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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 28707 Based on interview and record review, it was determined the facility failed to ensure residents were notified of changes to services covered by Medicare and/or Medicaid as soon as possible for one of three sampled residents reviewed for appeal writes (Resident (R)38). R38 received therapeutic services; however, the facility failed to inform the resident in writing of the end date to services or of their right to appeal. The findings include: During the task of Beneficiary Notification Review, the State Survey Agency (SSA) determined for the three residents selected, there was no documented evidence one of the residents received form CMS 10055 (Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage) or form CMS 10123 (Notice of Medicare Non-Coverage). Continued review revealed, of the three residents, one resident was voluntarily discharged from services as family elected hospice services (R125). Per review, a second resident opted to discharge from services and returned home with home health with almost two weeks remaining (R126). Further review revealed one resident (R38) should have received both the CMS 10055 and CMS 10123; however, did not receive that documentation. Review of R38's medical record revealed the facility readmitted the resident from the hospital on 08/22/2024. Continued record review revealed R38 was scheduled to receive Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) under Medicare Part A payment. Review of the resident census revealed R38's last covered day under Medicare Part A was 10/25/2024. However, further record review and review of facility documentation revealed no evidence the facility issued or resident representative was provided a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) or form CMS 10123 Notice of Medicare Non-Coverage (NOMNC) form. In interview on 11/20/2024 at 9:24 AM, the facility's Admissions Coordinator (AC) stated R38 was not given a SNF ABN or NOMNC as she had not been informed or included in the email which was how she was notified of that information. She said since she had not received the email, she had no idea the resident or family should have received the SNF ABN and NOMNC letters. The AC reported it was important the letter(s) were available for informing both staff and the resident of the end date of the resident's skilled services. She further stated it was also important as well for providing residents or families other billing options for continued services or the opportunity to appeal if they desired to do that. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 11/21/2024 at 1:09 PM, the Interim DON stated the SNF ABN and NOMNC were forms the facility completed. She stated she expected those forms to be discussing the resident's progress in morning meeting prior to the end of services for the resident receiving services. The Interim DON said the SNF ABN and NOMNC were important for payment of care residents were receiving, so that residents or family members could file an appeal if they felt services were still needed. She further stated the expectation was for residents or their responsible parties to be alerted in a timely manner so they had opportunity to respond. In interview on 11/21/2024 at 2:09 PM, the Interim Administrator stated the NOMNC should be issued to the resident or responsible party as appropriate, and should be issued prior to the cut off date. She stated the NOMNC was to be provided in order for the resident or responsible party to have time to respond and to have a plan for a safe discharge or to appeal. The Interim Administrator said she had only been at the facility four or five days, and did not know the facility's process for beneficiary notification. She further stated her expectation was for it to be issued timely, with the facility maintaining a copy, in addition to, those provided to the resident or responsible party. The Interim Administrator additionally stated the AC would be receiving training on her role in the SNF ABN/NOMNC process.

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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 0655 Level of Harm - Actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51155 Based on interview, record review, and facility policy review, the facility failed to develop and implement a baseline care plan for new residents that included instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for one of 26 sampled residents (Resident (R)425). R425 required hemodialysis treatments that included parameters for the resident's vital signs and had a known history of falls. However, the facility failed to implement a baseline care plan upon R425's admission to address his hemodialysis needs and risk for falls. Refer to F689 and F698 The findings include: Review of the facility's policy titled, Care Plan Development in the HER Policy and Procedure, dated 11/2016, revealed it was the policy of the facility that the care plan was a living document that was started upon admission. Per review, the care plan was started upon a resident's admission from information gathered from the resident, family, admission assessments completed by each department, physician's prescriptions and records from the transferring facility or referral source. Further review revealed every effort was made to assure the resident's individual history, patterns, preferences, and choices were included, as that information became available to the care plan team members. 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. Additional review of R425's EHR revealed End Stage Renal Disease (ESRD) with Hemodialysis listed on his medical diagnosis list. 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 EHR record revealed it contained no documented evidence of an admission assessment and baseline care plan completed upon the resident's admission on 11/08/2024. Further review revealed documentation from a hospital discharge summary dated 10/14/2024, with noted R425 was dependent on dialysis due to ESRD. 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. (continued on next page)

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F 0655 Level of Harm - Actual harm Residents Affected - Few	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 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. In interview on 11/21/2024 at 9:14 AM, Licensed Practical Nurse (LPN) 6 stated residents' baseline care plans were located in the admission packets. LPN6 further stated the baseline care plans were to be completed on a resident's admission then turned into the MDS Nurse. 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 . The MDS Nurse said baseline care plans were important and helped in developing the comprehensive care plan. She stated the baseline care plan was also 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 for R425 and had completed one after being asked for it by the State Survey Agency (SSA) Surveyor. In interview on 11/22/2024 at 10:51 AM, Registered Nurse (RN) 7 revealed there was an admission packet on all units and it contained a baseline care plan for the admitting nurse to complete. In interview on 11/22/2024 at 12:51 PM, RN1 stated he had not completed a baseline care plan for R425 because he did not know the resident was being transferred from personal care to skilled care. He said he did not know that one needed to be completed because of that. RN 1 further stated he reached out to the Director of Nursing (DON) and she never got back with him. (continued on next page)

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F 0655 Level of Harm - Actual harm Residents Affected - Few	In interview on 11/22/2024 at 1:50 PM, the Interim DON stated all nurses had access to and were to complete baseline care plans for all new residents. She further stated baseline care plans were to be completed on all residents for the residents' safety. In interview on 11/21/2024 at 1:55 PM, the Interim Administrator stated it was her expectation for baseline care plans to get completed timely and accurately so staff could care for residents appropriately.

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44001 Based on interview, record review, and review of the facility's policy, the facility failed to review and revise the comprehensive care plan (CCP) for one of 26 sampled residents (Resident (R)76). R76 fell on [DATE], and after having a change in mental status was transferred to the hospital on 05/17/2024, where she was diagnosed with a transient ischemic attack (a brief stroke-like attack). R76 returned to the facility on [DATE]. R76's family requested the resident remain in her room to rest after her hospitalization . However, staff on duty failed to update the CCP to include interventions aimed at preventing future falls or to incorporate the family's request for the resident to rest in her room. R76 sustained another fall on 05/19/2024, resulting in a fracture of the intertrochanteric region of her hip. Refer to F689 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. This plan should include measurable objectives and timeframes. Additionally, the policy 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 representatives. Furthermore, the policy stated the facility was to ensure each resident's care plan was reviewed and revised as necessary to reflect any changes in their care needs during their stay. Review of the facility's policy titled, Falls Policy and Procedure, revised 11/18/2024, revealed that all residents who were at risk for falls would be care planned. Further review of the policy revealed care plans would be reviewed and updated quarterly, if indicated. 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 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 severe cognitive impairment. Further review revealed R76 was independent with mobility, toileting, transfers, and ambulation by herself with no assistance from a helper. The resident could walk 150 feet with the assist of a walker independently. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of R76's CCP, dated 05/11/2024, revealed she was identified as a fall risk on 05/11/2023, related to gait/balance problems, psychoactive drug use, and a history of falling. Interventions initiated 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 the resident's 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 up out of bed for fall safety, follow facility fall protocol, and keep walker in reach and encourage her to use when getting up. 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). Per the note, the SRNA found the resident attempting to pull herself off the floor using her walker and leaning on the wall. Continued review revealed R76 stated she bent down trying to pick something up and lost her balance, causing her to fall. Review of R76's Nurse Progress Notes, dated 05/17/2024 at 7:10 PM and signed by Registered Nurse (RN) 2, revealed the resident was transferred to the local hospital via emergency medical services (EMS) as per the physician's order and at the family's request. Review of R76's Emergency Department (ED) Note, dated 05/17/2024 at 7:05 PM, revealed she presented to the local Emergency Department (ED) following a fall, and the physician assessed the resident as having an altered mental status, symptoms of dysarthria and prolonged elevated blood pressure. 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 discharge MDS with an ARD of 05/17/2024, revealed the resident did not attempt a sit to stand due to medical conditions. Further, 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. Continued review revealed R76 had one fall resulting in a major injury. Further review of the CCP, revealed there were no revisions made or additional interventions initiated after R76's fall on 05/16/2024. Review of R76's hospital Patient Discharge Summary Report, dated 05/19/2024 at 10:12 AM, revealed the resident was diagnosed with a TIA and transferred back to the facility on [DATE]. New orders were given for medication to include acetaminophen 650 milligrams by mouth every six hours as needed for mild pain and Amlodipine 5 milligrams by mouth once daily for high blood pressure. The Summary did not include 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 State Registered Nurse Aide (SRNA) redirected R76 to remain seated. Per the note, R76 was very confused and expressed a desire to go inside. The SRNA then assisted R76 back into the building; however, left her alone to care for another resident. The note stated, at 2:53 PM, R76 stood up, tripped, fell on to her right hip, and hit her head. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	Review of R76's Health Status Note, dated 05/19/2024 at 3:14 PM, revealed a SRNA alerted R76's nurse the resident was observed to have fallen outside the Activity Room. According to the note, there was no visible injury; however, R76 complained of pain in her right hip and neck and was transferred to the local hospital via emergency medical services (EMS). Review of R76's hospital Discharge Summary, dated 05/21/2024 at 3:40 PM, revealed the resident presented to the ED after experiencing an unwitnessed fall from a standing height, resulting in severe right hip pain and altered mental status. Per the Summary, R76 suffered a traumatic right hip fracture, which caused significant pain. R76'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 revealed R76 had been independent in her Activities of Daily Living (ADLs) prior to the fall, and at her baseline, she ambulated with a walker. Additional 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. Per the Summary, the resident was discharged to home with hospice care. During interview with F3, on 10/04/2024 at 2:31 PM, she stated when R76 returned to the facility on [DATE], the family requested the resident rest in bed and refrain from participating in any activities. However, F3 stated staff got R76 out of the bed and 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 physical therapy (PT) in order to use the wheelchair. She further stated she received a call from a nurse who stated R76 had been taken to an activity outside and sustained a fall near the Activity Room while trying to get out of her wheelchair. F3 stated R76 sustained a fracture of the intertrochanteric portion of her hip. According to F3, R76's family decided against surgical intervention due to the resident being a poor surgical candidate and her marked decline since the fall. F3 further stated R76 was taken home with hospice care. During an interview with Licensed Practical Nurse (LPN)5 on 11/20/2024 at 2:06 PM, she stated she was told nurses on the floor did not have access to update the residents' care plans. LPN5 stated if the MDS Nurse was unavailable, she would make the Director of Nursing (DON) aware of any updated needed. During an interview with LPN6 on 11/21/2024 at 9:14 AM, she stated that she was not aware that nurses had access to update care plans. LPN6 stated that only the MDS Nurse and the DON were responsible for updating the care plans. During an interview with RN1 on 11/22/2024 at 12:51 PM, he stated that only the MDS Nurse had access to update a resident's care plan. He revealed that he had not received training to make changes to a resident's care plan. RN1 stated if new interventions need to be added, he would communicate that information to the MDS Nurse. During a telephone interview with RN2, on 10/04/2024 at 1:33 PM, she stated she did not update R76's CCP to include additional interventions to prevent future falls after the resident sustained the fall on 05/16/2024. The nurse stated the CCP should have been updated immediately to include interventions to alert staff and to keep R76 safe. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	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 following R76's first fall on 05/16/2024. She stated the CCP should have been updated with a new intervention to prevent further falls. Furthermore, the CCP should have included the family's request for the resident to rest in bed and avoid activities after returning from the hospital on 05/19/2024. During an interview with the former DON, on 10/09/2024 at 3:01 PM, she stated R76 should have been care planned with additional interventions to ensure all staff was aware of how to care for and monitor her after her fall on 05/16/2024. The DON stated the CCP should have included the family's request for the resident to rest in bed and avoid activities after returning from the hospital on 05/19/2024. Additionally, she stated it was the responsibility of the MDS Nurse to update and revise the CCP and she did not know why the MDS Nurse had not updated the CCP. The DON stated revising and implementing the CCP was essential because it instructed staff on how to best care for and keep the residents safe. During a follow-up interview with the MDS nurse on 11/14/2024 at 9:41 AM, she stated all nurses have access to revise and update the CCP. The MDS Nurse stated that R76's care plan should have been updated following her fall to include monitoring for changes in condition. During an 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 and revise care plans to ensure resident-centered care and safety for the residents. During an interview with the former Administrator, on 10/25/2024 at 12:45 PM, he stated it was his expectation staff follow the facility's CCP policy and update care plans as needed to ensure care for residents was appropriate and safe. During an interview with the Interim DON on 11/21/2024 at 10:45 AM, she stated the MDS Nurse was responsible for conducting baseline and comprehensive assessments on all residents. Additionally, the Interim DON stated the MDS Nurse ensured resident care plans were updated and revised as necessary and in a timely manner. The interim DON stated, however, the nurses have the authority to access, update, and revise the care plans if needed. During an interview with the Interim DON on 11/21/2024 at 3:45 PM, she stated that it was her expectation that all nurses implemented, updated and revised the CCP as needed to ensure residents received comprehensive, patient-centered care. She stated R76's care plan should have had a care plan developed with additional interventions to ensure all staff were aware of how to care for and monitor for the resident ' s decline in condition, including altered mental status. The Interim DON stated further that implementing the care plan was essential, as it provided instructions to staff on how to best care for the residents and ensure their safety. Further, she stated it was her expectation that staff followed all facility policies to ensure the safety of the residents. During an interview with the Interim Administrator on 11/22/2024 at 2:02 PM, she stated it was her expectation that staff would follow 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51155 Based on interview and review of facility policy, the facility failed to have systems in place to ensure there were an adequate number of staff always present who were properly trained and/or certified in Cardiopulmonary Resuscitation (CPR) for Healthcare Providers to be able to provide CPR until emergency medical services arrived. The deficient practice had the potential to affect all facility residents who required CPR. The findings include: Review of the facility's policy titled, CPR Certification, dated ,d+[DATE], revealed all licensed nurses were responsible for obtaining a Basic Life Support (BLS) CPR certification from an accredited licensing agency. Per review, all Kentucky Medication Aides (KMA) were also responsible for obtaining a Basic Life Support (BLS) CPR certification from an accredited licensing agency. Review of the facility's list of all its nurses and KMA's with CPR certification, provided by the Interim Director of Nursing (DON), revealed eight nurses currently employed had expired CPR certifications. Per review of the list, two of the nurses, Licensed Practical Nurse (LPN) 2 and LPN6, were being staffed as charge nurses on [DATE]. During interview on [DATE] at 11:53 AM, Registered Nurse (RN) 4 stated several staff members in the building had expired CPR certification. She stated she knew that because her license had recently expired. RN4 reported prior to her CPR certification expiring, she went to Infection Preventionist (IP) Nurse to let her know. She stated the IP told her she had to get a class together because several employees' CPR certification had expired. RN4 stated however, a CPR class was never offered and her CPR certification expired. She further stated she ended up going to an outside company to renew her CPR certification, but she had worked as a charge nurse for one week with it expired. During interview on [DATE] at 2:00 PM, the IP Nurse stated she provided classes for CPR certification; however, it was not part of her job duties to keep up with who had expiring certification. During interview on [DATE] at 9:14 AM, LPN4 stated she did not know her CPR certification had expired. She stated she was attending a CPR class on that date provided by the IP Nurse. During interview on [DATE] at 10:05 AM, the Quality Assurance (QA) Nurse stated she was not the one responsible for keeping a record of CPR certifications for staff. She further stated she was not sure whose responsibility it was to do that. During interview on [DATE] at 10:34 AM, the Scheduler/Staff Coordinator stated, I do not keep up with CPR certifications of full-time staff. Agency staff falls on me. I would assume it would be the IP because she does the classes. She stated, I check agency and keep up with agency [staff]. The Scheduler/Staff Coordinator further stated it was important to have staff qualified with active CPR certification, Because when you have a code you need to know how to respond, it's good to be up to date with what studies show works best. (continued on next page)

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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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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on [DATE] at 10:45 AM, the Interim DON stated the two nurses currently working today (LPN2 and LPN6) with expired CPR certifications now had active CPR certifications. She said the IP Nurse taught a class and got them re-certified. The Interim DON further stated the IP Nurse would now be the person responsible for keeping up with staff's CPR certifications and the expiration dates. During interview on [DATE] at 10:50 AM, the Interim Administrator stated it was her expectation that all nurses had active CPR certifications for the safety of all the residents.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 51155 Based on interview, record review, and facility policy review, the facility failed to ensure residents requiring dialysis services, received those services consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for one of one residents sampled for dialysis services, out of the total sample of 26 residents, (Resident (R)425). The facility failed to ensure there was documented evidence of ongoing assessments of R425's condition and monitoring for complications before and after dialysis treatments was done. The facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding R425's dialysis care and services was completed. The findings include: Review of the facility's policy titled, Dialysis Policy, undated, revealed, pre and post dialysis assessments will be completed for each visit. Continued policy review revealed the thrill and bruit were to be monitored and documented per the dialysis assessment and as needed. Further review revealed the dialysis shunt/fistula was to be monitored on a regular basis by nursing staff. Review of the facility document, Dialysis Communication Form, for R425's dialysis, revealed there were only four forms located. Further review revealed no documented evidence of post dialysis assessments completed. Review of R425's face sheet, located in the electronic health record (EHR) revealed the facility admitted the resident on 11/08/2024, with diagnoses of Congestive Heart Failure. Continued review of the EHR revealed End Stage Renal Disease with Hemodialysis was listed in R425's medical diagnosis list. Review of R425's Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 11/19/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of nine out of 15, indicating moderate cognitive impairment. Review of R425's comprehensive care plan 11/13/2024, revealed the facility care planned the resident for dialysis with a goal of no signs/symptoms of complications from dialysis through the next review date of 02/06/2025. Continued review revealed the interventions included checking the arteriovenous (AV) fistula for thrill and bruit which was added on 11/15/2024. Review of R425's physician orders revealed an order dated 11/15/2024, to obtain a full set of vital signs every day with parameters to notify the physician for a systolic blood pressure (B/P) greater than 170 or less than 90 and a pulse greater than 120 or less than 50. Continued review revealed a physician's order dated 11/21/2024, for the dialysis shunt in the resident's left upper arm to be assessed for thrill and bruit every day and night. Further review revealed a physician's order also dated 11/21/2024, to obtain R425's weight prior to dialysis and document on the dialysis communication form to send to dialysis with the resident on day shift every Monday, Wednesday, and Friday. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R425's progress notes dated: 11/11/2024, 11/13/2024, 11/15/2024, 11/18/2024, and 11/20/2024, revealed the only date that post dialysis vital signs were completed was on 11/15/2024. Further review of the 11/15/2024 note revealed no documentation addressing the resident's dialysis fistula site. The State Survey Agency (SSA) Surveyor requested pre/during/post dialysis assessment communication information, but the facility was unable to produce all the dialysis pre/during/post dialysis assessment communications. The SSA Surveyor received five communication forms of which four were not completed. (According to R425's dialysis schedule, the resident should have received five dialysis treatments before the SSA exited on 11/22/2024.) During interview on 11/20/2024 at 8:20 AM, Licensed Practical Nurse (LPN) 5 stated she assessed the fistula sites on dialysis residents when they left for dialysis and when they returned to the facility. However, additional review of R425's EHR revealed no documented evidence of assessment of the resident's fistula for 11/11/2024, 11/13/2024, and 11/18/2024. Further review of R425's EHR review, after the interview with LPN5 on 11/20/2024, revealed the LPN had documented an assessment of the resident's fistula in a progress note for that date. During interview on 11/20/2024 at 11:53 AM, Registered Nurse (RN) 4 stated the dialysis communication forms and reassessments were not done consistently. RN4 said the form did not appear for use until the end of October after she brought it to the facility's leadership's attention. She stated the front desk let the nurses know when a resident returned from dialysis. The RN reported after a dialysis resident returned she obtained a set of vitals (vital signs); checked the resident's fistula site and glucose; provided food if the resident had not eaten; and asked if the resident wanted to do activities. She said R425 never wanted to participate in activities after his dialysis. RN4 stated R425 was always confused after dialysis and would not take his medications until he spoke to his daughter. She reported R425 would also get aggressive, and staff would have to stay with him for about 30 minutes. The RN stated the parameters for residents' vitals were not listed in their care plan. She said however, with her history of working with dialysis residents, she felt the parameters should be on the care plans. RN4 further stated she had not received any training by the facility, but had received training at her previous place of employment. In interview on 11/20/2024 at 2:06 PM, LPN5 stated she received dialysis training/CEU's through the agency she worked for. She further stated she had not received any training by the facility. In interview on 11/21/2024 at 9:07 AM, State Registered Nurse Aide (SRNA) 5 stated she had not worked with a lot of dialysis residents, and said, most of what I would do is get them ready for dialysis. SRNA5 said she got the dialysis residents dressed and in a wheelchair and took them to the front of the building to wait for their transportation. She stated she had not received any training and that every resident got a full set of vitals taken on Tuesdays. The SRNA reported she knew not to get a B/P in the arms residents had any implantable device in. She further stated, the nurse would let us know if we couldn't use a side. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 11/21/2024 at 9:14 AM, LPN6 stated she had only taken care of R425 once in the past. She said for dialysis residents she would check their vitals, glucose, and fistula site every day. The LPN stated she had not received any recent education; however, looked things up herself when she got something she had not had in a while. She stated she looked at resident's care plans for their parameters. LPN6 reported she obtained all her residents' vitals herself because we don't have full time staff. She said she did not know the SRNA's and said, they could go in there and tell me anything. The LPN stated if a resident's vital signs were saved incorrectly, the system would not let you undo the charting. She further stated when R425 returned from dialysis I would write a nurse's note because the Dialysis Communication Form was just a piece of paper that could get lost. In interview on 11/21/2024 at 9:42 AM, the MDS Nurse stated the parameters for vitals being in dialysis residents' care plans was important in order for staff to know the resident's normal/baseline and when any changes were going on. She stated the communication forms between the dialysis clinic and the facility were not being completed as required. The MDS Nurse further stated however, the communication form was important because it was a good tool for communication between the clinic and facility. During interview on 11/21/2024 at 10:05 AM, the Quality Assurance (QA) Nurse stated the facility rarely has dialysis residents and that all of our staff are certified and should know how to care for dialysis residents. When the State Survey Agency (SSA) Surveyor asked the QA Nurse about what education staff had received from the facility regarding dialysis, she indicated she was unable to answer that question and the facility had no process in place to ensue that. She stated she did not provide any education or training to staff; however, when asked who provided education she said Probably me . When asked why having trained, qualified staff was important she stated, Dialysis residents are fragile and definitely need to be monitored closely. The QA Nurse further stated the issue would be addressed in clinical meetings going forward. In interview on 11/21/2024 at 10:45 AM, the Interim Director of Nursing (DON) stated the parameters for vitals should be included on residents' care plans. She stated a new process was being put into place for dialysis residents. The DON reported the communication between the dialysis clinics and the facility was not being done; however, a new form had been created and was awaiting the board's approval for use. She further stated communication between dialysis and the facility was important, Because it tells you everything you need to know and if there are any new issues. During interview on 11/21/2024 at 10:45 AM, the Interim Administrator stated residents should be care planned appropriately to include whatever parameters the provider wanted for that (dialysis) resident. The Interim Administrator said a new process was being worked on currently. She stated communication between the dialysis clinics and the facility should be done consistently for resident safety. The Interim Administrator further stated a new communication form had been created and she was awaiting the board's approval for its use.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 49050 Based on observation, interview, poilcy review, and the facility assessment the facility failed to ensure the licensed nurses and other nursing personnel had the knowledge, competencies and skill sets to provide care and respond to each resident's individualized needs as identified in his/her assessment and care plan. In interview agency staff stated they had not received training or education prior to being assigned to residents' care. The findings include: Review of the facility's policy titled, Resident Rights, undated, revealed residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety to the resident or other residents. Review of the facility document titled, Facility Assessment Tool: [Facility Name], Inc. undated, revealed there was no accommodation for agency staffing in the assessment. Per review of the Assessment, in the section titled, Table 3.1: Staff Competencies and Skills Based in Resident Population, the categories for training/assessment, competency approach, and competency listed licensed nurses, nursing assistants, dietary, environmental services, administration, therapy. However, continued review revealed no categories regarding agency staffing's training/assessment, competency approach, and competency. Continued review of the facility document titled, Facility Assessment Tool: [Facility Name], Inc. undated, regarding Table 3.1 revealed it identified competencies for licensed nurse and nursing assistants were to be assessed during orientation, annually, and pre/post test. During interview on 11/20/2024 at 10:07 AM, the Schedule Coordinator (SC) stated she had been in her position since 08/14/2024, and was also a State Registered Nurse Aide (SRNA) and Kentucky Medication Aide (KMA). She stated her duties at the facility included employee onboarding and orientation. The SC said she had previously worked for a staffing agency and was familiar with the process for using agency staff. Per the SC in interview, for Unit 1, there were four nurse aides staffed, and during breakfast and lunch two of the aides went to the dining room and two stayed on the unit for resident care. She reported there was one Registered Nurse (RN) to cover the residents' needs and one Licensed Practical Nurse (LPN) who strictly passed medications. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In continued interview on 11/20/2024 at 10:07 AM, the SC stated staff rotated through on the weekends with in-house and agency staff. She said having agency made things harder because the agency staff might not know the residents as well as facility staff. The SC stated having in-house staff made a difference with residents, and she was working with the Administrator to understand the facility's assessment and how to determine the Hours Per Resident Day (HPRD). She stated she was not currently familiar with the facility's assessment and its purpose. The SC reported when an agency employee started working at the facility, she set them up with a login for the facility's computer system, and agency staff could not pick up a shift if they were out of compliance with their trainings. She stated no one tracked the agency staff, but they were not allowed to provide care to residents if their online training was not current. She said when she was working for an agency, notifications were sent to her to complete necessary trainings or additional education before she was able to pick up shifts. In further interview on 11/20/2024 at 10:07 AM, the SC stated all agency staff were trained by their agency through a computerized training program which incorporated online videos and posttests to determine staffs' competency. She said once agency staff arrived for work at the facility all their training and certifications had already been imported from their agency. The SC reported agency personnel shadowed facility staff to become familiar with the resident, the charting system, and layout of the facility. She further stated agency staff competencies were completed prior to providing resident care, and they were not allowed to care for residents without passing their competencies. The SC also stated the agencies who supplied staffing for the facility were required to validate the credentials of staff who were to work at the facility. During interview on 11/22/2024 at 9:39 AM, LPN3 stated she was and agency nurse and had worked at the facility for a month. She stated the nurse aides who worked on the unit she did were mostly agency, but as they had worked at the facility for a long time, she felt like the aides knew the residents. The LPN said she received no education or training when she started working at the facility, and had not received any competency assessments since she started working. She stated her staffing agency made sure we have all of our trainings up to date. LPN3 reported she had not worked at the facility long enough to know if they provided check offs or had competency trainings. During interview on 11/22/2024 at 12:43 PM, R25 stated the agency staff did not know him or his preferences. He stated agency had to be told what to do, especially at night and on the weekends. R25 further stated, They don't know nothin, I have to tell them everything to do. During interview on 11/22/2024 at 12:51 PM, RN 2 (an agency nurse) stated when R425 came back from the hospital on 11/08/2024, they just dropped him off, and no one told him the resident was being admitted to skilled nursing from where he previously resided on the facility's personal care unit. He reported he texted the former Director of Nursing (DON) and received no response from her, so he called the house supervisor who assisted him. RN2 stated They didn't tell me I needed to do an initial assessment, I thought it was a transfer. He further stated when he told the former DON, she told him nothing, and said, You're basically left on your own. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/22/2024 at 2:01 PM, with RN1 (an agency nurse) he stated he worked on the facility's Unit 2. He stated he was the only nurse working on the unit and must pass medication, do treatments, assessments, discharges and admissions. The RN stated he felt overwhelmed at times, and said the nurse aides on his unit did not know the residents' needs and preferences. He said he was unsure if agency staff knew anything about the residents they were caring for. The RN reported he had not received any training from the facility or the agency he worked fro on competencies. He said when he was hired to work, there had been no education or skills check off, and the facility had not provided any additional skills or assessment verification. RN1 stated agency staff did not ensure continuity of care because some were not qualified or had not received proper training. He further stated he obtained his residents' vital signs because he did not trust the aides to accurately obtain them for him. During interview on 11/22/2024 at 1:15 PM, RN7 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 jobs. The RN stated she had not received training from the agency she worked for; however, had been required to do online education. She further stated the facility had not provided her any skills check off or testing. During interview on 11/22/2024 at 2:04 PM, SRNA21 stated it was her sixth shift working at the facility, two shifts at night and the rest of the shifts during the day. She stated she was just placed on the floor to work with no training or had not been able to shadow another STNA. SRNA21 said she got report from the previous SRNA about her residents and that was it. She stated she completed some computer modules at the agency she worked for, and had been trained on Enhanced Barrier Precautions (EBP). During interview on 11/21/2024 at 1:19 PM, the Interim DON stated there was a huge problem with staffing from an agency stand point. She said she and the Interim Administrator figured the staffing was at 4.25 PPD which was high for the facility with the acuity level of the residents currently. The Interim DON reported we have a lot of agency staff currently, and when she looked at the staffing ratio for the last two days it revealed 68% of the facility's staffing was agency filled. She stated she and the Interim Administrator had presented their concerns to the facility's board of directors as recently as 11/20/2024. The Interim DON further stated with all the agency staff currently, there could not be continuity of care, and the residents needed to know who was going to be taking care of them consistently. During interview on 11/21/2024 at 2:09 PM, the Interim Administrator stated my role in developing the staffing schedule covered working with the Schedule Coordinator to ensure we have enough staffing to provide for the residents' needs.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51155 Based on observation, interview, record review, and facility policy review, the facility failed to ensure all drugs used in the facility were labeled in accordance with professional standards. Observation revealed undated, opened medications, found in one of four medication carts, which included laxatives, cough medication, and nasal sprays. The findings include: Review of the facility's policy titled, General Dose Preparation and Medication Administration, dated 12/01/2007, and revised 01/01/2013, revealed, Once any medication or biological package is opened . the facility was to follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Per policy review, facility staff were to record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication had a shortened expiration date once opened. Further review revealed facility staff were to also comply with applicable law and the State Operations Manual when administering medications. Observation on 11/20/2024 at 3:30 PM, revealed the Unit 3 medication cart contained opened, undated medications. Per observation the medications included: Flonase (steroid) inhalers Resident (R)5, R12, and R29; Ipratropium Bromide nasal spray for R12; Milk of Magnesia (laxative) and Geri-Tussin (cough syrup) for R56, Keppra (seizure medication) for R33, and Guaifenosorb (used to treat chest congestion) for R29. During interview on 11/20/2024 at 3:30 PM, Kentucky Medication Aide (KMA) 2 stated she did not know the actual medication container needed to be dated. During an interview on 11/21/2024 at 9:14 AM with Licensed Practical Nurse (LPN) 6, she stated medications should be dated when they are opened to ensure they are not used after expiration date. She revealed that any opened medication that was undated should be discharged and reordered by the pharmacy. During interview on 11/21/2024 at 10:45 AM, the Interim Director of Nursing (DON) stated it was her expectation of staff to date any opened medication. She further stated that was so staff would know when the medication expired. During interview on 11/21/2024 at 10:50 AM, the Interim Administrator stated it was her expectation that staff would follow the facility's medication policy and date medications when they were opened for residents' safety.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28707 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure each resident received food and drinks which were palatable, attractive, and at a safe and appetizing temperature for five of nine sampled residents reviewed for food temperatures (Residents (R)68, R29, R9, R65, and R58). During resident council, residents expressed concerns of their food being served cold when the aides passed their trays. Observation of the lunch meal on 11/20/2024, revealed the beef and noodle entree and vegetable medley were not at an appetizing and acceptable temperature. The findings include: Review of the facility's policy titled, Food Temperatures, dated 2003-2004, revealed the appropriate serving temperature (temp) of hot foods was for the food to be over 140 degrees (140) Fahrenheit (F) for hot foods. Review of the facility's Room Test Tray Evaluation Form, undated, noted the acceptable point of service (POS) temp for hot foods was 135 to 160 F. Review of the facility's form titled, Food Temperatures, undated, revealed the POS temp for hot foods was 115 to 125 degrees F. Review of the Test Tray Report Form, undated, (provided after review of the Room Test Tray Evaluation Form) noted the acceptable POS temp was greater than 120 F for hot foods, and less than 45 F for cold foods. Review of the facility's Resident Council Meeting Minutes, dated 08/05/2024, revealed a resident (R68) complained about the food being cold when the aides passed out trays. Per review, the resident who complained resided on the facility's Unit 2. Review of the Resident Council Meeting minutes dated 10/07/2024, revealed two residents (R68 and R29), who both resided on Unit 2, complained of their food being cold when it was delivered to their rooms. Review of the Resident Council Meeting minutes dated 11/04/2024, revealed R68 and R29 both reported their concerns regarding cold food. Continued review of the 11/04/2024 minutes revealed it was noted the residents' concerns had not been resolved and was an ongoing issue. During the Resident Group meeting held on 11/18/2024 at 3:30 PM, with nine residents in attendance, four residents complained about cold food. R9, from Unit 2, stated during the meeting the food was always cold, because it sits out in the hallway and gets cold. R9 additionally stated staff said they could not reheat the food. R29 also stated during the meeting, the food was always cold and R65, from Unit 1, agreed the food was always cold. R58, from Unit 2, also stated the food was only ever warm at best. (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/20/2024 at 11:30 AM of the steam table temperatures taken for food for the Unit 1, Cart 1 revealed: beef entree temp was 192 F; starch temp (noodles) was 186 F; and vegetable temp was 191 F. The Unit 1, Cart 1 was observed to leave the kitchen at 11:48 AM, and arrived on the unit at 11:52 AM. Observation revealed the last tray was delivered at 12:04 PM. The SSA Surveyor checked the palatability of the test tray at 12:04 PM, and determined both the entree/starch (beef and noodles) and vegetable medley had cool temperatures. Observation of the temp checks for the test tray food at POS was: 125 F for both the entree and starch, and 120 F for the vegetable medley. In interview on 11/20/2024 at 12:43 PM, the Dietary Manager (DM), when asked about the large drop in food temps from the tray line to the POS, she stated staff were up and down the hall multiple times opening and closing the food cart. The DM reported however, she was not certain that caused the food temps to drop. She stated she would have another test tray on Unit 1 tomorrow at lunch to see if the issue was isolated. Review of the Test Tray Report Form for lunch service on 11/21/2024, revealed the Unit 1, Cart 1 was loaded at 11:33 AM, was on the unit at 11:37 AM, and the last tray was delivered from the cart at 11:54 AM. Review revealed it was a total of 17 minutes on the unit or 21 minutes from the time the cart was prepped until the time the last tray was delivered. Review of the food temps on the Report form revealed: the starch (potato wedges) was 182 F on the steam table, but was 120 F at the POS; milk was 37 F on ice in the kitchen, but was temping at 47 F at POS. In follow up interview on 11/21/2024 at 10:54 AM, the DM stated she had used the wrong form yesterday, which was the Room Test Tray Evaluation Form. She stated the correct form was the Test Tray Report Form. The DM reported that, according to measures on the correct form, the entree yesterday had been in an acceptable range at 120 F, and the vegetable had been bordering on acceptable range. When asked by the SSA Surveyor if the DM had been able to determine why the food temps dropped so greatly yesterday from the steam table to POS, she said she was uncertain. In additional interview on 11/21/2024 at 12:42 PM, with the DM following the lunch service, she reported the entree (fish) temp was 136 F; the vegetable (potato wedges) at 120 F; [NAME] slaw at 41 F; coffee at 130 F; and milk at 47 at POS. When the DM was asked about the vegetable being below the desired temp of greater than 120 F, she stated they were not as dense and tended to lose their temp a lot faster. She stated there was only one aide and one nurse delivering trays on the floor at lunch service on Unit 1, as both other aides had been providing resident care at the time. The DM stated she was going to have maintenance look at the plate warmer to see if the temp could be increased, as a hotter plate might make a difference. When the DM was asked about the residents' complaints brought up in resident council meetings, the DM said those were reported to the dietician, who did test trays and had not noted any food temp concerns. In interview on 11/21/2024 at 1:02 PM, the Interim Director of Nursing (DON) stated she had not heard any concerns about cold food in her eight (8) days at the facility. She stated her expectation was that residents be satisfied with their food and the temperature of it. The Interim DON further stated she expected residents' food to be delivered to them warm. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In interview on 11/21/2024 at 2:16 PM, the Interim Administrator stated in the short time she had been in the facility, no one had expressed concern to her regarding food temps. When the SSA Surveyor shared with her the various conflicting standards for expected food temps at POS, she stated her expectation was for there to be consistency in policy on what the facility's expectations were. She further stated the food temperatures should be acceptable to residents, with residents never getting cold food.

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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** 44001 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. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 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. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 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. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview with the QA Nurse, on 10/23/2024 at 3:10 PM, she stated she was a member of the QAPI Committee. She stated she had attended QAPI, and the issues with legionellosis contamination test results were discussed and control measures to close the Unit 2 shower were decided. She stated she could not recall any other specific items related to water contamination or mitigation discussed in previous QAPI meetings. She stated the DEHP's recommendations were discussed at an Ad Hoc QAPI meeting when the committee discussed the IJ Removal Plan. She further stated the WMP, CDC training, and infection surveillance was discussed. The QA Nurse stated the committee awaited guidance from the LHD and Certified Legionella Water Safety Expert (CLWSE) to proceed with the WMP. The QA Nurse further stated it was important to follow the DEHP's recommendations to ensure the safety of residents. During an interview with the IP, on 10/08/2024 at 9:10 AM, she stated in August 2024 the DEHP 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. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 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. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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. 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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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 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** 44001 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. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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, 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. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 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. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 proper WMP. The DEHP noted the facility's score on the WMP assessment was one out of nine (1/9), noting healthcare facilities should achieve a score of eight or higher (8/9). B.) Water sampling had been insufficient to evaluate the growth reservoir in the building's water system. C.) There were no documented logs to confirm the flushing procedures. Per further review of the report, the DEHP recommended the following steps to prevent future outbreaks or occurrences of legionellosis: A.) Remind healthcare providers to include legionellosis in their differential diagnoses. B.) Continue enhanced surveillance for new cases of legionellosis and review residents' charts daily for potential radiographs, lab tests, or diagnoses related to possible or atypical pneumonia. C.) Complete the Water Infection Control Risk Assessment (WICRA) before developing a WMP. D.) Create a WMP that incorporated the recommendations from the CDC. E.) Validate the plumbing diagram with greater detail according to the CDC guidelines and document the recirculation system. F.) Ensure all Water Management Team (WMT) members completed the CDC Prevent LD training module. G.) The third-party contractor was to familiarize themselves with legionella sampling protocols by completing the CDC's Prevent LD training module. H.) Submit sampling plans to the local health department before conducting any additional sampling. Review of an email, dated 08/05/2024, from the Public Health Director at the LHD to the facility's Administrator, DON, and IP, revealed the LHD attached the findings from the DEHP's Legionellosis Full Investigation Preliminary Findings, dated 07/26/2024. The Director requested that the recipients review the attachment and contact her with any questions. Review of a letter dated 08/20/2024, addressed to the facility's providers from the Infection Preventionist (IP) revealed the facility's water system had shown detectable levels of legionella. Per review, 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. Further review revealed the letter was sent out 15 days after the facility received the DEHP's recommendations and not immediately after receival of the recommendations on 08/05/2024. Review of the facility's Certificates of Training for the CDC's Prevent Legionnaires' Disease course revealed only five of the eight members of its Water Management Team (WMT) had certificates of completion. Per review, the five members who completed the course included the Director of Nursing (DON), Infection Preventionist (IP), Dietary Manager (DM), Quality Assurance (QA) Nurse, and the Certified Legionella Water Safety Expert (CLWSE) had certificates of completion. The Administrator, Director of Maintenance (DOM), Housekeeping Director (HSKD), and third-party contractor had not completed the recommended training. The facility did not provide documentation logs of daily water flushes for the showers in Units 1, 2, and 3. Furthermore, there was no documentation of daily flushes in empty rooms. There was no documentation of the method and duration of flushing. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on 10/03/2024 at 9:50 AM, of resident rooms in Units 1, 2, and 3 revealed that none of the residents had bottled water in their rooms. Units 1 and 2 did not have any gallon jugs of spring water available for use, while Unit 3 had only one gallon jug located in the nurse's station. Additionally, there were no individual bottles of water found in the nourishment refrigerators. Continued observation of Unit 1, 2, and 3 showers revealed [NAME] filters had been placed on the showers. During interview with Family 1 (F1) on 10/03/2024 at 10:32 AM, he stated that there had been ongoing water contamination at the facility for at least four weeks. He stated he was not notified of the 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. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 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. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 instructed him on how to flush water lines, the MA stated the DOM. The MA reported when performing a water line flush, he first flushed the commode, then turned on the hot and cold water simultaneously in the sink and the tub and ran the water for 20 minutes. He stated he did not run the water through the shower head, and did not check the temperature of the water. Review of an email to the Director of Maintenance (DOM) from the IWSC on 10/02/2024 at 9:46 AM, revealed the email included recommendations from the CLWSE. Per review, the CLWSE made the following recommendations: continue weekly testing for legionella; and maintain and replace all point-of-use ([NAME]) filters as specified by the manufacturer, including routine checks to ensure they were functioning correctly. Additionally, review revealed the recommendations noted while the recommendations were based on industry standards and best practice it remained the facility's responsibility to assess implement and manage the risk associated with legionella. During interview with the Director of Maintenance (DOM) on 10/04/2024 at 10:50 AM, he stated the facility's WMT had participated in online meetings with the Local Health Department (LHD), State Public Health Department (KDPH), IWSC, and CLWSE to discuss ongoing positive legionella results. The DOM stated the CLWSE had conducted an onsite visit and he had just received his (CLWSE's) recommendations, but had not yet reviewed them. He stated that housekeeping had been flushing unused water sources such as faucets in empty rooms and unused tubs, showers, and sinks on a weekly basis. The DOM stated since April 2024, maintenance had been flushing faucets in empty rooms and dead-end water sources daily. He reported however, there was no documented evidence of the daily flushing being performed. The DOM said the facility had not yet acted on the DEHP's recommendations because they were awaiting action from the CLWSE. He stated during an online meeting with the LHD and KDPH, the DON said the CLWSE had informed the team he was capable of writing a WMP for the facility and would take care of doing that. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an additional interview with the DOM on 10/09/2024 at 1:33 PM, he stated he had not received formal training on how to properly flush water lines. He stated he instructed his Maintenance Assistant (MA) to open both the hot and cold water lines in the tub and sink faucets and run the water for 20 minutes. The DOM stated he had not instructed the MA to run the water through the shower wands as he stated he didn't know if he was supposed to do that or not. He further stated no external water hoses were currently being used, but he did not perform a flush on those. During an additional interview with the DOM on 11/20/2024 at 10:45 AM, he said the facility has expanded their water testing. The DOM said the recent testing which began on 10/10/2024, had shown increased levels of legionella SG1 and non-pneumophila throughout the building. He said it had been found in the rooms where residents resided. The DOM reported the sinks in the Activity Room tested positive. He stated based on the results, dated 10/31/2024, the CLWSE recommended a whole facility monochloramine treatment. The DOM stated however, the facility had yet to do the recommended whole building monochloride treatment despite continued positive testing. In continued interview on 11/20/2024 at 10:45 AM, the DOM stated the monochloride treatment had been delayed due to broken water valves. He stated the water softener had a water feed valve, a bypass valve, and a discharge valve. The DOM reported the bypass valve was broken in the closed position, and the discharge valve was broken in the open position. He said in order to do the monochloramine treatment, the softener must be bypassed to ensure the monochloramine was not diluted, which meant the valve could not be opened to do that. During telephone interview with the IWSC 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 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. (continued on next page)

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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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. 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 that call it was expressed the facility needed to hire a CLWSE to inspect, assess, and help develop a WMP in accordance with CDC guidelines and industry standards. He reported he had not had a con [TRUNCATED]