the LHD regarding the safety of using the showers with no detectable bacteria levels. According to the DON in interview, no detectable levels of Legionella pneumophila were found in the showers on Units 1 and 3, while Legionella pneumophila was detected in the Unit 2 shower. When the State Survey Agency (SSA) Surveyor asked her why residents on Unit 2 were not taken to use the other showers, the DON stated all three shower rooms were closed out of extra precautions. She said the IP emailed the LHD in September 2024 asking if residents could use Units 1 and 3 showers. The DON reported however, the facility had yet to receive definitive instructions about using the showers from the LHD. She further stated she expected staff to follow facility policies in order to protect resident rights, as it was important for their quality of life and well-being. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview with the Administrator on 10/03/2024 at 10:50 AM, he stated the facility closed all showers in early September 2024 due to positive results for Legionella pneumophila in the water testing. He stated after that, staff provided residents with bed baths instead of showers. The Administrator said it was safe for residents to use water from the faucets in their rooms for washing hands, face, and oral care. He reported although the Unit 1 and Unit 3 showers tested negative for any bacterial contaminants based on the microbiology analysis report dated 09/13/2024, the facility was awaiting the LHD and the CLWSE to confirm all showers were safe for resident use. Review of the microbiology analysis report, performed by a third party IWSC to test for legionella, dated 09/13/2024, revealed testing for the Unit 2 shower showed Legionella non-pneumophila 0.1 CFUs/ml with a detection limit of 0.1 CFU/ml, indicating well-controlled growth. Additionally, review of the microbiology analysis report, performed by a third party IWSC to test for legionella, dated 09/18/2024, revealed testing for the Unit 2 shower showed Legionella non-pneumophila SG1 at 0.4 CFUs/ml with a detection limit of 0.1 CFU/ml, indicating well-controlled growth. During a follow up interview with the Administrator on 10/25/2024 at 12:45 PM, he stated it was his expectation for all staff to adhere to the facility's Resident Rights policy to protect residents' rights to ensure their quality of life. During telephone interview with the Medical Director on 10/25/2024 at 11:01 AM, he stated the facility decided to close the showers until no legionella growth was detected to ensure the residents' safety. He stated further decision that it was his expectation all staff members adhered to the facility's policies and procedures regarding resident rights. The Medical Director further stated protecting resident rights was important to maintaining a high standard of quality of life. During interview with the SSW on 11/19/2024 at 8:01 AM, she stated the issue regarding legionella contamination was brought up by residents who attended the facility's Resident Council Meeting. She stated those residents in attendance were informed about the ongoing issues with contaminated water. The SSW reported she could not recall the specifics of what was discussed or the questions that were asked at those meetings, but she said the residents expressed their understanding of the situation. She stated however, the residents were not informed about the extent of the contamination. When asked by the SSA Surveyor whether all residents had the right to know about the extent of the contamination and what the facility was doing to address it, she responded, I guess. When questioned further about whether the facility had a duty to be transparent with its residents, she stated, Sure. During interview with the Interim Director of Nursing (DON) on 11/21/2024 at 3:45 PM, she stated it was her expectation that all nursing staff follow facility policies and procedures regarding resident rights. She stated protecting residents' rights was important to maintaining a high standard of quality of life. During interview with the Interim Administrator on 11/22/2024 at 2:02 PM, she stated it was her expectation all staff followed the facility's Resident Rights policy to ensure the well-being of all residents.

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F 0580

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.

Based on interview, record review, and review of the facility's policy, it was determined the facility failed to notify the resident's physician of a significant change in the resident's physical status for one of 26 sampled residents, (Resident (R)76).

R76 sustained an unwitnessed fall on 05/16/2024 at 1:15 PM, and Registered Nurse (RN) 2 (an agency nurse) notified the Nurse Practitioner (NP), who advised monitoring the resident, with no new orders given. RN2 noted R76 had prolonged elevated blood pressure readings, with systolic readings between 180 and 190 until 7:00 PM. However, RN2 failed to inform the NP of R76's continued elevated blood pressure readings.

On 05/17/2024, R76's blood pressure continued to remain elevated, and the resident presented a mental status change which included: lethargy, confusion, and incoherent speech. However, RN2 failed to document the mental status changes observed and failed to notify the physician/NP of R76's worsening physical condition. R76's family arrived to visit the resident at 6:00 PM on 05/17/2024 and expressed their concerns about R76. They expressed concern over R76's increased lethargy, confusion, change in speech pattern, and persistent high blood pressure. RN2 then contacted the physician regarding the family's request for R76 to be transferred to the hospital for evaluation. R76 was admitted to the hospital for observation and diagnosed with a transient ischemic attack (TIA, temporary blockage of blood flow to the brain).

Immediate Jeopardy (IJ) was identified on 11/14/2024 and was determined to exist on 05/16/2024, in the area of 42 CFR §483.10 Resident Rights, F580 at a Scope and Severity (S/S) of a J. The facility was notified of the IJ on 11/14/2024.

The facility provided an acceptable IJ Removal Plan, on 11/22/2024, alleging removal of the IJ on 11/22/2024. The State Survey Agency (SSA) validated the IJ had been removed on 11/22/2024 as alleged, prior to exit on 11/22/2024. Remaining non-compliance continued at a S/S of a D while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

Refer to F684

The findings include:

Review of the facility's policy titled, Notification of Change of Condition, undated, revealed the facility was to inform the resident's physician when there was an accident involving the resident that resulted in injury and had the potential for requiring physician intervention. Additionally, the physician was to be notified when there was a deterioration in the resident's physical mental or psychosocial status.

Review of the Face Sheet for R76, located in the resident's electronic medical record (EMR), revealed the facility admitted the resident on 08/22/2022, with diagnoses to include metabolic encephalopathy, general anxiety disorder, and essential (primary) hypertension.

Review of the Annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 05/03/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(BIMS) score of four out of 15, which indicated severely impaired cognition. Continued MDS review revealed R76 was assessed as independent with mobility, toileting, transfers, and ambulated by herself with no assistance from a helper. Per review of the MDS, R76 was able to independently walk 150 feet with the assist of a walker. Review of R76's Nurse Progress Note, dated 05/16/2024 at 1:42 PM, revealed the resident had been found lying on the floor by a State Registered Nurse Aide (SRNA). Per review, the SRNA found R76 attempting to pull herself up off the floor using her walker and leaning against the wall. Continued review revealed R76 told the SRNA she bent down trying to pick something up and lost her balance, causing her to fall. The note stated R76 hit her head during the fall, but stated it had not caused her any pain. Further review revealed the nursing assessment noted no redness or swelling observed to R76's head; the resident had full range of motion (ROM); and her neurological (neuro) checks were at baseline. Per review of the Note, R76's blood pressure was 190/70, which was elevated from her baseline. Additionally, review revealed the nurse notified the NP, and no new orders were received. Review further revealed the note stated the resident's family, and the DON were notified. Review of the Neurological Record, for R76 dated 05/16/2024, revealed the neurological (neuro) checks, including vital signs, pupil size, level of consciousness, speech, and motor responses, were conducted at the following intervals: every 15 minutes times four; every 30 minutes times four; every hour times four; and every two hours times four. Review revealed the results of R76's neuro checks at 1:15 PM, revealed the resident's b/p was recorded as 190/70. Continued review revealed the 1:15 PM assessment noted R76 as alert; her speech as coherent; with full ROM in all extremities; and her pupils as equal and reactive at baseline. Subsequent review of the Neurological Record assessments showed R76's neuro checks remained at baseline. Further review revealed R76's systolic b/p readings remained elevated until 7:00 PM, and were documented as follows: 1:30 PM, 182/72; 1:45 PM, 184/72; 2:00 PM, 182/70; 2:30 PM, 184/72; 3:00 PM, 172/70; 3:30 PM, 176/72; 4:00 PM, 182/72; 5:00 PM, 190/70; and 6:00 PM, 182/70. Additional review revealed at 7:00 PM, R76's b/p was 133/56, with pupil response, speech, and motor responses remaining unchanged. Review further revealed the 8:00 PM b/p reading documented was illegible. Continued review of R76's Neurological Record, documentation dated 05/17/2024, revealed neuro checks, including vital signs, pupil size, level of consciousness, speech, and motor responses, were conducted at the following intervals: every four hours times three; and then every eight hours times four. Per review of the assessment documentation, R76 was alert; her speech was coherent; she had full ROM in all extremities; and her pupils were equal and reactive at baseline. Review of subsequent assessment documentation revealed R76's neuro checks remained at baseline. Continued review revealed at 4:00 PM, R76's level of consciousness (LOC) was initially marked as drowsy, stuporous, and unconscious; however, that information was marked with the word error handwritten over them. Further review of the assessment documentation revealed R76's b/p readings noted at 12:00 AM and 4:00 AM were illegible. Additional review revealed R76's b/p at 8:00 AM was 148/78 and at 4:00 PM was 146/70 (the last taken before the resident was transferred to the hospital). Review of R76's Nurse Progress Notes, dated 05/17/2024 at 7:10 PM, authored by RN2, revealed the resident was transferred to the local hospital via emergency medical services (EMS) per the physician's order and at family's request. Continued review revealed R76's family arrived at 6:00 PM on 05/17/2024, and requested the facility send R76 to the local hospital for evaluation of her increased lethargy and elevated b/p throughout the day. Further review revealed no documented evidence written in the Note related to any neuro changes exhibited by R76. (continued on next page)

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	185283	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bourbon Heights Nursing Home	2000 South Main Street Paris, KY 40361

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview with Family Member (F)3 on 10/04/2024 at 2:31 PM, she stated she was told by her daughter (F4), that R76 had sustained a fall on 05/16/2024. F3 stated F4 was a SRNA who was employed at the facility at the time of the incident and had been at the facility for an in-service the day the fall occurred. F3 said F4 visited R76 on 05/16/2024, and the resident told F4 she sustained a fall. She stated R76 also told F4 she hit her head during the fall and was experiencing a headache. F3 reported when she visited R76 on 05/17/2024, the resident's systolic b/p was severely elevated, reaching the 190's, and she was exhibiting behavior that was noticeably different from her baseline. She stated the nurse on duty told her (F3) she had notified the NP and the NP's orders included monitoring R76's blood pressure. F3 said R76's speech was garbled, and she (the resident) seemed incoherent. She further stated she requested R76 be sent to the hospital, where she was admitted for two nights for BP monitoring and change in mental status. During telephone interview with RN2 on 10/04/2024 at 1:33 PM, she stated on 05/16/2024 at 1:00 PM, she was informed by the SRNA that R76 had sustained a fall while returning from the bathroom. She stated she assessed R76 and found no injuries, but the resident's systolic b/p had been elevated, with readings in the 190's. RN2 stated she performed neuro checks and vital signs according to the facility's fall protocol, and although the resident's b/p was elevated, she had no concerns. She said R76 did not exhibit any change in her LOC, and she notified the resident's family, the DON, and the NP of R76's fall and elevated b/p. The RN reported the NP told her to follow the facility's protocols and let her know if there were changes in the resident; and no other new orders were received. RN2 stated R76 did not have specific b/p parameters to follow. She stated the family visited and expressed concern about R76's elevated b/p; however, RN2 said she reassured them the NP indicated the elevated b/p was likely due to anxiety following the fall. RN2 further stated, R76's b/p came within her baseline after several hours, and she did not call the NP back to update her with R76's physical status. In continued interview on 10/04/2024 at 1:33 PM, RN2 stated on 05/17/2024, R76 started exhibiting a change in mental status. The RN said R76 was lethargic and was speaking incoherently at times. She stated when R76's family arrived at 6:00 PM that day, they requested the resident be evaluated at the local hospital due to her increased lethargy and elevated b/p during the day. The RN reported she called the provider, who gave the order for R76 to be transferred to the hospital. Additionally, RN2 said she could not recall if she had read the facility's Notification of Change policy. Review of R76's Emergency Department (ED) Note, dated 05/17/2024 at 7:05 PM, revealed the resident had been transferred there from the facility. Per review, the physician noted R76 had altered mental status; dysarthria (difficulty in speech due to weakness of speech muscles); and significantly elevated b/p, with systolic readings in the 170's and 180's compared to the normal range of 120's to 130's. Further review revealed R76 exhibited staccato (broken speech) and repetitive speech and rated a headache at five out of 10, on a scale of one to 10, for pain. In addition, review revealed due to those issues, R76 was admitted to the hospital for observation and diagnosed with a TIA. During interview with the DON on 10/09/2024 at 3:01 PM, she stated the nurse on duty followed the facility's protocol for neuro checks. The DON stated however, the nurse should have sent R76 to the hospital for evaluation due to her elevated b/p and changes in mental status. She stated, I would have sent her [R76] out if I had been the nurse. The DON emphasized that when a resident experienced a change in condition or mental status, the nurse was to notify the medical provider. She stated R76's increased b/p and altered mental state might have indicated the resident had sustained an injury. During interview with the NP on 11/15/2024 at 11: 22 AM, she stated it was her expectation that RN2 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	should have called her back to make her aware of R76's continued elevated b/p readings. She said she would have sent R76 to the local hospital for further evaluation based on the resident's elevated b/p. The NP stated when there was a change in a resident's mental status, either she or the physician were to be notified immediately. She further stated making the provider aware of any change in condition because that was important for the safety and well-being of the resident. During a telephone interview with the Medical Director on 11/14/2024 at 1:45 PM, he stated the nurse on duty should have communicated changes in the resident's condition to the providers. He stated nurses were to use their nursing judgment and notify the provider on call in emergency situations. The Medical Director stated there were standing orders regarding nursing parameters, which included elevated b/p's. He said any neurological changes in a resident should prompt immediate notification. Per the interview, the Medical Director stated it was his expectation that staff followed all facility policies to ensure the safety of the residents. During interview with the Interim DON on 11/21/2024 at 3:45 PM, she stated that it was her expectation for all nursing staff to follow the facility's policies and procedures regarding resident change in condition. She stated nursing staff should notify the physician immediately of any injury or decline in status as per the policies and procedures. The Interim DON said following procedures related to a resident's change in condition ensured the resident received appropriate and timely care. She further stated in her review of the facility and its operations to date there were no systems in place to ensure staff were following the facility's policies and protocols. During interview with the Interim Administrator on 11/22/2024 at 2:02 PM, she stated that she expected staff to follow the facility's Notification of Change policy to ensure safe and appropriate care for all residents.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and review of the facility's policies, the facility failed to have an effective system in place to ensure residents' Comprehensive Care Plans (CCP's) interventions were implemented when a change of condition occurred for one of 26 sampled residents, (Resident (R)76). Review of the facility's CCP developed for R76 revealed the resident was care planned for hypertension to include interventions to monitor, document, and report to the medical provider any signs and symptoms of headache, confusion, and lethargy. R76 sustained an unwitnessed fall on 05/16/2024 at 1:15 PM, and Registered Nurse (RN) 2 notified the Nurse Practitioner (NP) who advised monitoring the resident. RN2 documented normal neurological (neuro) checks for R76. However, the resident experienced prolonged elevated blood pressures (B/P's) with systolic readings between 180 and 190 (The resident's baseline systolic readings were 120 to 130) until 7:00 PM. R76 also verbalized a compliant of a headache to staff. However, RN2 failed to follow the care plan to monitor, document, and report R76's elevated B/P and headache to the NP. On 5/17/2024, R76's blood pressure readings remained elevated with the systolic between 140 and 150 and the resident exhibited a change in mental status to include lethargy and incoherent speech at 4:00 PM. However, RN2 again failed to follow R425's CCP's interventions to document the change in condition, the resident's complaints of headache, or report to the medical provider any signs and symptoms of elevated blood pressure. At the family's request, the physician was notified at 6:00 PM on that date, and R76 was transferred to the hospital for increased lethargy and elevated blood pressure. R76 was subsequently admitted to the hospital and diagnosed with a transient ischemic attack (a brief stroke-like attack). The facility's failure to have an effective system in place to ensure residents' care plans were implemented to address monitoring of residents with a change in condition is likely to cause serious injury impairment or death if immediate action is not taken. Immediate Jeopardy (IJ) was identified on 11/14/2024, and was determined to exist on 05/16/2024, in the area of 42 CFR §483.21 Comprehensive Resident Centered Care Plan, F-656 at a Scope and Severity (S/S) of a J. The facility was notified of the IJ on 11/14/2024. The facility provided an acceptable Immediate Jeopardy Removal Plan, on 11/22/2024, alleging removal of the IJ on 11/22/2024. The State Survey Agency (SSA) validated the IJ was removed on 11/22/2024 as alleged, prior to exit on 11/22/2024. Remaining non-compliance continued at a S/S of a D while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. Refer to F684 The findings include: Review of the facility's policy titled, Care Plan Development in the EHR [electronic health record] Policy and Procedure, undated, revealed the facility must create and implement a comprehensive, person-centered care plan for each resident in accordance with their rights. Per review, the care plan (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	should include measurable objectives and timeframes. Continued review revealed the facility was required to develop and implement services aimed at helping residents achieve or maintain their highest possible levels of physical, mental, and psychosocial well-being, in consultation with the residents and their representative. Review of the facility's policy titled, Falls Policy and Procedure, revised 11/18/2024, revealed the facility was to care plan all residents who were at risk for falls. Review of R76's Face Sheet, located in the facility's electronic medical record (EMR), revealed the facility admitted the resident on 08/22/2022, with diagnoses to include general anxiety disorder, metabolic encephalopathy, and essential (primary) hypertension. Review of the Annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 05/03/2024, revealed the facility assessed R76 to have a Brief Interview for Mental Status (BIMS) score of four out of 15, which indicated severe cognitive impairment. Continued MDS review revealed R76 was assessed as independent with mobility, toileting, transfers, and ambulated by herself with no assistance from a helper. Additionally, MDS review further revealed R76 was assessed as able to walk 150 feet with the assist of a walker independently. Review of R76's CCP, dated 05/11/2024, revealed the facility identified R76 as as having hypertension on 10/22/2022, with a goal for the resident to remain free of complications. Continued review revealed the interventions included monitoring, documenting, and reporting any signs and symptoms of hypertension. Further review revealed the interventions staff were to monitor, document, and report the following signs and symptoms of hypertension which included headaches, visual problems, confusion, disorientation, and lethargy. Further review revealed however, the facility failed to implement the resident's care plan to ensure adequate assessmen, monitoring, and notification to the medical provider when the resident developed a sustained change in condition. Review of R76's Nurse Progress Note, dated 05/16/2024 at 1:42 PM, revealed the resident had been found lying on the floor by a State Registered Nurse Aide (SRNA). Per review, R76 reported hitting her head during the fall, but it was not causing her any pain. Continued review of the Note revealed the nurse's assessment noted no redness or swelling noted to R76's head and the resident had full range of motion (ROM). Further review revealed R76's neuro checks were documented as at baseline; however, the resident's B/P was noted at 190/70, which was elevated from her baseline. In addition, review revealed the nurse notified the NP who recommended monitoring R76, and no new orders received. Review of R76's Nurse Progress Note, dated 05/17/2024 at 7:10 PM, signed by RN2, revealed per R76's family's request and physician's order the resident had been transferred to the local hospital via emergency medical services (EMS). Per review of the Note, the resident's family arrived to visit R76 on 05/17/2024 at 6:00 PM, and requested she be transferred to the local hospital for evaluation of her increased elevated B/P and lethargy throughout the day. During telephone interview with SRNA6 on 10/07/2024 at 1:23 PM, she stated she responded to R76's call light on 05/16/2024, and asked her if she needed help going to the bathroom. SRNA6 stated the resident indicated she needed assistance with her walker so she assisted R76 with that and with going into the bathroom. SRNA6 reported the resident came out the bathroom on her own with her walker and sustained a fall near the closet. Per the SRNA in interview, she had been in the room at the time but had not witnessed R76 fall. She said she and another staff member, whom she could not recall, helped the resident up off the floor and assisted her back to bed. SRNA6 stated the resident no (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	complaints other than a headache at the time. She said when RN2 came to assess R76, she reported the resident's complaint of a headache to the nurse. The SRNA stated she did every 15-minute checks of the resident for two hours following the fall, which included taking her vital signs. She further stated R76's blood pressure was higher than normal and she communicated that information to RN2. In a telephone interview on 10/04/2024 at 1:33 PM, RN2, she stated on 05/17/2024, R76 exhibited a change in her mental status, was lethargic and speaking incoherently at times. She stated R76's family arrived at 6:00 PM on 05/17/2024, and requested the resident be evaluated at the local hospital due to her increased lethargy and elevated blood pressures during the day. RN2 further stated she called the provider, who gave the order for the transfer. Review of R76's, Emergency Department (ED) Note, dated 05/17/2024 at 7:05 PM, revealed the resident presented to the local ED following a fall at the facility. Per review, the physician assessed R76 to have: an altered mental status; symptoms of dysarthria (slurred speech), staccato and repetitive speech; and prolonged elevated blood pressure. Continued review revealed R76's systolic B/P was noted as significantly elevated, measuring in the 170's and 180's, compared to the resident's systolic baseline range of 120's to 130's. In addition, review revealed R76 was admitted to the hospital for observation of her elevated B/P, change in speech and mental status, and diagnosed with a transient ischemic attack (TIA). In a telephone interview with RN2, on 10/04/2024 at 1:33 PM, she stated she had not updated R76's CCP to include additional interventions to prevent future falls after the resident sustained the fall on 05/16/2024. The nurse stated however, R76's CCP should have been updated immediately to include interventions to alert staff and to keep the resident safe. During interview with the MDS Nurse on 10/04/2024 at 1:10 PM, she stated no new interventions were added to R76's CCP following the resident's first fall on 05/16/2024. She stated however, the resident's CCP should have been updated with a new intervention to prevent further falls and to monitor her for changes in condition. The MDS Nurse stated all resident falls were discussed in the morning meeting, where the team developed interventions to prevent/reduce falls and injuries. She further stated an Interdisciplinary Team (IDT) Note should have been placed in the resident's chart related to the fall; however, she could not locate such a Note. In interview with the former DON (who was the DON at the time of the interview), on 10/09/2024 at 3:01 PM, she stated R76 should have been care planned with additional interventions after her fall on 05/16/2024. The former DON said adding interventions after the fall was to ensure all staff were aware of how to care for and monitor R76 for changes in condition. She stated it was the responsibility of the MDS Nurse to update and revise residents' CCP and she did not know why the MDS Nurse had not updated R76's CCP. The former DON further stated implementing residents' CCP's was essential because it instructed staff on how to best care for and keep residents safe. During interview with the Medical Director, on 10/25/2024 at 11:01 AM, he stated it was his expectation staff would adhere to the facility's CCP policy. He further stated it was his expectation staff revised care plans to ensure resident-centered care and safety for the residents. In interview with the former Administrator, on 10/25/2024 at 12:45 PM, he stated it was his expectation staff followed the facility's CCP policy. He said he expected staff to update care plans as needed to ensure care for residents was appropriate and safe. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an additional interview with the MDS Nurse on 11/14/2023 at 9:41 AM, all nurses had access to revise and update the CCP. The MDS Nurse stated R76's care plan should have been updated following her fall to include monitoring for changes in condition. Additionally, she stated R76's care plan should have incorporated interventions to notify the physician of prolonged elevated B/P, pain, and any changes in the resident's mental status. During additional interview with the Medical Director on 11/14/2024 at 1:45 PM, he stated the nurse on duty should have communicated the changes in R76's condition to the provider on call. Medical Director stated it was his expectation staff followed all facility policies, including the care plan policies, to ensure the safety of the residents. During interview with the Interim DON on 11/21/2024 at 10:45 AM, she stated the MDS Nurse was responsible for the comprehensive assessments of all residents. The Interim DON stated the MDS Nurse ensured residents' care plans were updated and revised as necessary and in a timely manner. She further stated however, all nurses had the authority to access, update, and revise the care plans if needed. During additional interview with the Interim DON on 11/21/2024 at 3:45 PM, she stated that it was her expectation that all nurses implemented and revised residents' CCP's as needed to ensure residents received comprehensive, patient-centered care. She stated R76 should have had a care plan developed with additional interventions to implement to ensure all staff were aware of how to care for and monitor her for a decline in condition, including altered mental status. The Interim DON further stated implementing residents' care plans was essential, as it provided instructions to staff on how to best care for the residents and ensure their safety. She additionally stated it was her expectation for staff to follow all facility policies to ensure the safety of the residents. In interview on 11/22/2024 at 2:02 PM, the Interim Administrator stated it was her expectation staff followed the facility's CCP policy and update care plans as needed to ensure the safe and effective care of all residents.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to promptly identify and intervene for a change in the resident's condition and ensure the resident received prompt assessment and emergency care for one of 26 sampled residents, (Resident (R)76). R76 sustained an unwitnessed fall on 05/16/2024 at 1:15 PM and Registered Nurse (RN) 2 (an agency nurse) notified the Nurse Practitioner (NP) who ordered continued monitoring of the resident, with no additional orders. RN2's assessments noted R76's neurological (neuro) checks were within normal limits (WNL) and the resident was experiencing prolonged elevated blood pressure (B/P), with systolic readings consistently between 180 and 190 until 7:00 PM. However, RN2 failed to notify the NP about R76's elevated B/P. On 05/17/2024 at 8:00 AM and 4:00 PM, R76's B/P remained elevated and at 4:00 PM, the resident was also exhibiting a change in mental status, to include lethargy and incoherent speech. However, RN2 failed to document those findings and did not notify the physician of R76's change in condition. The resident's family arrived at 6:00 PM on 5/17/2024, and due to their concerns over R76's increased lethargy, confusion, and elevated B/P, they requested the facility send the resident to the hospital for evaluation. R76 was subsequently admitted to the hospital with a diagnosis of transient ischemic attack (TIA, a brief blood flow blockage to the brain). Immediate Jeopardy (IJ) was identified on 11/14/2024 and was determined to exist on 05/16/2024, in the area of 42 CFR §483.25 Quality of Care, F684 at a Scope and Severity (S/S) of a J. The facility was notified of the IJ on 11/14/2024. The facility provided an acceptable IJ Removal Plan, on 11/22/2024, alleging removal of the IJ on 11/22/2024. The State Survey Agency (SSA) determined the IJ was removed on 11/22/2024, prior to exit on that date. With remaining non-compliance at a S/S of a D while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. Refer to F580 and F656 The findings include: Review of the facility policy titled, Quality of Care, undated, revealed quality of care was a fundamental principle that applied to all treatment and care provided by the facility. Per policy review, the facility must ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person centered care plan, and the resident's choices. Review of the Face Sheet, found in R76's electronic medical record (EMR), revealed the facility admitted the resident on 08/22/2022, with diagnoses including essential (primary) hypertension, metabolic encephalopathy, and general anxiety disorder. Review of R76's Annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 05/03/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of four out of 15, indicating severely impaired cognition. Per review, the facility (continued on next page)

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

also assessed R76 to be independent with mobility, toileting, transfers, and able to ambulate on her own with a walker and no assistance from a helper.

Review of the Comprehensive Care Plan (CCP), dated 05/11/2024 for R76, revealed the facility identified a problem for the resident related to having hypertension (high blood pressure) on 10/10/2022. Per review, the goal dated 05/11/2024 and revised on 11/13/2023, for the resident to remain free of complications related to hypertension. Continued review revealed the interventions dated 10/22/2022 included: giving antihypertensive medications as ordered; and monitoring and documenting any edema. Further review revealed additional interventions included monitoring, documenting, and reporting any signs and symptoms of hypertension such as, headache, visual problems, confusion, disorientation, and lethargy.

Review of the Nurse Progress Note, dated 05/16/2024 at 1:42 PM for R76, revealed State Registered Nurse Aide (SRNA) 6 found the resident lying on the floor. Continued review revealed the nursing assessment noted no redness or swelling to R76's head; full range of motion (ROM) to extremities; and neuro checks were at baseline. Per review of the Note, R76's B/P was 190/70, which was elevated from her baseline. Further review revealed the nurse notified the NP, and no new orders were received. In addition, the Note stated the resident's family, and the DON were also notified.

Review of R76's Neurological Record, for 05/16/2024, revealed her neuro checks were conducted: every 15 minutes (four times); every 30 minutes (four times); every hour (four times); and every two hours (four times). Per review of the Record, the results of the neuro checks at 1:15 PM revealed: R76's B/P was 190/70; the resident was alert with coherent speech; had ROM in all extremities, and her pupils were equal and reactive at baseline. Continued review revealed subsequent neuro check assessments noted R76's neuro checks remained at baseline. Further review revealed R76's systolic B/P readings were as follows: 182/72 at 1:30 PM; 184/72 at 1:45 PM; 182/70 at 2:00 PM; 184/72 at 2:30 PM; 172/70 at 3:00 PM; 176/72 at 3:30 PM; 182/72 at 4:00 PM; 190/70 at 5:00 PM; and 182/70 at 6:00 PM. Additionally, review of the Record revealed R76's B/P was 133/56 at 7:00 PM and at 8:00 PM, the B/P reading was illegible.

Review of R76's Neurological Record, for 05/17/2024, revealed her neuro checks, were conducted every four hours (three times); and then every eight hours (four times). Per review, R76 was alert, her speech was coherent, she had a full ROM in all extremities, and her pupils were equal and reactive at baseline. Continued review revealed at 4:00 PM, R76's level of consciousness (LOC) was initially marked as drowsy, stuporous, and unconscious; however, that was marked through with the word error handwritten over them. Further review revealed R76's B/P readings at 12:00 AM and 4:00 AM were illegible. In addition, review revealed R76's B/P at 8:00 AM, was noted as 148/78 and at 4:00 PM as 146/70.

In interview with R76's Family (F) 3, on 10/04/2024 at 2:31 PM, she stated when she visited the resident on 05/17/2024, R76's systolic B/P had been severely elevated, reaching the 190's, was exhibiting garbled speech, and was confused, which was noticeably different from her baseline. She stated during her visit, R76 told her she (the resident) had hit her head during the fall and was having a headache. F3 reported the nurse on duty communicated to her that she (nurse) had notified the NP, and the NP's ordered monitoring R76's B/P. She further stated she requested R76 be sent to the hospital, where she was admitted for two nights.

During telephone interview with SRNA6 on 10/07/2024 at 1:23 PM, she stated she responded to R76's call light and asked the resident if she needed help getting to the bathroom. She said R76 indicated she required assistance with her walker which she helped the resident with and assisted her into the

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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 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bourbon Heights Nursing Home	2000 South Main Street Paris, KY 40361

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	bathroom. SRNA6 reported after that R76 exited the bathroom on her own with her walker and fell near the closet. She stated she had been in the room at the time but had not actually witnessed the fall. SRNA6 said she and another staff member, whom she could not recall, helped R76 off the floor and assisted her in returning to bed. Per SRNA6 in interview, R76 had no complaints except for a headache, and when RN2 came in to assess R76, she reported the resident's complaint of a headache to the nurse. She stated she conducted every 15-minute checks on R76 for two hours after her fall and her checks of the resident taking her vital signs. SRNA6 recalled that R76's blood pressure was higher than normal and she communicated that information to RN2. In telephone interview on 10/04/2024 at 1:33 PM, RN2 stated she was informed by a SRNA on 05/16/2024 at 1:00 PM, that R76 had sustained a fall while returning from the bathroom. She stated she assessed R76 with no injuries, and an elevated systolic B/P with readings in the 190's. The RN reported she performed neuro checks and vital signs according to the facility's fall protocol, and although the resident's B/P had been elevated, she had no concerns. She said R76 had not exhibited any change in her LOC. RN2 stated she notified R76's family, the DON, and the NP of R76's fall and elevated B/P. She stated the NP told her to follow the facility's protocols and let her know if there were changes, and no other new orders were received. RN2 shared that R76 did not have specific B/P parameters to follow. The RN further stated R76's B/P readings came within her baseline after several hours, and she did not call the NP back to update her on the resident's status. In continued telephone interview on 10/04/2024 at 1:33 PM, RN2 stated on 05/17/2024, R76 started exhibiting a change in mental status. RN2 said R76 became lethargic and was speaking incoherently at times. She stated she could not recall if the facility had provided an in-service related to the signs and symptoms (S/S) of a stroke. RN2 reported however, the S/S of a stroke were slurred speech, instability, weakness, and facial drooping. She said the family visited on 05/17/2024 at 6:00 PM, and expressed concern about R76's elevated B/P. The RN said she reassured them the NP had indicated the resident's elevated B/P was likely due to anxiety following her fall. She stated however, the family requested R76 be evaluated at the local hospital due to her increased lethargy and elevated B/P during the day. RN2 said she called the provider, who gave the order for R76's transfer to the hospital. She further stated she could not recall if she had read the facility's Quality of Care policy. Review of R76's Emergency Department [ED] Note dated 05/17/2024 at 7:05 PM, revealed the resident had been transferred from the facility after a fall. Continued review revealed the ED physician noted R76 had altered mental status and dysarthria (slurred speech). Per review, the ED physician also noted R76 had significantly elevated B/P, with systolic readings in the 170's and 180's compared to her normal range of 120's to 130's. Review further revealed R76 exhibited staccato and repetitive speech and rated a headache at five on a scale of one to 10, with 10 the worst for pain. In addition, review revealed due to those issues, R76 was being admitted to the hospital for observation and diagnosed with a TIA. In interview on 11/14/2024 at 9:51 AM, SRNA 1 (an agency SRNA) stated the S/S of stroke included limited movement and decreased activity. SRNA1 said she immediately reported anything abnormal in a resident to the nurse. She stated she had only worked at the facility for one week, but said she had not received any training when she onboarded. During interview with SRNA 9 (an agency SRNA) on 11/14/2024 at 10:08 AM, she stated the S/S of a stroke included one sided weakness, facial drooping, and slurred speech. SRNA9 stated she immediately reported anything abnormal in a resident to the nurse. She reported she would keep an eye on the resident and monitor their B/P and oxygen saturation. The SRNA said the frequency of assessments was up (continued on next page)

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

to the nurse; however, it was usually every 15 minutes. She further stated if there was no improvement in a resident's vitals and she felt the nurse was not doing anything about following the protocols, she would report her concerns to the nursing supervisor.

In interview on 11/14/2024 at 10:14 AM, SRNA10 stated she had been employed at the facility since 06/2024. She stated the S/S of a stroke included changes in the face, eyes, and speech. SRNA10 stated she would report any change in a resident to the nurse immediately, and a resident experiencing S/S should be assessed by the nurse every 15 to 30 minutes. She further stated she received stroke in-service provided by the Infection Preventionist (IP) Nurse.

During interview with SRNA11 (an agency SRNA) on 11/14/2024 at 10:38 AM, he stated he had worked at the facility through an agency for approximately six years. He stated the S/S of stroke were slurred speech, instability, weakness, and facial drooping. SRNA11 stated he would check a resident's vital signs every 15 minutes if they were displaying S/S. He stated he would report an elevated B/P to the nurse depending on the resident's history. SRNA11 said he could not recall any specific education related to S/S of a stroke.

In interview on 11/14/2024 at 10:31 AM, Licensed Practical Nurse (LPN) 2 stated if staff observed any S/S of stroke including slurred speech, drooping face, and weakness that should be reported to the nurse immediately. LPN2 stated she would monitor a resident's B/P and heart rate (HR), if they were experiencing S/S, at least every 15 minutes. She said she received her education for stroke during an in-service, which were usually provided by Social Worker (SW), IP Nurse, or DON. LPN2 further stated the facility did not offer computer-based training modules.

During interview with Kentucky Medication Aide (KMA) 2 on 11/14/2024 at 10:03 AM, she stated she had been employed at facility for over six years. She said any S/S of stroke, including slurred speech, drooping face, and weakness, should be reported to the nurse immediately. KMA2 stated the resident should be assessed by taking vital signs. She further stated neuro checks would be done by the nurse. She additionally stated she had received stroke education before; however, was not sure if it was at her previous employer or the facility.

In interview on 11/14/2024 at 10:20 AM, the Staffing Coordinator/KMA stated she had been employed at the facility for over a year, and had received stroke education prior to her hire date. The Staffing Coordinator/KMA stated staff were to report any S/S of numbness, weakness, facial drooping to the nurse on duty. She further stated a resident's vital signs should be assessed every 10 minutes.

During interview with LPN3 on 11/14/2024 at 10:42 AM, she stated she had been employed at facility for about four years. She stated the S/S of a stroke included numbness, weakness, slurred speech, and facial drooping. LPN3 further stated she would notify the provider after one or two hours if there were no improvement in a resident's vitals who might be experiencing S/S of a stroke.

In interview on 11/14/2024 at 10:25 AM, RN3 (an agency nurse) stated she had been working at the facility since 05/2024. She stated the S/S of stroke were FAST which stood for facial drooping, arm weakness, speech difficulty, and time symptoms appeared. RN3 stated a resident experiencing S/S should be monitored for hypertension. She reported neuro checks and vitals were to be taken every 15 minutes times four; every 30 minutes times two; every one hour times six hours; and then every four hours. The RN further stated if a resident's B/P did not return to baseline or the resident changed in their mental status, she would notify the physician immediately.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview with the Quality Assurance (QA) Nurse on 11/14/2024 at 9:45 AM, she stated the facility did not provide specific in-service training on the sign and symptoms of strokes. The QA Nurse stated, Licensed nursing staff should know the signs of stroke. She reported however, it was important for them to recognize the different signs and symptoms of a stroke, as a resident might require an increased level of care or emergency intervention. She reported she encouraged staff to report anything that seemed off with a resident to the nurse on duty. During interview with the NP on 11/15/2024 at 11: 22 AM, she stated it was her expectation that RN2 should have called her back to notify her of R76's continued elevated B/P readings. She said if the nurse had notified her, she would have sent R76 to the local hospital for further evaluation based on her elevated B/P. The NP stated quality of care dictated when there was a change in a resident's mental status, either she or the physician were to be notified immediately. She further stated making the provider aware of any change in condition was important for the safety and well-being of the resident. In interview on 10/09/2024 at 3:01 PM, the former DON stated the nurse on duty followed the facility's protocol for neuro checks. She reported however, the nurse should have sent R76 to the hospital for evaluation due to her elevated B/P and changes in mental status. The former DON stated she would have sent R76 out if I had been the nurse. She emphatically said when a resident experienced a change in condition or mental status, the nurse was to notify the medical provider. The former DON additionally stated R76's increased B/P and altered mental status could have indicated the resident had sustained an injury. During interview with the Interim DON on 11/21/2024 at 3:45 PM, she stated she expected all nursing staff to follow the facility's policies and procedures regarding quality of care. The Interim DON said she also expected staff to notify the physician immediately of any injury or decline in a resident's status. She stated following standards of practice related to a resident's change in condition ensured the resident received appropriate and timely care. The Interim [NAME] further stated her review of the facility and its operations to date had revealed there are no systems in place to ensure staff were following the facility's policies and protocols. In interview on 11/22/2024 at 2:02 PM, the Interim Administrator stated it was her expectation for staff to follow the facility's Quality of Care policy to ensure safe and appropriate care was provided for all residents. During interview with the Medical Director on 11/14/2024 at 1:45 PM, he stated the nurse on duty should have communicated the changes in R76's condition to the on call provider. The Medical Director said nurses should use their nursing judgment based on their standards of care and notify the provider on call in emergency situations. He stated there were standing orders regarding nursing parameters, which included elevated B/P. The Medical Director said any neuro changes was to have immediate notification to the provider. He further stated he expected nursing staff to follow all facility policies related to quality of care. The Medical Director said that was to ensure the residents received quality care according to current nursing care standards. The facility provided an acceptable IJ Removal Plan on 11/22/2024 that read verbatim: Root Cause: The facility failed to promptly identify and intervene for a change in a resident's condition when (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident 76 (R76) had an elevated blood pressure for a prolonged period. The resident's family requested for the facility to transport the resident to the hospital. The resident was admitted to the hospital with broken/repetitive speech and rated her headache at five out of ten for pain. The resident was diagnosed with a transient ischemic attack (TIA) (mini stroke). Resident Affected: o Resident 76 (R76) was the resident affected; however, all residents currently have the potential to be affected. o On 11/17/24 Quality Assurance Nurse (QA), Minimum Data Set Coordinator (MDS) and Infection Control Nurse (IP) called all resident's physicians to get blood pressure parameters. All resident orders and careplans were updated with blood pressure parameters given by the physician(s). o On 11/18/24 Administrator pulled up Risk Management and reviewed all falls since 11/1/24 to ensure physician or ARNP and responsible party was notified of the fall. All notifications were completed from 11/1/24 to current. o On 11/18/24, Administrator pulled up 72-hour report to review any residents with change of condition to ensure physician or ARNP was notified of the change. All notifications from the 72-hour report were completed. Education/Training: o Director of Nursing and or Administrator trained the Minimum Data Set Coordinator (MDS), Quality Assurance Nurse (QA), Infection Control Nurse (IP), and Director of Adult Day on Notification of Change Policy on 11/19/24. Staff will sign in for the education and complete a post test. o On 11/19/24 MDS, QA, IP and Director of Adult Day started education on Notification of Change Policy to all nursing staff to include Licensed Practical Nurses (LPN) and Registered Nurses (RN) to include any new hires and agency LPNs and RNs. All current RNs and LPNs will be educated by 11/21/24. Any LPN or RN who has not been educated will be educated prior to working their next shift to include new hires and agency staff. Education will be completed by Minimum Data Set Coordinator (MDS), Quality Assurance Nurse (QA), Infection Control Nurse (IP), and Director of Adult Day. Staff will sign in for the education and complete a post test. o Director of Nursing and or Administrator trained the Minimum Data Set Coordinator (MDS), Quality Assurance Nurse (QA), Infection Control Nurse (IP), and Director of Adult Day on Develop/Implementation of Care Plan Policy on 11/19/24. Staff will sign in for the education and complete a post test. o On 11/19/24 MDS, QA, IP and Director of Adult Day started education on Develop/ Implementation of Care Plan Policy to all nursing staff to include Licensed Practical Nurses (LPN), Certified Nursing Assistants (CNAs) and Registered Nurses (RN) to include any new hires and agency LPNs and RNs. All current RNs, CNAs and LPNs will be educated by 11/21/24. Any LPN, CNA or RN who has not been educated will be educated prior to working their next shift to include new hires and agency staff. Education will be completed by Minimum Data Set Coordinator (MDS), Quality Assurance Nurse (QA), Infection Control Nurse (IP), and Director of Adult Day. Staff will sign in for the education and complete a post test. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o On 11/19/24 MOS, QA, IP and Director of Adult Day started education to CNAs on how to find the [NAME] charting tool on Point Click Care (PCC). This will enable the CNAs to see the resident's care plans. All CNAs will be educated by 11/21/24. Any CNA who has not been educated will be educated prior to working their next shift to include new hires and agency staff. Education will be completed by Minimum Data Set Coordinator (MDS), Quality Assurance Nurse (QA), Infection Control Nurse (IP), and Director of Adult Day. Staff will sign in for the education and complete a post test. o Director of Nursing and or Administrator trained the Minimum Data Set Coordinator (MDS), Quality Assurance Nurse (QA), Infection Control Nurse (IP), and Director of Adult Day on Falls Protocol to include monitoring resident who had a fall for next 72 hours and report any changes in vitals out of baseline to the physician immediately on 11/19/24. Staff will sign in for the education and complete a post test. o On 11/19/24 MDS, QA, IP and Director of Adult Day started education with RNs and LPNs to include new hires and agency staff on the falls protocol to include monitoring resident who had fall for the next 72 hours and report and changes in vitals out of baseline to the physician immediately. All current RNs and LPNs will be educated by 11/21/24. Any LPN or RN who has not been educated will be educated prior to working their next shift to include new hires and agency staff. Education will be completed by Minimum Data Set Coordinator (MDS), Quality Assurance Nurse (QA), Infection Control Nurse (IP), and Director of Adult Day. Staff will sign in for the education and complete a post test. Monitoring: o Starting 11/19/24 Director of Nursing (DON) or QA Nurse, MDS Coordinator, or IP Nurse will review all falls daily in morning clinical meeting to validate resident's care plan was updated. This will be part of the morning clinical meeting to check within 24 hours including weekends. o Starting 11/19/24, Director of Nursing, Administrator, QA Nurse, MDS Coordinator, or IP Nurse will monitor in daily clinical meeting any resident with a change of condition the residents care plan is updated. This will be part of the morning clinical meeting to check within 24 hours including weekends. o ADHOC QAPI was held on 11/20/24, the following members attended Medical Director, Administrator, DON, IP, MDS, Social Service Director/Activities Director, Maintenance Director, Human Resources, [NAME] Manager, admission Director, Scheduler, Rehab Program Manager, Housekeeping Director and Dietary Director. During this meeting tag F684 was discussed and the plan of correction was discussed and reviewed with the team. o All monitoring will be reported to the Quality Assurance Performance Improvement (QAPI) Committee weekly for the next six (6) months. The QAPI Committee consists of Medical Director, Administrator, DON, IP, MDS, Social Service Director/Activities Director, Maintenance Director, Human Resources, [NAME] Manager, admission Director, Scheduler, Rehab Program Manager, Housekeeping Director and Dietary Director. If there are any issues found prior to the monthly QAPI meeting an ADHOC meeting will be called to address the issues.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policies, the facility failed to ensure the residents' environment remained as free of accident hazards as possible and failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for one of 26 sampled residents (Resident (R)76). 1. R76 sustained an unwitnessed fall on 05/16/2024 while ambulating from the bathroom to the bed. The resident had a change in mental status and was taken to the local hospital where she was admitted with dysarthria (a speech disorder caused by weak or hard-to-control muscles in the mouth, face or upper respiratory system), prolonged elevated blood pressure, and was also diagnosed with a transient ischemic attack (TIA) (a brief stroke-like attack). The resident returned to the facility from the hospital on [DATE]. Further, after R76's return from the hospital, the family requested that the resident remained in her room to rest after her hospitalization. Despite this, staff assisted the resident out of bed, placed her in a wheelchair, and took her outside for an activity. After the activity, R76 was left unsupervised in a hallway while she waited for help to return to her room. While unsupervised, R76 attempted to get out of the wheelchair without assistance, which caused her to fall. R76 sustained a comminuted (broken in at least two places) fracture of the intertrochanteric region of her right hip as a result of the fall on 05/19/2024. 2. Additionally, R425 was transferred to the facility from the Personal Care Home and was a risk for falls, having fallen while at the Personal Care Home. The facility; however, failed to care plan the resident for falls to ensure his safety. The facility admitted the resident on 11/08/2024 and since his admission, he fell two times on 11/09/2024 and sustained a subdural hematoma and an abrasion to his scalp, and he fell again on 11/11/2024. Refer to F657 The findings include: Review of the facility's policy titled, Falls Policy and Procedure, with a revision date of 08/2021, revealed the intent of the policy was to maintain the safety of residents, promote the highest level of physical functioning, and ensure the resident's environment remained as free from accidents and hazards as possible. Per review, the guidelines included fall risk assessments to be performed upon admission, readmission, quarterly, annually, and with a significant change of condition to identify fall risks. Continued review revealed referrals would be made to the therapy department. Further review revealed a care plan (CP) was to be implemented based upon the resident's risk of falls. 1. Review of R76's Face Sheet found in the resident's electronic medical record (EMR) revealed the facility admitted the resident on 08/22/2022 with diagnoses to include metabolic encephalopathy, general anxiety disorder, and essential (primary) hypertension. Review of R76's Fall Risk Score Total, dated 03/31/2024 at 9:54 PM, revealed a fall score of seven, indicating she was not considered at high risk for falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R76's PT [Physical Therapy] Evaluation & Plan of Treatment, dated 04/23/2024, revealed PT assessed R76 as needing therapy due to documented physical impairments and associated functional deficits to prevent further decline in function and immobility and increased dependency on caregivers. According to the PT note, R76 had not been assessed for using a wheelchair. Review of R76's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/03/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of four out of 15, which indicated the resident had severely impaired cognition. Continued review revealed R76 was independent with mobility, toileting, transfers, and ambulation by herself with no assistance from a helper. Per the MDS, the resident could independently walk 150 feet with the assist of a walker. Review of R76's Comprehensive Care Plan (CCP), dated 05/11/2024, revealed the resident was identified as a fall risk on 05/11/2023, related to gait/balance problems, psychoactive drug use, and a history of falling. Interventions placed on 05/11/2023 included staff assist as needed for transfers, place the resident's call light within reach and encourage the resident to use it for assistance as needed, respond promptly to resident requests for assistance, encourage resident to ring call bell for assistance prior to getting up, ensure resident had nonskid socks/slippers/shoes on at all times when out of bed for fall safety, follow facility fall protocol, and keep her walker in reach and encourage her to use it when getting up. On 10/04/2024 at 11:15 AM, the State Survey Agency (SSA) Representative requested the fall incident reports for falls R76 sustained on 05/16/2024 and 05/19/2024. However, according to the Director of Nursing (DON), the facility did not have these incident reports. Review of R76's Nurse Progress Note, dated 05/16/2024 at 1:42 PM, revealed the resident was found on the floor by a State Registered Nurse Aide (SRNA). According to the note, the SRNA found the resident attempting to pull herself off the floor using her walker and leaning on the wall. Further review revealed R76 stated she bent down trying to pick something up and lost her balance, causing her to fall. The note stated R76 hit her head during the fall, but stated it did not cause her any pain. Nursing assessment revealed no redness or swelling noted to the head; the resident had full range of motion; and neurological (neuro) checks were at baseline. Review of R76's Emergency Department (ED) Note, dated 05/17/2024 at 7:05 PM, revealed the resident presented to the local Emergency Department (ED) following a fall, and the physician assessed R76 as having altered mental status, symptoms of dysarthria and prolonged elevated blood pressure. As a result of these findings, R76 was admitted to the hospital for observation of elevated blood pressure and change in speech and mental status. R76 was diagnosed with a transient ischemic attack (TIA). Review of R76's Fall Risk Score Total, dated 05/17/2024 at 7:22 PM, after the resident was transferred to the hospital, revealed a fall score of 13, indicating she was considered at risk for falls. According to the fall risk assessment, R76's risk for falls increased in the past three months related to poor vision, use of a walker for ambulation, predisposing disease, and receiving three to four medications. Continued review of the CCP, revealed there were no revisions made or additional interventions placed after R76's fall on 05/16/2024. Review of R76's discharge MDS with an ARD of 05/19/2024, revealed the resident did not attempt a (continued on next page)

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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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	sit to stand due to her medical conditions. Additionally, R76 required supervision (helper provided verbal cues and or touching, steadying, and or contact guard assistance as the resident completed the activity, assistance might be provided throughout the activity) from staff for mobility, toileting, transfers, and ambulation. Further review revealed R76 had one fall resulting in a major injury. During an interview with the Minimum Data Set (MDS) Nurse, on 10/04/2024 at 1:10 PM, she stated no new interventions were added to R76's CCP on 05/16/2024, following R76's first fall. She stated the CCP should have been updated with a new intervention to prevent further falls. During an interview with Family Member (F) 3, on 10/04/2024 at 2:31 PM, she stated she was told by her daughter (F4), that R76 had sustained a fall on 05/16/2024. F3 stated F4 was a State Registered Nurse Aide (SRNA) and was employed at the facility at the time of the incident. Per the interview, F4 was at the facility for an in-service the day the fall occurred. F3 stated F4 visited R76 on 05/16/2024, and the resident told F4 she fell. F3 stated R76 also told F4 she hit her head during the fall and was experiencing a headache. F3 stated when she visited R76 on 05/17/2024, the resident's systolic blood pressure was severely elevated, reaching the 190s, and she exhibited behavior that was noticeably different from her baseline. During a telephone interview with F4, on 10/09/2024 at 1:47 PM, she stated she was employed at the facility as a SRNA, and happened to be at the facility for an in-service on 05/16/2024, the day R76's fall occurred. F4 stated the in-service was canceled, so she visited R76. F4 stated during the visit, R76 told her she had hit her head during the fall and was experiencing a headache. F4 further stated, She told me she was hurting. F4 explained R76's roommate told her R76 did fall near the closet. F4 stated she asked the SRNA on duty about a fall, and SRNA6 stated, Yes, she fell. F4 stated SRNA6 explained she came into the room and found R76 on the floor near the closet. F4 further stated the nurse on duty told her she had notified the Nurse Practitioner (NP) of the fall. During a telephone interview with SRNA6, on 10/04/2024 at 1:23 PM, she stated she was an agency SRNA, and she had only worked one shift at the facility. The SRNA stated she was responding to a call light and asked R76 if she needed help getting to the bathroom. The resident indicated she needed assistance with her walker, so SRNA6 helped R76 into the bathroom. SRNA6 stated the resident came out of the bathroom using her walker for ambulation, but then fell near the closet. The SRNA stated she was in the room, but did not actually see the fall happen. She stated she performed 15-minute checks on R76 for two hours to include vital signs. During a telephone interview with Registered Nurse (RN) 2 (an agency nurse), on 10/04/2024 at 1:33 PM, she stated on 05/16/2024 at 1:00 PM, she was informed by the SRNA that R76 had sustained a fall while returning from the bathroom. She stated she assessed the resident and found no injuries. RN2 stated she performed neurological checks and vital signs according to the fall protocol. She stated she notified the family, the DON, and the NP of R76's fall. During further interview with RN2, on 10/04/2024 at 1:33 PM, she stated on 05/17/2024, R76 started exhibiting a change in mental status. RN2 stated R76 was lethargic and was speaking incoherently at times. She stated when R76's family arrived at 6:00 PM on 05/17/2024, they requested R76 be evaluated at the local hospital due to increased lethargy and elevated blood pressures during the day. She stated she called the provider, who gave the order for the transfer. During an interview with the DON, on 10/09/2024 at 3:01 PM, she stated she did not have a fall incident report related to R76's fall on 05/16/2024 and noted there was no Interdisciplinary Team (IDT) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	note related to the fall in the resident's chart. Furthermore, she stated she could not explain why the documents were not in R76's chart. The DON stated the nurse on duty followed the facility's protocol for neuro checks. Review of R76's hospital Patient Discharge Summary Report, dated 05/19/2024 at 10:12 AM, revealed she was diagnosed with a TIA and transferred back to the facility on [DATE]. There were no instructions related to activity or physical therapy. Review of R76's Behavior Note, dated 05/19/2024 at 3:13 PM, revealed the resident attempted to stand up from her wheelchair multiple times during outside activities, and the SRNA redirected R76 to remain seated. The note revealed R76 was very confused and expressed a desire to go inside. The SRNA then assisted R76 back into the building, but left her alone to care for another resident. Per the note, at 2:53 PM, R76 stood up, tripped, fell onto her right hip, and hit her head. Review of R76's Health Status Note, dated 05/19/2024 at 3:14 PM, revealed a SRNA alerted R76's nurse that R76 was observed to have fallen outside the Activity Room. The note stated the nurse observed the resident on the floor. According to the note, there was no visible injury; however, R76 complained of pain in her right hip and neck. R76 was transferred to the local hospital via EMS. Review of the Computed Tomography (CT) scan of the pelvis, dated 05/19/2024 at 4:58 PM, revealed R76 sustained a comminuted, angulated, and mildly impacted non-displaced intertrochanteric fracture of the right femoral neck. Further review revealed there was a comminuted non-displaced right inferior pubic ramus fracture. Review of R76's hospital Discharge Summary, dated 05/21/2024 at 3:40 PM, revealed R76 presented to the ED after experiencing an unwitnessed fall from a standing height, which resulted in severe right hip pain and altered mental status. Per the Summary, the resident suffered a traumatic right hip fracture, which caused significant pain. The resident's risk for general anesthesia and hip repair was high, and her wound healing ability was compromised due to poor overall and nutritional status. The Summary stated R76 had been independent in her Activities of Daily Living (ADLs) prior to the fall, and at her baseline, she ambulated with a walker. Continued review revealed R76's family elected to forego any surgical intervention on the advice of both the physician and surgeon given the resident's low probability of successful healing and a high probability of harm due to surgery. According to the Summary, the resident was discharged to home with hospice care. During continued interview with F3, on 10/04/2024 at 2:31 PM, she stated when R76 returned to the facility on [DATE], they requested the resident to rest in bed and refrain from participating in any activities. However, F3 stated staff assisted R76 out of bed into a wheelchair within hours of her return from the hospital and took her to an outdoor activity. F3 stated R76 was unfamiliar with using a wheelchair and had not been assessed by PT to use the wheelchair. F3 stated she received a call from a nurse who stated the resident had been taken to an activity outside, and R76 had fallen near the Activity Room while trying to get out of her wheelchair. F3 stated the resident sustained a fracture of the intertrochanteric portion of her hip. She further stated the family decided against surgical intervention due to R76 being a poor surgical candidate and her marked decline since the fall. During an interview with SRNA8/Activity Aide (AA), on 10/04/2024 at 3:02 PM, she stated before R76's fall and recent hospitalization on 05/17/2024, she had been a regular participant in activities and would typically use a walker to ambulate to the Activities' Room. SRNA8/AA stated, on 05/10/2024, staff brought R76 to a group activity where 10 to 15 residents were gathered outside in the (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

courtyard. During the activity, R76 appeared disengaged and attempted to get in and out of her wheelchair. She further stated, R76 appeared confused, with nonsensical speech, and was not at her usual baseline. SRNA8/AA stated, after the activities concluded, she wheeled R76 back inside the building to a location near the entrance of the Activities' Room and secured her wheelchair. She stated she then left R76 alone briefly to get another resident. Upon returning, SRNA8/AA stated she discovered R76 trying to stand up. She stated the foot pedals on the wheelchair were engaged, and as R76 stood, she tripped over them and fell, landing on her side.

During interview with the former DON, on 10/25/2024 at 12:01 PM, she stated R76 should not have been left unsupervised and alone in the wheelchair on 05/19/2024. She stated it was her expectation nursing staff followed the facility's Fall policy to prevent accidents and injuries and to keep residents safe.

During an interview with the former Administrator, on 10/25/2024 at 12:45 PM, he stated it was his expectation staff followed the facility's Fall policy to prevent accidents and injuries and to keep residents safe.

2. Review of R425's face sheet, located in the electronic health record (EHR) revealed the facility admitted him on 11/08/2024 with diagnoses of Congestive Heart Failure.

Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed R425 to have a Brief Interview for Mental Status (BIMS) score of nine out of 15, indicating moderate cognitive impairment.

Review of R425's Progress Notes dated 11/05/2024 at 12:59 PM, from his Personal Care medical record (where the resident resided prior to his transfer to the facility's skilled nursing on 11/08/2024) revealed he had sustained a fall on 11/05/2024.

Review of the facility's Baseline Care Plan developed 11/11/2024, for R425 revealed a problem for falls with interventions being added on that date.

Review of R425's Progress Notes dated 11/09/2024 at 11:08 AM, revealed the resident had a history of three or more falls in the past three months and a Fall Risk Score of 18.0, which indicated being at high risk for falls. Per review, R425's level of consciousness (LOC)/mental status was documented as intermittent confusion and his vision as adequate. Continued review revealed R425 was noted as being ambulatory; to require an assistive device; and as having a balance problem while standing. Further review revealed R425's systolic blood pressure was noted to have no drop between lying and standing. Recent hospitalization history in last 30 days.

Review of R425's Progress Notes dated 11/09/2024 at 6:23 PM, revealed the resident sustained another fall on this date and was sent to the hospital for further evaluation. Per review, report on the resident was received from the emergency room (ER) at 6:00 PM, regarding the resident's return to the facility. Continued review revealed the ER discharge summary received upon R425's return, the resident sustained a subdural hematoma which was unchanged by the scan completed, and an abrasion to his scalp.

Review of R425's Progress Notes dated 11/11/2024 at 6:13 PM, revealed the resident had experienced another fall. Continued review revealed R425 was sitting in the wheelchair in his room and was alert and oriented time three (x 3), to person, place, and time). Further review revealed R425's

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F 0689 Level of Harm - Actual harm Residents Affected - Few	neurological (neuro) checks were within normal limits and his respirations were even and unlabored. In addition, review further revealed R425 had no signs/symptoms of adverse reaction related to the fall. Review of R425's Fall Risk Evaluation dated 11/13/2024, revealed a score of eight, indicating he was not a high fall risk. Interview was attempted on 11/19/2024 at 8:30 AM, with R425 however, the resident was confused and unable to tell the State Survey Agency (SSA) Surveyor anything about his falls. During an interview on 11/21/2024 at 9:30 AM with Admissions Coordinator, she stated R425 had visited and toured facility prior to admission. She stated the resident was a falls risk, upon admission, and did not feel as though the resident was safely admitted from the Personal Care Home. During an interview on 11/21/2024 at 9:42 AM with the MDS nurse, she stated R425 should have been care planned for falls with interventions in place upon arrival to the skilled nursing facility for his safety. During an interview on 11/21/2024 at 9:59 AM with the Social Service Director (SSD), she stated it took a few weeks to move R425 to SNF because the facility was trying interventions to figure out if the change in environment was the cause of the resident's decline. She stated the resident had a noticeable decline from when he toured the facility to when he was admitted . In interview on 11/21/2024 at 9:42 AM, the MDS Nurse stated all nurses on the floor were responsible for completing baseline care plans when a resident was admitted . She stated the baseline care plan was important to implement/revise appropriately and timely so staff knew how to care for residents. The MDS Nurse further stated she could not find the original baseline care plan. During an interview with the Interim DON on 11/21/2024 at 10:45 AM, she stated it was her expectation that residents were assessed for falls so appropriate interventions were in place to keep residents safe. She stated further that it was her expectation staff followed the policies related to falls to prevent accidents and injuries and to keep residents safe. During an interview with Interim Administrator on 11/21/2024 at 10:50 AM, she stated it was her expectation that fall precautions were put into place to prevent any harm and for resident safety. She stated that it was her expectation staff followed facility policies to prevent accidents and injuries.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the Director of Nursing Services (DON) and Administrator's Job Descriptions, review of the facility's employee agreement for the Administrator, review of the Division of Epidemiology and Health Planning's (DEHP) Findings and Recommendations, and review of the facility's policies, the facility failed to ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for the total census of 74 residents. On 05/28/2024, Legionella pneumophila Serogroup 1 Strain (SG1) and Legionella pneumophila Serogroup 2 Strain (SG2-15) were identified at uncontrolled growth levels in the Unit 3 shower. Review of the Division of Epidemiology and Health Planning's (DEHP) Findings and Recommendations, dated 07/26/2024, revealed the DEHP recommended steps to prevent future outbreaks or occurrences of legionellosis. However, the facility's administration failed to review the findings and implement the DEHP's recommendations from 07/26/2024, as communicated by the Local Health Department (LHD), to prevent and control legionellosis. Test results reviewed through 09/18/2024 continued to show uncontrolled growth of legionella bacteria in other tested areas of the facility. Immediate Jeopardy (IJ) was identified on 10/11/2024 and was determined to exist on 08/05/2024, in the area of 42 CFR 483.70 Administration, F-835 at a Scope and Severity (S/S) of an L. The facility was notified of the IJ on 10/11/2024. The facility provided an acceptable IJ Removal Plan, on 10/22/2024, alleging removal of the IJ on 10/22/2024. The State Survey Agency (SSA) determined the IJ had been removed on 10/22/2024, prior to exit on 11/22/2024, with remaining non-compliance at a S/S of an F while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. Refer to F837, F867, and F880 The findings include: Review of the facility's Job Description for Administrator, dated 10/03/2022, revealed the Administrator directed the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that governed nursing facilities to assure the highest degree of quality care could be provided to residents at all times. Further review revealed the Administrator's Scope of Duties included: the purchase of all commodities, supplies, and services required to operate the facility; the evaluation of the need for all new equipment; the maintenance of proper records of all transactions; overseeing and managing the maintenance of all the building and grounds that comprised the facility; ensuring the residents of the facility received quality care; and ensuring effective and timely communications with residents and their families. Review of the Facility Administrator Employment Agreement, dated 10/03/2022, revealed the Administrator was responsible for the day-to-day operations of the facility, including ensuring compliance with all federal, state, and local laws and regulations governing long-term care, ensuring residents received quality care, and overseeing and managing building maintenance. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's Job Description for Director of Nursing Services, undated, revealed the DON planned, organized, developed, and directed the overall operation of the facility's nursing department in accordance with current federal, state, and local standards, guidelines, and the established policies and procedures that governed the facility to ensure the highest degree of quality care was maintained at all times. Per the Job Description, the DON's essential functions included: to participate in the developing and implementation of resident care; to direct and assure that quality assurance developed and implemented appropriate plans of action to correct identified deficiencies; and to serve on, participate in, and attend committees of the facility to include quality assurance and infection control. Review of the facility's policy titled, Infection Prevention and Control Program (IPCP), undated, revealed its purpose was to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Review of the facility's policy titled, Legionella Water Management Plan, undated, revealed the facility would promote proactive steps to establish a healthy environment for residents, staff, and visitors. According to the water management plan (WMP), contraction of Legionnaires' Disease (LD) was often the result of exposure to inadequately managed building water systems, which could be prevented. In addition, the facility stated its mission was to properly manage its water system to prevent exposure to LD. Review of the microbiology analysis report, performed by a third party independent water service company (IWSC) to test for legionella, dated 05/28/2024, revealed the sample result from the Unit 3 shower showed a positive result for Legionella pneumophila Serogroup 1 Strain (SG1) at 11.0 colony-forming units per milliliter (CFU/ml) with a detection limit of 0.1 CFU/ml, indicating uncontrolled growth. Additionally, the report for the Unit 3 shower showed Legionella pneumophila Serogroup 2 Strain (SG2-15) at 11.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating uncontrolled growth. Review of other microbiology analysis reports, performed by the IWSC to test for legionella, showed uncontrolled growth on 1) 06/14/2024, the sample result from the Unit 2 shower showed legionella non-pneumophila at 2.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth; 2) 08/07/2024, the sample result from room [ROOM NUMBER] showed a positive result for legionella pneumophila SG1 at 2.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth and legionella non-pneumophila at 3.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth; 3) 08/29/2024, the sample result from room [ROOM NUMBER] showed a positive result for legionella pneumophila SG1 at 3.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth and legionella non-pneumophila at 3.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth; the sample result for the Unit 2 shower showed legionella non-pneumophila at 1.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth; 4) 09/04/2024, the sample result from the Unit 2 shower showed legionella non-pneumophila at 1.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth; 5) 09/13/2024, the sample result from room [ROOM NUMBER] showed a positive result for legionella pneumophila SG1 at 1.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth; and 6) 09/18/2024, the sample result from room [ROOM NUMBER] showed a positive result for legionella pneumophila SG1 at 2.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth and legionella non-pneumophila at 1.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Review of the Division of Epidemiology and Health Planning's (DEHP) Findings and Recommendations, (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	dated 07/26/2024, revealed several concerns identified by the state's Legionella Team and the Regional Epidemiologist. These concerns included: 1) the facility failed to document all the necessary elements of a proper WMP as evidenced by the facility's unacceptable score on the WMP assessment of one out of nine (acceptable score was eight or higher); 2) water sampling had been insufficient to evaluate the growth reservoir in the building's water system; and 3) there were no documented logs to confirm the flushing procedures. Further review of the DEHP's Findings and Recommendations, dated 07/26/2024, revealed the DEHP recommended steps to prevent future outbreaks or occurrences of legionellosis. These steps included: 1) remind healthcare providers to include legionellosis in their differential diagnoses; 2) continue enhanced surveillance for new cases of legionellosis and review resident charts daily for potential radiographs, lab tests, or diagnoses related to possible or atypical pneumonia; 3) complete the Water Infection Control Risk Assessment (WICRA) before developing a WMP; 4) create a WMP that incorporated recommendations from the Centers for Disease Control and Prevention (CDC); 5) validate the plumbing diagram with greater detail according to CDC guidelines and document the recirculation system; 6) ensure all water management team (WMT) members completed the CDC Prevent LD training module; 7) the third-party contractor should familiarize themselves with legionella sampling protocols by completing the CDC's Prevent LD training module; and 8) submit sampling plans to the LHD before conducting any additional sampling. Review of an email from the Director of the LHD, dated 08/05/2024, to the Infection Preventionist (IP), DON, and Administrator, revealed a document titled, [Facility Name] Preliminary Report was attached in the email. The message from the Director read, Please see attached preliminary report with findings and recommendations. Attached were the DEHP's Findings and Recommendations, dated 07/26/2024. Review of a letter dated 08/20/2024, addressed to facility providers from the IP, indicated the facility's water system had shown detectable levels of legionella. The letter recommended facility providers obtain a urine antigen test for legionella, along with a chest radiograph, whenever a suspected case of pneumonia or pneumonia-like illness was identified. Although the IP received the email from the LHD on 08/05/2024 which contained the DEHP findings and recommendations, the IP did not send the letter to the providers until 08/20/2024, 15 days later. During an interview with the IP, on 10/25/2024 at 12:15 PM, she stated she received the email sent on 08/05/2024 from the LHD, which contained the DEHP findings and recommendations in the attachment at the top of the email. She stated the Administrator and the DON were also copied on this email. The IP stated the attachment at the top of the email contained the DEHP document. She further stated, following the receipt of the email, she, along with the DON and the Administrator, discussed the DEHP's preliminary findings and recommendations. Furthermore, she stated, based on those recommendations, she sent a letter to the providers on 08/20/2024, which was approved by both the DON and the Administrator. During an interview with the Interim DON, on 10/08/2024 at 9:21 AM, she stated her role was to direct and implement all aspects of nursing care. The DON stated she was a member of the Quality Assurance and Performance Improvement (QAPI) Committee, which met every month to discuss issues concerning the quality of care in the facility. She stated the QAPI Committee had discussed the ongoing levels of legionella bacteria in the water. She further stated the committee decided to reopen the showers in Unit 1 and Unit 3 for all residents on 10/04/2024. Prior to this decision, she stated all showers had been closed for over a month, and residents received bed baths. The DON stated she was aware of (continued on next page)

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F 0835

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

the recommendations from the DEHP; however, she stated the IP was responsible for implementing all infection control and health department guidelines.

In further interview with the Interim DON, on 10/08/2024 at 9:21 AM, she stated the IP was tasked with sending out a letter to providers, informing them of the DEHP's recommendations for enhanced surveillance of LD. Furthermore, the DON stated the IP conducted daily chart reviews, although there had only been three residents with a possible diagnosis of pneumonia. She stated per the DEHP's recommendations, any resident exhibiting symptoms related to pneumonia was required to undergo a chest radiograph and a urine antigen test to rule out LD. She further stated while the IP monitored healthcare-associated infections (HAI), it was not documented on a spreadsheet. The DON further stated she did not keep track of documentation for enhanced surveillance of possible new legionella cases. In further interview, the DON stated the facility had not yet completed and submitted the Water Infection Control Risk Assessment (WICRA) form to the LHD. She stated it was the responsibility of the IP, but the committee was waiting for the Certified Legionella Water Safety Expert (CLWSE) to write the Water Management Plan (WMP).

During an additional interview with the Interim DON, on 10/09/2024 at 10:40 AM, she stated the facility had yet to follow up on the DEHP's recommendations because they were waiting for the CLWSE to write the WMP. She stated during an online meeting with the LHD and the State Department of Public Health (KDPH), the CLWSE indicated he knew how to write a WMP and would do this for the facility. The DON stated she took that to mean he would write the WMP and follow-up on the DEHP recommendations. When the DON was questioned whether the CLWSE had a contractual relationship with the facility, the DON replied, No.

During an additional interview with the Interim DON, on 10/25/2024 at 12:01 PM, she stated the facility did not begin to implement the DEHP's recommendations upon receipt of the email on 08/05/2024. The DON stated she was unaware of the DEHP's preliminary findings until the State Survey Agency (SSA) Representative brought the recommendations to her attention. The DON stated following her conversation with the SSA Representative, she asked the IP about the recommendations. The DON stated the IP informed her the recommendations were included as an attachment in an email sent on 08/05/2024 from the LHD. The DON stated she then checked her email and found the email, but noted the attachment was hidden within it. She stated when she first opened the email, she did not realize it contained any document from the DEHP. The DON further stated it was the responsibility of the IP to have communicated the receipt of the recommendations to her and the Administrator.

During an interview with the Administrator, on 10/03/2024 at 10:50 AM, he stated his role was to take care of the building for all departments, to make sure residents were taken care of, and to make sure their rights were upheld.

During an additional interview with the Administrator on 10/04/2024 at 2:32 PM, he stated the facility had collaborated closely with the LHD and the KDPH to develop a WMP. The Administrator stated the KDPH's Environmental and Occupational Countermeasures Program Manager (EOCPM) recommended the facility seek out a certified water safety and management expert (CLWSE) to address the building's contaminated water lines. He stated the independent water service company (IWSC) was responsible for finding the expert. The Administrator stated the CLWSE conducted an onsite visit in September 2024 and the Ad Hoc QAPI Committee was scheduled to meet to discuss the CLWSE's recommendations sent on 10/02/2024. When asked if the facility had an acceptable WMP, the Administrator stated the facility's WMT consisting of the Administrator, DON, IP, Director of Maintenance (DOM), Housekeeping Director (HSKD), Dietary Manager (DM), and Quality Assurance (QA) Nurse participated in a meeting with the LHD,

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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 11/22/2024
NAME OF PROVIDER OR SUPPLIER Bourbon Heights Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 South Main Street Paris, KY 40361	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	KDPH, IWSC, and the CLWSE to discuss continued positive legionella results. During that meeting, the Administrator stated the CLWSE told the group, I can write the plan. However, according to the Administrator, the facility had not yet established a contractual relationship with the CLWSE to develop a comprehensive WMP. The Administrator stated he was under the assumption the CLWSE was working Pro bono to help the facility. The Administrator stated he did not enter into a contractual agreement with the CLWSE until 10/04/2024, when he signed an agreement for the CLWSE to provide a WMP for the facility. During an additional interview with the Administrator, on 10/25/2024 at 12:45 PM, he stated he was not aware the 08/05/2024 email from the LHD contained an attachment with the DEHP's preliminary findings and recommendations until the SSA Representative brought the recommendations to his attention. He further stated it was the responsibility of the IP to have communicated the receipt of the email containing the attachment with the DEHP's recommendations to him.

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 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bourbon Heights Nursing Home	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)

F 0837

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on interview, record review, review of the Division of Epidemiology and Health Planning's (DEHP) Findings and Recommendations, review of the facility's Bylaws, and review of the facility's policies, it was determined the facility's Governing Body failed to ensure the facility's policies were implemented regarding the management and operation of the facility for the total census of 74 residents.

On 04/04/2024, Immediate Jeopardy (IJ) was identified in the area of F880 (Infection Control) during an Abbreviated Partial Extended Survey with an exit date of 04/05/2024. The facility submitted a Plan of Correction (POC) for deficiencies, cited on 04/05/2024, alleging substantial compliance on 05/20/2024. However, during the Recertification/Abbreviated Survey concluded on 11/22/2024, it was determined the facility failed to maintain substantial compliance. The facility failed to implement their plan of correction as described in the documents issued to the State Survey Agency, which included to follow the direction of the Local Health Department (LHD).

Legionella pneumophila SG1 and Legionella pneumophila SG2-15 were identified at uncontrolled growth levels in the Unit 3 shower on 05/28/2024. Review of the state's Division of Epidemiology and Health Planning's (DEHP) Findings and Recommendations, dated 07/26/2024, revealed DEHP made recommendations to mitigate outbreaks of occurrences of legionellosis. On 08/05/2024, the Infection Preventionist (IP) received an email from the Local Health Department (LHD), which communicated the DEHP's recommendation to mitigate the outbreak of LD. However, the facility's Governing Body failed to provide effective oversight to ensure the facility's Administration implemented recommendations from the state's DEHP recommendations as communicated by the Local Health Department (LHD), to prevent and control legionellosis.

IJ was identified on 10/11/2024 and was determined to exist on 08/05/2024, in the area of 42 CFR 483.70 Administration, F-837 at a Scope and Severity (S/S) of an L. The facility was notified of the IJ on 10/11/2024.

The facility provided an acceptable IJ Removal Plan, on 10/22/2024, alleging removal of the IJ on 10/22/2024. The State Survey Agency (SSA) determined the IJ had been removed on 10/22/2024, prior to exit on 11/22/2024, with remaining non-compliance at a S/S of an F while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes.

Refer to F835, F867, F880

The findings include:

Review of the facility's Amended and Restated Bylaws ., dated 06/2007, revealed the Board of Directors (BOD)/(Governing Body) managed the facility to include dealing with issues brought to them by the Administrator.

Review of the facility's policy titled, Quality Assessment and Assurance and Quality Assessment and Performance Improvement, undated, revealed the Governing Body was responsible and accountable for ensuring that an ongoing quality assurance and performance improvement program was defined,

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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	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	implemented, maintained, and addressed identified priorities. Review of the facility's policy titled, Infection Prevention and Control Program (IPCP), undated, revealed its purpose was to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Furthermore, the IPCP provided a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, and visitors. Review of the facility's policy titled, Legionella Water Management Plan, undated, revealed the facility would promote proactive steps to establish a healthy environment for residents, staff, and visitors. According to the Water Management Plan (WMP), contraction of Legionnaire's Disease (LD) was often the result of exposure to inadequately managed building water systems, which could be prevented. The facility's mission was to properly manage its water system to prevent exposure to LD. Review of the facility's POC for deficiencies cited during the Abbreviated Partial Extended Survey with an exit date of 04/05/2024 and compliance date of 05/20/2024, revealed the facility alleged the following was implemented: Education was provided to the IP by the DON to follow the direction of the health department and state personnel related to infection control procedures. Further review revealed the QAPI committee worked with the local health department and state infection prevention team to develop a water maintenance plan and ensure the facilities water maintenance policy was being followed. Continued review of the PoC revealed the QAPI committee assessed and modified the action plan as needed to ensure continued compliance. Review of the microbiology analysis report, performed by a third party independent water system company (IWSC) to test for legionella, dated 05/28/2024, revealed the sample result from the facility's Unit 3 shower, showed a positive result for Legionella pneumophila Serogroup 1 Strain (SG1). Per review the positive result was at 11.0 colony-forming unit per milliliter (CFU/ml) with a detection limit of 0.1 CFU/ml, indicating uncontrolled growth. Continued review of the report for the Unit 3 shower showed Legionella pneumophila Serogroup 2 Strain (SG2-15) at 11.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating uncontrolled growth. Review of the microbiology analysis reports, performed by the IWSC to test for detectable levels of legionella on 06/14/2024, 08/07/2024, 08/29/2024, 09/04/2024, 09/13/2024, and 09/18/2024, revealed continued detectable levels of legionella. (Refer to F880) Review of the Division of Epidemiology and Health Planning's (DEHP) Findings and Recommendations, dated 07/26/2024, revealed several concerns identified by the state's Legionella Team and the Regional Epidemiologist. These concerns included: 1) the facility failed to document all the necessary elements of a proper WMP as evidenced by the facility's unacceptable score on the WMP assessment of one (1) out of nine (9) (acceptable score was eight or higher); 2) water sampling had been insufficient to evaluate the growth reservoir in the building's water system; and 3) there were no documented logs to confirm the flushing procedures. Review of the DEHP Findings and Recommendations, dated 07/26/2024, revealed recommendations to mitigate outbreaks or occurrences of legionellosis. Recommendations included: 1) remind healthcare providers to include legionellosis in their differential diagnoses; 2) continue enhanced surveillance for new cases of legionellosis and review resident charts daily for potential radiographs, lab tests, or diagnoses related to possible or atypical pneumonia; 3) complete the Water Infection Control Risk Assessment (WICRA) before developing a WMP; 4) create a WMP that incorporated recommendations from (continued on next page)

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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	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0837

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

the Centers for Disease Control and Prevention (CDC); 5) validate the plumbing diagram with greater detail according to CDC guidelines and document the recirculation system; 6) ensure all water management team (WMT) members completed the CDC Prevent LD training module; 7) the third-party contractor should familiarize themselves with legionella sampling protocols by completing the CDC's Prevent LD training module; and 8) submit sampling plans to the LHD before conducting any additional sampling. However, the facility's Governing Body failed to ensure the facility followed the DEHP's recommendations.

Review of an email from the Director of the LHD, dated 08/05/2024, to the Infection Preventionist (IP), Director of Nursing (DON), and Administrator, revealed the document titled, [Facility Name] Preliminary Report was attached in the email. The message from the Director stated, Please see attached preliminary report with findings and recommendations.

In an interview with the IP, on 10/25/2024 at 12:15 PM, she stated she received the email sent on 08/05/2024 from the LHD, which contained the DEHP findings and recommendations in the attachment at the top of the email. She stated the DON and the Administrator were also copied on this email. The IP stated the attachment at the top portion of the email contained the DEHP document. She further stated, following receipt of the email, she, along with the DON and the Administrator, discussed the DEHP's preliminary findings and recommendations. Additionally, she stated, based on those recommendations, she sent a letter to the providers on 08/20/2024, which was approved by both the DON and the Administrator.

Review of a letter dated 08/20/2024, addressed to facility providers from the IP, revealed the facility's water system had shown detectable levels of legionella. The letter recommended facility providers obtain a urine antigen test for legionella, along with a chest radiograph, whenever there was a suspected case of pneumonia or pneumonia-like illness was identified.

Review of a Memorandum, dated 10/18/2024, authored by the Certified Legionella Water Safety Expert (CLWSE), revealed the CLWSE trained all seven (7) Board Directors on: 1) the findings and recommendations from the DEHP dated 07/26/2024; 2) the importance of ensuring the administration under the BOD's oversight complied with the recommendations from the DEHP and the LHD to prevent further legionellosis outbreaks; and 3) the deficiencies specifically directed at the facility's administration and the BOD, highlighting the failure to implement timely water management infection control measures.

During an interview with Family Member (F)1, on 10/03/2024 at 10:32 AM, he stated there had been ongoing water contamination at the facility for at least four weeks. However, he stated he was not notified of the water situation and only found out after asking the Administrator about it directly. F1 stated showers were not available, and the Administrator told him the LHD and the State Department for Public Health (KDPH) had been discussing when the facility could resume shower usage. He stated the Administrator told him legionella bacteria was detected in Unit 2's shower during a test. He further stated the Administrator told him the issue of whether there was a risk to residents if they used the shower on the second floor had been under discussion. In further interview, F1 stated the Administrator told him neither the LHD nor the KDPH had provided the facility with a clear answer on whether to open the showers. F1 further stated he purchased water for his resident family member so she had clean water to wash her hands and face and to brush her teeth, as the facility only provided water for drinking.

During a telephone interview with the Director of the LHD, on 10/03/2024 at 10:42 AM, she stated the facility had been dealing with contaminated water since November 2023. She stated the facility had

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bourbon Heights Nursing Home	2000 South Main Street Paris, KY 40361

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0837

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

been working closely with the LHD and the KDPH. In further interview the Director of the LHD, stated the facility hired an independent water service company (IWSC) that had conducted weekly water tests. After conducting ongoing tests of four shower heads and random room sink faucets since the State Survey Agency's (SSA's) last inspection in April 2024, reports had shown varying results regarding the presence of legionella contaminants. She stated in response, the KDPH's Environmental and Occupational Countermeasures Program Manager (EOCPM) recommended the facility enlist the resources of a Certified Legionella Water Safety Expert (CLWSE) to address the facility's ongoing contamination issues. According to the Director of the LHD, in September 2024, a third-party Certified Legionella Water Safety Expert (CLWSE) was consulted to do an onsite building assessment.

During an interview with the KDPH's EOCPM, on 10/04/2024 at 3:13 PM, she stated in April 2024, she recommended the facility hire a qualified water safety management expert. However, the EOCPM stated the facility did not consult with a CLWSE until September 2024. Additionally, she stated she had neither contributed to nor approved the facility's WMP, and to date, had yet to see any updates to it. She stated during her conversations with the Administrator, she told him the facility's current water sampling practices were inadequate. She further stated the facility's independent water service company (IWSC) needed to conduct comprehensive testing, which should include 25 to 50 samples from all water sources within the building. She stated this approach would involve much more than the current limited testing conducted on showers and a few rooms.

During a telephone interview with the CLWSE, on 10/04/2024 at 2:42 PM, he stated the IWSC had consulted with him to diagnose and evaluate the facility's water system, WMP, current control measures, and to determine if the facility needed additional control measures or a supplemental disinfection system. He stated he assessed the building and its water system in September 2024 and reviewed the remediation efforts that had been carried out since legionella was discovered in February 2024. He further stated the IWSC performed weekly legionella testing, and it was his understanding the facility tested random water temperatures and flushed the water system. Additionally, he stated the facility had installed [NAME] filters on three ice machines and all four shower heads. However, he stated per his assessment, the facility had no other control measures in place. The CLWSE stated the facility must conduct a more comprehensive sampling for legionella testing to maintain ongoing protection. He further stated it was important to keep using the showers and faucets, as stagnant water and warmer temperatures could encourage the growth of legionella bacteria.

During continued telephone interview with the CLWSE, on 10/04/2024 at 2:42 PM, he stated he assessed the risk as acceptable, and even though there was no scientific reason against using showers based on the recent test results, They still chose not to use showers. He stated he had discussed the possibility of temporary showers, but the facility opted not to implement that solution. In addition, he stated the facility did not develop a decision-making tree to provide clear instructions on the actions to take based on testing parameters. The CLWSE stated since September 2024, he had repeatedly informed the facility that while he provided recommendations based on industry standards and best practices, it was ultimately their responsibility to assess, implement, and manage the risks associated with legionella. However, he stated he thought the facility wanted a third party to assume the risk and tell them what to do. Furthermore, the CLWSE stated he noted concerns during his assessment of the facility, specifically the lack of documentation for a flushing plan and inadequate sampling for a building of that size. He pointed out they sampled the same areas repeatedly, but the sampling needed to be more comprehensive. He further stated a well-developed plan was crucial to prevent stagnation in the water system, which was a leading cause of bacterial growth.

During an additional telephone interview, with the CLWSE, on 10/09/2024 at 9:38 AM, he stated he

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bourbon Heights Nursing Home	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)
F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	did not have a contractual relationship with the facility in early September 2024. He stated he provided an estimate for his services to the IWSC on 10/04/2024, and was contracted to develop a water management plan for the facility. During a telephone interview with Board Director (BD)1, on 10/10/2024 at 4:33 PM, he stated it was his understanding there had been a legionella outbreak earlier in 2024, and the problem with contaminated water had been an ongoing issue. BD1 stated the last Board of Directors (BOD) meeting occurred on 09/26/2024, and the agenda included a discussion about the facility's ongoing issues with contaminated water. He further stated the Administrator was in regular communication with the LHD to ensure problem-solving efforts were progressing and to find solutions and steps for remediation to guarantee the water was safe. Additionally, BD1 stated his overall impression was that it was a challenging situation. However, BD1 stated he believed the Administrator was collaborating with all parties involved and working toward a consensus. Per the interview, BD1 was not aware of the specific information concerning the DEHP's recommendations and actions the facility had taken to put the recommendations in place. During an additional telephone interview with BD1, on 10/24/2024 at 10:48 AM, he stated the CLWSE provided him with legionella education through an online training meeting. During this meeting, he stated the CLWSE discussed the findings and recommendations from the DEHP dated 07/26/2024. According to BD1, the training provided was the first time he had learned about the DEHP's recommendations, and he was unaware the facility had not acted on them promptly. He stated the CLWSE highlighted the importance of ensuring the administration, under the oversight of the BOD, complied with the DEHP and LHD recommendations to prevent future legionellosis outbreaks. Additionally, he stated the CLWSE reviewed the current deficiencies concerning the facility's administration and the BOD's failure to implement timely water management infection control measures. During a telephone interview with the Chairman of the BOD (CBOD), on 10/10/2024 at 4:43 PM, she stated the Administrator had communicated regularly regarding positive legionella test results. The CBOD stated the last BOD meeting occurred on 09/26/2024, and the agenda included a discussion about the facility's ongoing issues with contaminated water. She stated the BOD did not partake in the day-to-day management of the facility. However, she stated she believed the Administrator had managed the situation correctly. She further stated the facility was in continual contact with the local and state health departments for guidance and were waiting for their recommendations. During an additional interview with the CBOD, on 10/24/2024 at 10:20 AM, she stated she was provided education by the CLWSE via an online meeting regarding the facility's continued issues with legionella bacteria in the water system, the approved WMP, and steps for more comprehensive testing in the future. She stated the CLWSE updated the BOD on water sampling and testing. According to the CBOD, moving forward, it was her expectation the Administrator update the BOD frequently on the status of the WMP and Quality Assurance and Performance Improvement (QAPI) activities. During a telephone interview with BD4, on 10/24/2024 at 10:55 AM, he stated the BOD was aware of the situation regarding legionella bacteria in the facility's water system. However, he stated they were not fully aware of the severity of the problem. He stated the Administrator communicated with the board on a monthly basis and by text messages. Additionally, he stated at a recent board meeting, directors discussed several options for addressing the legionella issue and explored corrective actions and ongoing solutions. He stated he was not aware of the DEHP's preliminary findings and recommendations until he received training from the CLWSE. BD4 stated, according to legal counsel, the BOD was responsible for overseeing the Administrator, while the Administrator was responsible for the (continued on next page)

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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	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	day-to-day running of the facility. During a telephone interview with BD6, on 10/24/2024 at 11:45 AM, he stated the BOD was aware of the situation regarding legionella bacteria in the facility's water system. He stated he received legionella training from the CLWSE, which the facility hired to consult on the WMP. He further stated the CLWSE provided him with legionella education through an online training session. During this training, he stated the CLWSE discussed the findings and recommendations from the DEHP dated 07/26/2024. BD6 stated the Administrator explained to him the LHD sent an email with the DEHP's recommendations in an attachment sometime in August 2024. According to BD6, the Administrator told him he never received the email. In continued interview, on 10/24/2024 at 11:45 AM, BD6 stated he was concerned the Administrator did not receive the email from the DEHP, and he felt the facility should not be penalized for lack of action, primarily since the DEHP did not ensure their recommendations were sent in a reliable manner to guarantee receipt of the document. Additionally, BD6 stated, at a recent board meeting, the directors discussed several options for addressing the legionella issue and explored corrective actions and ongoing solutions. He stated he was aware the showers were not in use, a decision made by the Administrator for the safety of the residents. Furthermore, BD6 stated he believed the BOD and the facility's administration always did their best to ensure the safety and well-being of the residents. During a telephone interview with BD3, on 11/14/2024 at 4:25 PM, she stated she was made aware of legionella contamination in the facility's water the beginning of 2024. She stated the Administrator discussed water testing results during board meetings and he assured her and other board directors that the facility was doing everything the LHD recommended. She stated she was aware the showers were not in use for a time based on the water testing results. BD3 stated the Administrator had closed the showers for the safety of the residents. She further stated she learned of the Administrator's failure to follow the LHD recommendations after receiving the citation from the State Survey Agency (SSA). BD3 stated the Administrator told her he never received the email from the LHD with recommendations in August 2024. During a telephone interview with BD2, on 11/15/2024 at 10:30 AM, she stated she became aware of the legionella bacteria in the water while attending a recent board meeting. She stated the Administrator assured the BOD that the facility was following LHD recommendations. However, she stated she was only made aware of the seriousness of the situation regarding the facility's water system after the facility received the citation from the SSA. The BD2 stated the Administrator explained to the BOD that he never received the email with recommendations from the LHD in August 2024. During an interview with the Administrator, on 10/25/2024 at 12:45 PM, he stated he was not aware the 08/05/2024 email from the LHD contained an attachment with the DEHP's preliminary findings and recommendations until the State Survey Agency (SSA) Representative brought the recommendations to his attention. He stated, The e-mail came but I didn't look at it [attachment]. The Administrator stated the IP was tasked with calling the LHD regarding the status of the DEHP's report. He further stated it was the IP's responsibility to have communicated the receipt of the recommendations to him. The Administrator further stated it was his expectation the facility follow the facility's Infection Prevention and Control Program, policies to prevent the spread of infectious disease and to keep residents, staff, and visitors safe.

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 11/22/2024
NAME OF PROVIDER OR SUPPLIER Bourbon Heights Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 South Main Street Paris, KY 40361	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility documentation and it 2024 Facility Assessment, it was determined the facility failed to conduct and document a facility-wide assessment to determine the necessary resources for addressing the the ongoing legionella bacterial contamination in the facility's water system. Additionally, the facility failed to address the volume of agency staffing in its assessment to evaluate its resident population and identify resources essential for provision of the necessary care and services of those residents during day-to-day operations and emergencies. Refer to F880 and F726 The findings include: Review of the facility document titled, Facility Assessment Tool: [Facility Name], Inc., dated 06/01/2024, revealed under the Infection Control Risk Assessment section a requirement for a discussion on how the facility evaluated the effectiveness of its infection prevention and control program in identifying, reporting, investigating, and controlling infections and communicable diseases according to accepted national standards. However, continued review of the Infection Control Risk Assessment section revealed it had not been completed, and the facility's leadership failed to address or include legionella under that section of the Assessment when the legionella was first discovered in its water system in January 2024. Continued review of the facility's document titled, Facility Assessment [Facility Name], revealed the facility failed to update its Assessment to reflect the ongoing issues with legionella water contamination. Per review of the Additional Information section of the Assessment, the facility diminished the extent of legionella contamination in its water system, noting the contamination was only at traceable levels. (However, review of the testing documentation confirmed there was poorly controlled and uncontrolled levels of legionella bacteria found throughout the building). Further review of the Assessment revealed the facility noted it was following a Water Management Plan (WMP), (However, the facility's WMP had been determined as insufficient in the State's Division of Epidemiology and Health Planning's (DEHP) recommendations dated 07/26/2024, and communicated by the Local Health Department (LHD) to the facility on [DATE]). Additionally, review of the Assessment revealed the facility noted, The efforts to maintain legionella is ongoing and a collaborative approach with facility staff, contractors, [and the] state and local health department. Review of the DEHP recommendations dated 07/26/2024, revealed the recommendations included the facility needing to continue enhanced surveillance for new cases of legionellosis; to require an on-site water treatment consultant; complete the Water Infection Control Risk Assessment (WICRA); and complete a WMP, which incorporated the Centers for Disease Control and Prevention's (CDC) recommendations with a detailed plumbing diagram. In addition, the recommendations included the requirement for the facility to complete the CDC's course titled, Prevent Legionnaires' Disease, and follow accepted environmental sample protocols. During interview with the Director of Maintenance (DOM) on 11/20/2024 at 10:45 AM, he stated he was not familiar with the facility's Assessment or requirements. (continued on next page)

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Bourbon Heights Nursing Home	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)

F 0838

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

During interview with the Infection Preventionist (IP) on 11/21/2024 at 10:10 AM, she stated she was familiar with the facility's Assessment. She stated however, she was not involved in the process of determining its composition regarding infection control and prevention or the Infection Control Risk Assessment.

During interview with the Interim Director of Nursing (DON) on 11/21/2024 at 3:45 PM, she stated she did not know why the former administration had not completed the Facility Assessment as required. She further stated in her review of the facility and its operations to date had revealed that there were no systems in place to ensure proper administration of the facility.

During interview with the Interim Administrator on 11/22/2024 at 2:02 PM, she stated she did not know why the former administration had not completed the Facility Assessment as required. She stated the Infection Control Risk Assessment section should have been completed to describe the facility's current infection control risks, to include the ongoing legionella bacterial contamination in the facility's water system. The Interim Administrator further emphasized the need for a comprehensive assessment of the facility to adequately address the needs of the resident population and ensure the necessary resources for providing care and services.

2. Review of the facility's document titled, Facility Assessment Tool: [Facility Name] Inc dated 06/01/2024, revealed no documented evidence of an accounting for agency staffing located in the Assessment. Per review of the Assessment, it only addressed staff positions such as Registered Nurse (RN), Licensed Practical Nurse (LPN), and State Registered Nurse Aides (SRNA's)are direct care providers.

Review of the facility's staffing sheets for the week of 11/18/2024 to 11/22/2024, revealed agency staffing personnel comprised 68% of the 24-hour staffing assignments for the facility.

During interview on 11/20/2024 at 8:54 AM, Registered Nurse (RN) 4 stated the continuity of care for residents was not being addressed by the facility. She reported some of the agency SRNAs were not properly trained and the facility did not provide training for the agency staff before they started working on the floor.

During interview on 11/20/2024 at 10:18 AM, the Schedule Coordinator (SC) stated agency staff received onboarding and orientation training from their staffing agencies before starting to work on the floor at the facility. She stated having agency staff made it harder because agency might not know the residents as well as staff employed by the facility. The SC reported a staff member called out (not reporting for work) that morning and she was able to fill the position with another in-house staff person. She further stated having in-house staff made a difference with residents and continuity of care.

In interview on 11/22/2024 at 9:39 AM, LPN3 stated she was an agency nurse and had worked at the facility for a month. She stated she and the nurse got report from the previous shift nurses every morning on their residents. LPN3 stated the nurse aides who worked on the unit were mostly agency, but because they had been working here for a long time, she felt like they knew the residents. She reported she had received no education or training when she started at the facility. The LPN said she had not received any competency assessments from the facility since she started working there. She stated the staffing agency made sure we have all of our training up to date. Per LPN3 in interview, she had not worked at the facility long enough to know if they provided check offs or had any competency training.

(continued on next page)

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 11/22/2024
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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In interview on 11/22/2024 at 12:43 PM, Resident (R)25 stated agency staff did not know him or his preferences. He stated especially at night and on weekends agency staff had to be told what to do. R25 reported, They don't know nothin, I have to tell them everything to do. He further stated he had to tell a nurse aide everything he needed. In interview on 11/22/2024 at 1:15 PM, RN7 (an agency nurse) stated she had not received any training from the facility when she started. She stated there were a lot of new aides and it was hard to know if they were doing their job. The RN reported her agency required her to do online education. She further stated the facility had not provided any skills check off or testing. In interview on 11/22/2024 at 1:29 PM, State Registered Nurse Aide (SRNA) 16/Kentucky Medication Aide (KMA) 5 stated we have a few agency SRNA's who knew the residents; however, there were some SRNA's she did not know how they ever got their license. She reported there was no continuity of care, and they used to have education on every payday, but since the former DON came we got nothing. In interview on 11/21/2024 at 1:19 PM, the Interim DON stated there was a huge problem with the stand point of using staffing from an agency. She said she and the Interim Administrator figured the staffing was at 4.25 PPD which for the acuity level of the residents currently in the facility was high. The Interim DON stated We have a lot of agency staff currently. She reported she looked at the staffing ratio for the last two days and review revealed 68% of the staffing for the facility was agency filled. Per the Interim DON in interview, she and the Interim Administrator had presented their concerns to the facility's board of directors as recently as 11/20/2024. She further stated with all the agency staff currently, there could not be continuity of care for the residents. The Interim DON additionally stated residents needed to know who was going to be taking care of them.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of the facility's plan of correction from the 04/05/2024 survey, and review of the facility's policy, the facility failed to maintain an effective Quality Assurance Performance Improvement (QAPI) Program that developed and implemented appropriate plans of action to correct quality deficiencies. Quality deficiencies were evidenced by the facility's failure to establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment and to help prevent and control the development and transmission of communicable diseases. The facility was cited for infection control related to legionellosis and their water management system during the 04/05/2024 survey, and the facility submitted a plan of correction to address the deficiency. However, the facility failed to follow the plan of correction to complete a Water Infection Control Risk Assessment (WICRA) and develop a Water Management Plan (WMP). On 05/28/2024, Legionella pneumophila SG1 (the most serious and most likely to cause Legionnaires' disease in people who are exposed to it) and Legionella pneumophila SG2-15 (less dangerous forms of Legionella bacteria compared to serogroup 1) were identified at uncontrolled growth levels in the Unit 3 shower. Therefore, the facility stopped allowing showers for all residents. The facility received recommendations from the Division of Epidemiology and Health Planning's (DEHP) on 08/05/2024; however, the facility did not implement the recommendations to mitigate the spread of legionellosis. Immediate Jeopardy (IJ) was identified on 10/11/2024 and was determined to exist on 08/05/2024, in the area of 42 CFR 483.75 Quality Assurance and Performance Improvement, F-867 at a Scope and Severity (S/S) of an L. The facility was notified of the IJ on 10/11/2024. The facility provided an acceptable IJ Removal Plan, on 10/22/2024, alleging removal of the IJ on 10/22/2024. The State Survey Agency (SSA) determined the IJ had been removed on 10/22/2024, prior to exit on 11/22/2024, with remaining non-compliance at a S/S of an F while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. Refer to F835, F837, and F880 The findings include: Review of the facility's policy titled, Quality Assessment and Assurance, undated, revealed the program was designed to systematically monitor and evaluate the quality and appropriateness of resident care provided in the facility. Per the policy, the Director of Nursing Services (DON) was responsible for the establishment and maintenance of the program. Through committee review, the program committee would facilitate efficient operation of the facility and monitor infection control. In addition, the program committee would develop appropriate plans of action to correct identified and confirmed quality concerns and implement those plans of action. Continued review revealed the program committee would identify and prioritize issues, with clear expectations established regarding resident safety, quality, and rights. Review of the Plan of Correction (POC) to address the water deficiency cited for the Abbreviated Survey with an exit date of 04/05/2024, and a completion date of 05/20/2024, revealed: 1) the QAPI (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Committee had been working with the local health department (LHD) and state infection prevention team to develop a water maintenance plan (WMP) and ensure the facility's water maintenance policy was followed and would meet monthly to review compliance, to adjust as deemed necessary to maintain compliance; and 2) the QAPI Committee would assess and modify the action plan as needed to ensure continued compliance. Review of the microbiology analysis report, performed by a third party independent water system company (IWSC) to test for legionella, dated 05/28/2024, revealed the sample result from the facility's Unit 3 shower, showed a positive result for Legionella pneumophila Serogroup 1 Strain (SG1). Per review the positive result was at 11.0 colony-forming unit per milliliter (CFU/ml) with a detection limit of 0.1 CFU/ml, indicating uncontrolled growth. Continued review of the report for the Unit 3 shower showed Legionella pneumophila Serogroup 2 Strain (SG2-15) at 11.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating uncontrolled growth. Review of the microbiology analysis report, performed by a third party IWSC to test for legionella, dated 06/14/2024, revealed testing for Unit 1 and Unit 2 showers. Per review, the sample result from the Unit 1 shower showed a positive result for Legionella pneumophila SG1 at 0.1 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating well-controlled growth; and Legionella non-pneumophila at 0.1 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating well-controlled growth. Continued review revealed the sample result from the Unit 2 shower showed a positive result for Legionella pneumophila SG1 at 0.8 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating well-controlled growth; and Legionella non-pneumophila at 2.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Review of the facility's QAPI Agenda, dated 06/29/2024, attended by the Quality Assurance (QA) Nurse, Infection Preventionist (IP), Director of Nursing (DON), Housekeeping Director (HSKD), Dietary Manager (DM), Administrator, Activities Director (AD), Human Resources Director (HR), and the Director of Maintenance (DOM), revealed the agenda had the WMP, the Water Policy, and the WICRA listed under Other Business. There was no documentation supporting the development or implementation of a plan of correction by QAPI when the facility's water quality did not meet appropriate parameters according to third-party testing results. Review of the facility's QAPI Agenda, dated 07/25/2024, attended by the QA Nurse, HSKD, DOM, Rehabilitation Services Manager (RSM), IP, Minimum Data Set (MDS) Nurse, DM, HR, Social Services (SSW), Pharmacist (RPh), Medical Director, and the Administrator revealed the agenda listed WMP, the Water Policy, and the WICRA listed under Other Business. There was no documentation supporting the development or implementation of a plan of correction by QAPI when the facility's water quality did not meet appropriate parameters according to third-party testing results. Review of the Division of Epidemiology and Health Planning's (DEHP) Findings and Recommendations, dated 07/26/2024, revealed several concerns identified by the state's Legionella Team and the Regional Epidemiologist. These concerns included the following: 1) the facility failed to document all the necessary elements of a proper WMP as evidenced by the facility's unacceptable score on the WMP assessment of one out of nine (acceptable score was eight or higher); 2) water sampling had been insufficient to evaluate the growth reservoir in the building's water system; and 3) there were no documented logs to confirm the flushing procedures. Further review of the DEHP's Findings and Recommendations, dated 07/26/2024, revealed the DEHP recommended steps to prevent future outbreaks or occurrences of legionellosis. These steps included the (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	following: 1) remind healthcare providers to include legionellosis in their differential diagnoses; 2) continue enhanced surveillance for new cases of legionellosis and review resident charts daily for potential radiographs, lab tests, or diagnoses related to possible or atypical pneumonia; 3) complete the Water Infection Control Risk Assessment (WICRA) before developing a WMP; 4) create a WMP that incorporated recommendations from the Centers for Disease Control and Prevention (CDC); 5) validate the plumbing diagram with greater detail according to CDC guidelines and document the recirculation system; 6) ensure that all water management team (WMT) members completed the CDC Prevent [Legionnaires' Disease] LD training module; 7) the third-party contractor should familiarize themselves with legionella sampling protocols by completing the CDC's Prevent LD training module; and 8) submit sampling plans to the local health department (LHD) before conducting any additional sampling. Review of the microbiology analysis report, performed by a third party IWSC to test for legionella, dated 08/07/2024, revealed testing for room [ROOM NUMBER]. Continued review of the report revealed the sample result from room [ROOM NUMBER] showed a positive result for Legionella pneumophila SG1 at 2.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Review further revealed the room [ROOM NUMBER] sample result also showed a positive result of Legionella non-pneumophila at 3.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. No QAPI Agenda was provided for August 2024. Review of the microbiology analysis report, performed by a third party IWSC to test for legionella, dated 08/29/2024, revealed testing for room [ROOM NUMBER] and the Unit 2 shower. Per review, the sample result from room [ROOM NUMBER] showed a positive result for Legionella pneumophila SG1 at 3.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth; and Legionella non-pneumophila at 3.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Additionally, further review of the report revealed for the Unit 2 shower the results showed Legionella pneumophila SG1 at 0.5 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating well-controlled growth; and Legionella non-pneumophila at 1.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Review of the microbiology analysis report, performed by a third party IWSC to test for legionella, dated 09/04/2024, revealed testing for the Unit 2 shower. Continued review revealed the sample result from the shower showed a positive result for Legionella pneumophila SG1 at 0.1 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating well-controlled growth; and Legionella non-pneumophila at 1.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Review of the facility's QAPI Agenda, dated 09/05/2024, attended by the QA Nurse, HSKD, DOM, RSM, IP, MDS Nurse, DM, HR, SSW, Pharmacist (RPh), Medical Director, and the Administrator, revealed the agenda listed WMP/Policy and the WICRA listed under Other Business. There was no documentation supporting the development or implementation of a plan of correction by QAPI when the facility's water quality did not meet appropriate parameters according to third-party testing results. Furthermore, there was no documentation indicating the QAPI Committee was made aware of or addressed the DEHP's preliminary findings and recommendations. Review of the microbiology analysis report, performed by a third party IWSC to test for legionella, dated 09/13/2024, revealed testing for room [ROOM NUMBER], the Unit 2 shower, and the Physical Therapy (PT) sink. Per review, the sample result from room [ROOM NUMBER] showed a positive result for Legionella pneumophila SG1 at 1.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Continued review of the report revealed the Unit 2 shower testing results showed (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	provided recommendations for the facility to follow to help mitigate the spread of LD in the facility. She stated she attended QAPI meetings and these were discussed at the QAPI Committee and WMT meetings, but she could not state when this occurred. She further stated she informed all providers to include legionellosis in their differential diagnoses. Furthermore, the DEHP advised testing any resident with suspected healthcare-associated pneumonia for LD by conducting a urine antigen test and, if possible, a sputum culture. The IP confirmed that she had implemented these measures for all suspected cases of healthcare-associated pneumonia. The IP stated the facility conducted enhanced surveillance for new cases of legionellosis and reviewed patient [residents] charts daily for potential radiographs, lab tests, or diagnoses related to possible or atypical pneumonia. However, the IP stated she had no surveillance data or chart review logs documenting the recommendations were performed. During continued interview with the IP, on 10/08/2024 at 9:10 AM, she stated the WMT worked on a WMP earlier in the year, but the DEHP reviewed the WMP and indicated the WMP did not meet CDC criteria. She stated the DEHP recommended revising and resubmitting it. She stated the QAPI committee and the WMT did not attempt a revision to the WMP because they had been waiting for the CLWSE to write the plan for the facility. She stated the WICRA was a component of water management programs. The IP stated WMT members could use a WICRA to evaluate water sources, modes of transmission, patient [resident] susceptibility, patient [resident] exposure, and program preparedness. She stated she had not submitted the facility's completed WICRA to the LHD, but she completed the form several months ago. She stated the WICRA had not been approved yet by the QAPI committee and the WMT. During an interview with the Minimum Data Set (MDS) Nurse, on 10/23/2024 at 3:10 PM, she stated she was a member of the QAPI Committee and had attended Ad Hoc QAPI committee meetings where the committee discussed the State Survey Agency's (SSA's) findings and the facility's plan for IJ removal. She stated the committee was waiting on the LHD and the CLWSE to provide direction on the WMP. She stated the committee had moved forward in the last couple of weeks to include CDC training and increased flushing and had approved and submitted the WICRA. During an interview with the HSKD, on 10/23/2024 at 4:09 PM, she stated she was a member of the QAPI Committee and had attended Ad Hoc QAPI Committee meetings where the committee discussed the SSA's findings and the facility's plan for IJ removal. Prior to that, she stated issues with legionellosis contamination test results were discussed, but the committee was waiting on the LHD and the CLWSE to provide direction on the WMP. The HSKD could not remember the specific items discussed in previous QAPI meetings. She stated as part of the DEHP's recommendations, she completed the CDC's LD training. During an interview with the SSW, on 10/24/2024 at 8:55 AM, she stated she was a member of the QAPI Committee. She stated the committee reviewed water test results, which had continuously shown some level of contamination. She stated the committee had discussed changes to the WMP at the most recent meetings. She further stated the water contamination issue was on the QAPI agendas, but she did not remember the specific items discussed in previous QAPI meetings. During an interview with the DM, on 10/24/2024 at 10:09 AM, she stated she was a member of the QAPI Committee and had attended Ad Hoc QAPI committee meetings where the committee discussed the SSA's findings and the facility's plan for IJ removal. She stated she could not provide details on prior QAPI meeting discussions. She further stated the committee was waiting on the LHD and the CLWSE to provide direction on the WMP. During an interview with the AD, on 10/24/2024 at 10:15 AM, she stated she had been a member of the (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	QAPI Committee since September 2024. She stated she attended Ad Hoc QAPI committee meetings where the committee discussed the SSA's findings and the facility's plan for IJ removal. During an interview with the AR Clerk, on 10/24/2024 at 10:26 AM, she stated she had attended QAPI Committee meetings. She stated the committee discussed issues related to legionellosis contamination test results and control measures to mitigate the spread of LD. She further stated she could not elaborate on prior meeting discussions; however, most recently, the facility reviewed the plan for removal of the IJ and approved a new WMP. During an interview with HR, on 10/24/2024 at 10:32 AM, she stated she had attended QAPI Committee meetings. She stated the committee discussed issues related to legionellosis contamination test results and control measures to mitigate the spread of LD. She further stated most recently she attended an Ad Hoc QAPI committee meeting where the committee discussed the SSA's findings, the facility's plan for IJ removal, and voted to adopt a new WMP. During an interview with the RSM, on 10/24/2024 at 10:40 AM, she stated she had been a member of the QAPI Committee for seven years. She stated during the most recent Ad Hoc QAPI meeting, the committee discussed issues related to legionellosis contamination test results and control measures to mitigate the spread of LD. In addition, she stated they discussed the SSA's findings, the facility's plan for IJ removal, and voted to adopt the new WMP provided by the CLWSE. During an interview with the former DON, on 10/08/2024, at 9:21 AM, she stated the QAPI Committee had decided to reopen the showers in Unit 1 and Unit 3 for all residents on 10/04/2024. Prior to this decision, she stated all showers had been closed for over a month, and residents received bed baths instead. The DON stated she was aware of the recommendations from the DEHP; however, she stated the IP was responsible for implementing all infection control and health department guidelines. Additionally, she stated the IP was tasked with sending out a letter to providers, informing them of the DEHP's recommendations for enhanced surveillance of LD. She stated the QAPI Committee did not approve to submit the WICRA assessment to the LHD because they were waiting for the CLSWE to submit his recommendations. She further stated the QAPI Committee and the WMT did not attempt a revision to the WMP because it had been waiting for the CLWSE to write the plan for the facility. During an additional interview with the former DON, on 10/09/2024 at 10:40 AM, she stated the QAPI Committee had yet to follow up on the DEHP's recommendations because they were waiting for the CLWSE to do this for the facility. The DON stated during an online meeting with the LHD and the State Department of Public Health (KDPH), the CLWSE indicated to the WMT that he knew how to write a WMP and would do that for the facility. She stated she took that to mean he would write the WMP follow-up on the DEHP recommendations. During an interview with the former Administrator, on 10/04/2024 at 2:32 PM, he stated the QAPI Committee had collaborated closely with the LHD and the KDPH to develop a WMP. The Administrator stated the KDPH's Environmental and Occupational Countermeasures Program Manager (EOCPM) recommended the facility seek out a certified water safety and management expert (CLWSE) to address the building's contaminated water lines. He stated the facility's water testing company was responsible for finding the expert, which they did. The Administrator stated the CLWSE conducted an onsite visit in September 2024 and provided the facility with recommendations on 10/02/2024 based on that visit. The Administrator stated the QAPI process after May 2024 was primarily focused on waiting for recommendations from the DEHP and the LHD to prevent and control legionellosis. (continued on next page)

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Bourbon Heights Nursing Home	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)
F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an additional interview with the former Administrator, on 10/25/2024 at 12:45 PM, he stated he was not aware the 08/05/2024 email from the LHD contained an attachment with the DEHP's preliminary findings and recommendations until the SSA Surveyor brought the recommendations to his attention. Therefore, he stated it was not brought to the attention of the QAPI Committee. He stated, The e-mail came but I didn't look at it [attachment]. He further stated it was the responsibility of the IP to have communicated the receipt of the recommendations to him. During a telephone interview with the Medical Director, on 10/24/2024 at 11:01 AM, he stated he was a member of the QAPI Committee and had attended both scheduled and Ad Hoc QAPI meetings to address ongoing issues related to bacterial contamination in the water. He stated it was his expectation that the facility's QAPI Committee followed policy to ensure the safety and well-being of the residents and staff.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's documentation and policies, it was determined the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for the total census of 74 residents. During the Abbreviated/Partial Extended Survey that concluded on 04/05/2024, Immediate Jeopardy was identified in the area of F880 (Infection Control), with the highest scope and severity (S/S) of an L. The facility alleged substantial compliance on 05/20/2024, however; failed to maintain substantial compliance. Legionella pneumophila SG1 and Legionella pneumophila SG2-15 were identified at uncontrolled growth levels in the Unit 3 shower on 05/28/2024. Review of the state's Division of Epidemiology and Health Planning's (DEHP) Findings and Recommendations, dated 07/26/2024, revealed DEHP made recommendations to mitigate outbreaks of occurrences of legionellosis. On 08/05/2024, the Administrator, Director of Nursing (DON) and the Infection Preventionist (IP) received an email from the Local Health Department (LHD), which communicated the DEHP's recommendation to mitigate the outbreak of Legionnaire's disease (LD). The facility failed to ensure the recommendations were implemented as communicated by the LHD, to prevent and control legionellosis. Additionally, the facility failed to maintain an infection control prevention and control program to provide a safe, sanitary and comfortable environment as evidenced by staff observed providing care without sanitizing hands, adhering to the Enhanced Barrier Precautions protocol, failure to label and properly store feeding tubes, and in handling clean laundry. Immediate Jeopardy (IJ) was identified on 10/11/2024 and was determined to exist on 08/05/2024, in the area of 42 CFR 483.80 Infection Control, F-880 at a Scope and Severity (S/S) of an L. The facility's Administrator was notified of the IJ on 10/11/2024. The facility provided an acceptable Immediate Jeopardy Removal Plan, on 10/22/2024, alleging removal of the IJ on 10/22/2024. The State Survey Agency (SSA) determined the IJ had been removed on 10/22/2024, as alleged, prior to exit on 11/22/2024, with remaining non-compliance at a S/S of an F while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changes. The facility implemented the following: The findings include: Review of the facility's policy titled, Infection Prevention and Control Program (IPCP), undated, revealed its purpose was for the facility to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Per policy review, the IPCP was to address facility-specific infection control needs. Continued review revealed the IPCP was a facility wide effort involving all disciplines and was an integral part of the (facility's) Quality Assurance and Performance Improvement (QAPI) program. Further review revealed the IPCP provided a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, and visitors. 1. Review of the facility's policy titled, Legionella Water Management Plan (WMP), undated, revealed the facility was to promote proactive steps to establish a healthy environment for residents, (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	staff, and visitors. Per review of the Plan, contraction of Legionnaire's disease (LD) was often the result of exposure to inadequately managed building water systems, which could be prevented. Continued review revealed the facility's mission was to properly manage its water system to prevent exposure to LD. Policy review revealed the facility was to maintain documentation of its WMP in maintenance logs. According to policy review, if water quality did not meet appropriate parameters, further investigation was to take place, a plan of correction developed and implemented, and the results presented to the Quality Assurance and Performance Improvement (QAPI) Committee. Further review revealed hot water temperatures in resident areas, tubs, showers, full immersion wash stations, water heaters, and holding tanks was to be tested every week. Additionally, policy review revealed weekly sampling points for residents' rooms was to be rotated so all sinks were tested at least annually. Review of the policy further revealed if water quality was not within appropriate parameters, further investigation was to occur, a plan of correction developed and implemented if appropriate. Review of the Centers for Disease Control and Prevention's (CDC) Guideline, Developing a Legionella Water Management Program, updated 03/15/2024, revealed hot and cold water was to be flushed through all points of use (e.g., showers, sink faucets). Continued review of the Guideline revealed flushing was to continue until the hot water reached its maximum temperature. Per review, where possible, hot water at the tap was to reach at or above 120 degrees (°) Fahrenheit (F), unless anti-scalding controls and devices had limited the maximum temperature at the point of use. Further review revealed the method, temperature, and duration of flushing was to be recorded daily in a log book. Review of the American Society of Heating and Air-Conditioning Engineers (ASHAE) Guideline, Managing the Risk of Legionellosis Associated with Building Water Systems, dated 12/2023, revealed flushing involved opening taps and letting the water run. According to the ASHAE Guideline, flushing standards, staff needed to flush the sinks and fixtures for at least three minutes daily with hot and cold water, and cold water was to be flushed before hot water. Continued review revealed to flush cold and hot water at all water points of use (faucets, showers, toilets, drinking fountains, and water using devices such as eye wash stations). Review of the microbiology analysis report, performed by a third party IWSC to test for legionella, dated 05/28/2024, revealed the sample result from the facility's Unit 3 shower, showed a positive result for Legionella pneumophila Serogroup 1 (SG1)Strain. Per review, the positive result was at 11.0 colony-forming unit per milliliter (CFU/ml) with a detection limit of 0.1 CFU/ml, indicating uncontrolled growth. Continued review of the report for the Unit 3 shower showed Legionella pneumophila Serogroup 2 Strain (SG2-15) at 11.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating uncontrolled growth. Review of a written communication sent via the facility's internal Calling Post messaging system to residents and staff, dated 06/05/2024, revealed the facility notified its residents and staff about detected legionella in its water supply. Review of the microbiology analysis report, performed by a third party independent water systems company to test for legionella, dated 06/14/2024, revealed testing for Unit 1 and Unit 2 showers. The sample result from the Unit 1 shower showed a positive result for legionella pneumophila SG1 at 0.1 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating well-controlled growth; and legionella non-pneumophila at 0.1 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating well-controlled growth. The sample result from the Unit 2 shower showed a positive result for legionella pneumophila SG1 at 0.8 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating well-controlled growth; and legionella non-pneumophila at 2.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	growth. Review of the microbiology analysis report, performed by a third party independent water systems company to test for legionella, dated 08/07/2024, revealed testing for room [ROOM NUMBER]. The sample result from room [ROOM NUMBER] showed a positive result for legionella pneumophila SG1 at 2.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth; and legionella non-pneumophila at 3.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Review of the microbiology analysis report, performed by a third party independent water systems company to test for legionella, dated 08/29/2024, revealed testing for room [ROOM NUMBER] and the Unit 2 shower. The sample result from room [ROOM NUMBER] showed a positive result for legionella pneumophila SG1 at 3.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth; and legionella non-pneumophila at 3.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Additionally, the report for the Unit 2 shower showed legionella pneumophila SG1 at 0.5 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating well-controlled growth; and legionella non-pneumophila at 1.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Review of the microbiology analysis report, performed by a third party independent water systems company to test for legionella, dated 09/04/2024, revealed testing for the Unit 2 shower. The sample result from the shower showed a positive result for legionella pneumophila SG1 at 0.1 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating well-controlled growth; and legionella non-pneumophila at 1.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Review of the microbiology analysis report, performed by a third party independent water systems company to test for legionella, dated 09/13/2024, revealed testing for room [ROOM NUMBER], the Unit 2 shower, and Physical Therapy (PT) sink. The sample result from room [ROOM NUMBER] showed a positive result for legionella pneumophila SG1 at 1.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Unit 2 shower showed legionella non-pneumophila 0.1 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating well-controlled growth. Additionally, the report for the PT sink showed legionella pneumophila SG2-15 at 0.1 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating well-controlled growth. Review of the microbiology analysis report, performed by a third party independent water systems company to test for legionella, dated 09/18/2024, revealed testing for room [ROOM NUMBER] and the Unit 2 shower. The sample result from room [ROOM NUMBER] showed a positive result for legionella pneumophila SG1 at 2.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth; and legionella non-pneumophila at 1.0 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating poorly controlled growth. Additionally, the report for the Unit 2 shower showed legionella non-pneumophila SG1 at 0.4 CFUs/mL with a detection limit of 0.1 CFU/ml, indicating well-controlled growth. Review of a written communication sent via the facility's internal Calling Post messaging system to residents and staff regarding updates of additional testing, revealed no documented evidence to support the facility notified residents and staff of detectable levels of legionella in its water supply detected on 06/14/2024, 08/07/2024, 08/29/2024, 09/04/2024, 09/13/2024, and 09/18/2024. Review of the Division of Epidemiology and Health Planning's (DEHP), Findings and Recommendations, dated 07/26/2024, revealed concerns identified by the state's Legionella Team and the Regional Epidemiologist were as follows: A.) The facility failed to document all the necessary elements of a (continued on next page)

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F 0880

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

water situation and only found out after asking the Administrator about it directly. He stated that the Administrator informed him legionella bacteria was detected in Unit 2's shower during a test. He stated that he purchased water for R1, so she had clean water to wash her hands and face and use it to brush her teeth, as the facility only provided water for drinking.

During telephone interview with Family (F)6 on 11/15/2024 at 2:45 PM, she stated she was informed about something in the water several months earlier during a conversation with a nurse on the evening shift. F6 reported when she inquired about what steps the facility had taken to address the issue, the nurse told her it was not the facility's fault. She said the nurse told her the local water department was responsible for remediation of the water issue; however, when she contacted the local water department, they informed her the issue was indeed within the facility.

In continued interview on 11/15/2024 at 2:45 PM, F6 reported the first time the facility had been somewhat transparent about the issues related to legionella had been approximately six weeks ago when she saw a notice related to legionella posted inside the elevator. During the interview, F6 described the Administrator as evasive when she asked questions, and he claimed that the facility was following all recommendations from the local health department. She further stated the Administrator told her the water was safe to drink and there were no risks to residents, staff, or visitors.

During interview with State Registered Nurse Aide (SRNA) 3, on 10/03/2024 at 11:25 AM, she stated the facility had provided water for drinking and medication passes which were water jugs brought to the floor by staff and/or maintenance. The SRNA stated at no time had the facility's administration provided bottled water for distribution to the residents to use for their daily hand hygiene, or oral care. She reported staff were using the water from the sinks to perform hand hygiene, and residents could use water from the faucets in their rooms for bed baths, washing their hands, and oral care.

During interview with SRNA 1 on 10/03/2024 at 11:45 AM, she stated there were no gallon jugs of spring water available on the floor that morning, so staff members just passed ice to residents. She expressed concerns about the facility's water quality. She said staff had been providing bed baths for residents, but the residents continued to use the sink faucets in their rooms for hand hygiene, washing their faces, and oral care. The SRNA reported staff were also using the water from the sinks for their own hand hygiene. She stated the administration had not provided individual bottled water for residents for daily hand hygiene or oral care, but had provided water for drinking and for medication administration. SRNA 1 said she had received education on the IPCP, and the risks associated with legionella. She stated people could become infected with Legionella when they inhaled microscopic water droplets containing the bacteria, which could be present in the spray from a shower or faucet.

During interview with SRNA 5 on 10/03/2024 at 11:49 AM, she stated the facility provided water for drinking and medication passes; however, residents and staff used water from the faucets for bed baths, washing hands, and oral care. SRNA 5 said she had been educated on the IPCP. She further stated legionella was contracted when microscopic water droplets containing legionella bacteria were inhaled.

During interview with Kentucky Medication Aide (KMA) 1 on 10/03/2024 at 11:10 AM, she stated the facility supplied water for drinking and medication passes. Per interview, she stated staff could use water from the faucets in resident rooms to provide bed baths, washing hands, and oral care. The KMA also stated she had received education on the IPCPs and Legionella.

During interview with Licensed Practical Nurse (LPN) 1 on 10/03/2024, at 10:15 AM, she stated the

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	facility used spring water from gallon jugs for both hydration and medication administration. She reported the water jugs were delivered to the facility or obtained by staff from the kitchen. LPN 1 said residents and staff were also allowed to use water from the faucets for performing/providing activities of daily living (ADLs), such as bed baths, handwashing, and oral care. She further stated she had received education from the IP on IPCPs and Legionella. During an interview with Registered Nurse (RN) 1 (an agency nurse) on 10/03/2024 at 11:35 AM, he stated he believed the facility provided water for drinking and medication passes but stated the KMA's and SRNA's were responsible for those tasks. RN 1 stated residents could use water from the faucets in their rooms for bed baths, handwashing, and oral care. He said he could not remember whether he had received education related to the IPCP and Legionnaire's Disease. RN 1 indicated he was unable to explain how residents and staff might become infected with legionella bacteria. Review of the facility document titled, Housekeeping Helpers Schedule revealed weekly duties included Run hot water for about 5 minutes in sink and tub. Further review revealed however, no documented instructions on flushing the shower head or cold water faucets. During interview with Housekeeping Aide (HA) 1 on 10/09/2024 at 1:18 PM, she stated she flushed the water lines in Rooms 120 through room [ROOM NUMBER] every Monday and documented the completed task on her housekeeping sheet. When asked by the SSA surveyor who instructed her to flush water lines, she stated the Housekeeping Director (HSKD). HA 1 stated when she performed a water line flush, she turned on the hot water in the sink, shower, and tub and ran the water for five minutes. She further stated however, she did not check the temperature of the water. During interview with HA 2 on 10/09/2024 at 1:22 PM, she stated she flushed the water lines in rooms 130 through 140 every Wednesday and documented the completed task on her housekeeping sheet. When asked by the SSA Surveyor who instructed her to flush water lines, she stated the HSKD. HA 2 stated when she performed a water line flush, she turned on the hot and cold water in the sink, shower, and tub and ran the water for fifteen minutes. The HA further stated however, she did not check the temperature of the water. During interview with the HA 3 on 10/09/2024 at 1:29 PM, she stated she flushed the water lines while cleaning her rooms every Monday. She stated she was responsible for rooms 241 through 256, and she said she documented the completed task on her housekeeping sheet. When asked by the SSA Surveyor who instructed her to flush water lines, she stated the HSKD. HA 3 stated when she performed a water line flush, she turned on the hot water in the sink and tub and ran it for awhile. She further stated she did not run the cold water and did not run water through the showerhead. HA 3 further stated she did not check the temperature of the water. During interview with the HSKD on 10/09/2024 at 10:49 AM, she stated housekeeping staff went from room to room once a week and ran the water for five minutes in the showers, the bath, and the sink. When asked by SSA Surveyor who instructed her on how to flush water lines, she stated, No one. She stated her staff documented their weekly flushing on their Housekeeping Helpers Schedule sheets. The HSKD reported however, she had not kept a log of all the weekly flushing to include the locations, temperature, or duration. She further stated she had not received the CDC training on preventing LD. During interview with the Maintenance Assistant (MA) on 10/09/2024 at 2:20 PM, he stated he flushed the water lines in all vacant rooms daily. He stated he had been performing that task since February 2023, but had not kept detailed logs or documentation. When asked by the SSA Surveyor who (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	third-party water testing and treatment services for the facility. The IWSC said his company provided the facility with legionella testing, which included assessing the cooling tower, water heaters, and other areas of concern. He reported his main focus concerns had been on the shower units and room [ROOM NUMBER], which was currently vacant. The IWSC stated they had performed two system-wide disinfection procedures in the facility, with the most recent one conducted was on 06/25/2024. The IWSC stated however, despite their efforts, tests at point-of-use shower heads and the faucet in room [ROOM NUMBER] continued to show the growth of legionella pneumophila. In continued interview on 10/11/2024 at 9:58 AM, the IWSC said he participated in online meetings with representatives from the facility, the LHD, the KDPH, and the DEHP. He stated during those meetings, which had taken place since legionella pneumophilia was discovered in the facility in early 2023, the EOCPM advised the facility to employ a CLWSE's services and follow the recommendations from both the DEHP and CLWSE. The IWSC said he consulted with a CLWSE, who did an onsite visit and assessment of the facility in September 2024. He stated the CLWSE recommended continued flushing and the installation of medical-grade filters. The IWSC reported the facility was not in a contractual relationship with the CLWSE at that time. He confirmed in the interview, it was not until 10/04/2024, that he received a signed contract from the facility to hire the CLWSE to develop a water management program and purchase a water management software program. The IWSC stated the CLWSE sent recommendations to the facility on [DATE], which stated it was the facility's responsibility to make decisions based on their due diligence. During a telephone interview with the CLWSE on 10/04/2024 at 2:42 PM, he stated the IWSC had consulted with him to diagnose and evaluate the facility's water system, water management plan, current control measures, and to determine if the facility needed additional control measures or a supplemental disinfection system. He stated he assessed the building and its water system, and reviewed the remediation efforts that had been carried out since legionella was discovered in February 2024. The CLWSE said the IWSC performed weekly legionella testing, and it was his understanding the facility randomly tested water temperatures and flushed its water system. He stated the facility had installed [NAME] filters on three ice machines and all four shower heads, but per his assessment, the facility had no other control measures in place. In continued telephone interview on 10/04/2024 at 2:42 PM, the CLWSE stated that although there was no known safe concentration of legionella bacteria, the CDC had provided guidance on the concentration of legionella test results. He said any detection of bacteria up to 0.9 CFUs/mL indicated that the legionella growth appeared well-controlled. The CLWSE reported the facility must conduct a more comprehensive sampling for legionella testing to maintain ongoing protection. He stated the [NAME] filters and other water management strategies provided adequate protection if the legionella results remained non-detectable or at low levels. The CLWSE stated however, if CFUs/mL increased, remediation was necessary. He said it was important the facility ensured all the [NAME] filters were installed, maintained, and replaced according to the manufacturer's instructions. Per the CLWSE in interview, if the [NAME] filters were not appropriately managed, including regular replacement as specified by the manufacturer and routinely checked to ensure they functioned correctly, the [NAME] filters could lose their effectiveness over time. In additional telephone interview on 10/04/2024 at 2:42 PM, the CLWSE stated the facility did not develop a decision-making tree to provide clear instructions on the actions to take based on the testing parameters. He said since September 2024, he had repeatedly informed the facility that while he provided recommendations based on industry standards and best practices, it was ultimately their responsibility to assess, implement, and manage the risks associated with legionella. (continued on next page)

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 11/22/2024
NAME OF PROVIDER OR SUPPLIER Bourbon Heights Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 South Main Street Paris, KY 40361	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an additional telephone interview on 10/09/2023 at 9:38 AM, the CLWSE explained the IWSC initially contacted him to consult on the water contamination issues at the facility. He said he participated in a call with the KDPH's Environmental and Occupational Countermeasures Program Manager (EOCPM) to discuss ongoing contamination problems. The CLWSE stated during th[TRUNCATED]