

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

PRINTED: 11/15/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/31/2011
NAME OF PROVIDER OR SUPPLIER  BOYD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	To the best of my knowledge and belief, as an agent of Boyd Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid Requirements.	
F 226 SS-D	483.13 (F226) ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to implement written policies that prohibit mistreatment, neglect, and abuse of residents for one (1) of three (3) sampled residents. Resident #1 suffered an injury of unknown origin which was reported to nursing staff three (3) times, and which nursing staff failed to investigate two (2) times.  The findings include:  A review of the facility's Resident/Visitor Incident Reporting policy, dated 01/21/11, revealed that "an incident is an occurrence that is not consistent with the routine operation of the facility or the routine care of a particular resident." Further, the policy goes on to define falls as a reportable incident. A review of the facility's Abuse, Neglect and Exploitation policy, dated 07/01/09, revealed injuries of unknown origin are	F 226  Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.  It is the policy of Boyd Nursing and Rehabilitation Center to ensure the development and implementation of written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  Charge nurse (RN) notified Physician following discovery of bruise of Resident #1 on 10/16/11. X-ray ordered to right shoulder due to bruising and pain in movement. Loratab 3-500 BID for breakthrough pain as needed also ordered by physician. New orders received and noted by charge nurse. X-ray results fracture of distal clavicle with mild displacement. Charge nurse completed incident report 10/16/11.  SRNA #4 was immediately suspended on 10/19/11 upon investigation discovery of incident occurrence on 10/12/11 by Director	12/01/11	

RECEIVED  
NOV 22 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator (X6) DATE 11/22/2011

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 dischargeable 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 dischargeable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 11/15/2011  
FORM APPROVED  
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/31/2011
NAME OF PROVIDER OR SUPPLIER  BOYD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12000 PRINCELAND DRIVE ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 228	<p>Continued From page 1</p> <p>to be identified as potential abuse or neglect, and reported to the supervisor, Director of Nursing (DON), and Administrator immediately.</p> <p>Review of Resident #1's medical record revealed the facility admitted Resident #1 on 07/02/08 with diagnoses which included Alzheimer's Disease, Psychosis NOS, and Osteoporosis NOS. The facility assessed Resident #1, in a Quarterly Minimum Data Set (MDS) Assessment dated 08/05/11 as severely cognitively impaired.</p> <p>An interview with the Administrator, on 10/28/11 at 2:00 PM, revealed State Registered Nursing Assistant (SRNA) #4 did not report a fall Resident #1 incurred on the night of 10/12/11 while SRNA #4 was providing perineal care. Further, the Administrator revealed SRNA #1 noticed bruising on Resident #1 on 10/13/11 during a shower, which she reported to Registered Nurse (RN) #1. The Administrator went on to reveal RN #1 did nothing. The bruising was reported again to RN #1 on 10/16/11 by SRNA #2, which again went unreported by RN #1. Finally, SRNA #7 and the sister of Resident #1 noticed the bruising the evening of 10/16/11, which they reported to RN #2, who assessed Resident #1 and reported the injury. Resident #1 received an x-ray in-house on the night of 10/16/11, which revealed a "fracture of the distal clavicle with mild displacement".</p> <p>An interview conducted with SRNA #4, on 10/31/11 at 11:24 AM, revealed she was providing perineal care to Resident #1 on the night of 10/12/11. SRNA #4 revealed she was on her knees as Resident #1 had a low bed, and she accidentally rolled Resident #1 off of the bed towards her. SRNA #4 stated she caught</p>	F 228	<p>of Nursing. After completion of incident investigation the Director of Nursing terminated from employment with Boyd Nursing and Rehabilitation Center SRNA #4 on 10/21/11 for failure to report.</p> <p>RN #1 was terminated from employment with Boyd Nursing and Rehabilitation Center for failure to complete incident report and failure to report 10/25/11 by Director of Nursing.</p> <p>Social Service Director unable to conduct mood interview with Resident #1 related to resident severe cognitive impairment. Per nursing notes 10/16/11 and 10/17/11 no symptoms of distress or discomfort noted. No further counseling needed.</p> <p>Skin Assessments completed on all residents as of 10/28/11 by nursing staff. Assessments were reviewed by Staff Development Coordinator (RN). No issue involving skin assessment found that required additional follow-up.</p> <p>Administrator and DON reviewed policy and procedures for Incident Reporting and Abuse, Neglect and Exploitation on 11/04/11. No changes to policies were made.</p> <p>Education regarding proper reporting procedures for incidents was provided to all staff by the Staff Development Nurse as of 11/09/11. The facility does not employ any agency staff. This information will be provided to new hires or any staff not</p>	

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

PRINTED: 11/16/2011  
FORM APPROVED  
OMB NO. 0938-0891

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/31/2011
NAME OF PROVIDER OR SUPPLIER  BOYD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 2</p> <p>Resident #1 in her arms, and gently lowered Resident #1 to the ground. SRNA #4 stated she then got help from another aide and utilized a lift to get Resident #1 back into bed. SRNA #4 stated Resident #1 did not indicate either verbally or non-verbally that he/she was in any distress, either while finishing perineal care and changing Resident #1's gown, or while caring for Resident #1 the rest of the shift. SRNA #4 stated she didn't report the incident because at the time she did not consider it a fall, as she had caught Resident #1. SRNA #4 was off the following days, and was terminated from employment upon completion of a facility investigation.</p> <p>An interview with SRNA #2, on 10/28/11 at 12:05 PM, revealed she noticed bruising on Resident #1 on the morning of 10/16/11 while providing care to Resident #1, and went on to reveal she had reported it to RN #1 immediately after, even encouraging RN #1 to come in and check the resident. SRNA #2 stated RN #1 informed her it had already been reported. An interview with Licensed Practical Nurse (LPN) #2, on 10/28/11 also at 12:05 PM, revealed she was nearby passing medications when SRNA #2 reported the bruising to RN #1 on 10/16/11, and overheard SRNA #2 report the bruising to RN #1.</p> <p>RN #1 could not be reached over the course of the investigation, and a certified letter was sent on 11/14/11.</p> <p>Observations of Resident #1 conducted throughout the interview, on 10/28/11, revealed Resident #1 had flat affect, and rarely responded to outside stimuli. The only response observed was on 10/28/11 at 1:20 PM, during an interview</p>	F 226	<p>included in the above education by the Staff Development Coordinator prior to assuming any direct care assignment.</p> <p>Education regarding facility's Abuse, Neglect and Exploitation Policy was provided to all staff by the Staff Development Coordinator on 11/09/11 and will be completed by 12/01/11. The facility does not employ any agency staff. This information will be provided to new hires or any staff not included in the above education by the Staff Development Coordinator prior to assuming any direct care assignment. All staff are re-educated on the abuse policy at a minimum once a year by the Staff Development Coordinator utilizing Silver Chair, a computerized learning program, created especially for health care industries. Residents or the responsible party receive a copy of the facility abuse policy upon admission.</p> <p>The DON/designee (RN Supervisor) will conduct at least three random skin audits on non-interviewable residents for four weeks to ensure that any injuries of unknown origin have been reported and investigated as required.</p> <p>All incidents reports are reviewed Monday thru Friday at the daily Standup Meeting by the Administrator, Director of Nursing and Social Service Director to determine if additional follow-up is needed. Any unusual incident reports and the results of the above listed audits will be reviewed by the weekly Focus Committee. Focus</p>		

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

PRINTED: 11/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/31/2011
NAME OF PROVIDER OR SUPPLIER  BOYD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 3 with Resident #1's sister in Resident #1's room. Resident #1's sister was styling Resident #1's hair and accidentally pulled it, at which point Resident #1 stated "Ow." in a soft, flat voice.	F 226	Committee members include Director of Nursing, Administrator, Staff Development Coordinator, Medical Records, MDS Coordinator, Dietary Manager, Social Service Director, and Activities Director. Results will also be reviewed monthly by the CQI Committee for further monitoring and continued compliance. Members of CQI Committee include Administrator, Director of Nursing, Medical Director, Pharmacy Consultant, Medical Records, MDS Coordinator, Dietary Manager, Activities Director, Social Service Director, Housekeeping Supervisor and Maintenance Director. This process will remain in place.	