

Acceptable
10/31/13

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

PRINTED: 10/16/2013
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 10/02/2013
NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102	

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F 000 INITIAL COMMENTS

An Abbreviated Survey for ARO KY#00020775 was initiated on 10/01/13 and completed on 10/02/13. ARO KY#00020775 was substantiated with deficiencies cited.

F 221 SS=E 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, review of the medical record and review of the facility's policy, it was determined the facility failed to ensure each resident attained and maintained his/her highest practicable wellbeing. The facility failed to fully inform two (2) of three (3) sampled residents (Resident #1 and Resident #2), or the residents' legal representatives of the potential risks and benefits of the restraint devices prior to the application of the devices.

The findings include:

Review of the facility's policy titled, "Restraints - Physical", with an effective date of 08/01/12, revealed informed consent identifying the risk/benefits of the use of restraints was required by the resident and/or responsible party. The risk verses benefit section was located on the facility's consent for restraint form.

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 221 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 that residents are free from any physical restraints imposed for the purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

The Activity Tray for Resident #1 was re-assessed by the IDCPT (Interdisciplinary Care Plan Team) on October 1, 2013. All required documentation including, but not limited to assessments, physician order, consent, risk and benefits, and care planning were completed by the MDSC (Minimum data set coordinator) on October 1, 2013.

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

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

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F 221	<p>Continued From page 1</p> <p>Observation during initial tour on 10/01/13 revealed Resident #1 was in a wheel chair with an activity tray attached to the wheel chair. Further observation revealed Resident #2 was in a geri chair with a utility tray attached to the geri chair.</p> <p>Resident #1 was admitted by the facility on 08/12/13 with diagnoses which included Altered Mental Status, Muscle Weakness - Generalized, Difficulty In Walking, Dementia with Behavior Disturbances, and Generalized Anxiety Disorder. Review of Resident #1's Re-Entry Minimum Data Set (MDS) dated 08/16/13, revealed a Brief Interview for Mental Status (BIMS) score of 02/15, indicating cognitive impairment.</p> <p>Review of Resident #1's medical record revealed a Physician's order for an activity tray to be attached to the resident's wheel chair dated 09/27/13. Review of the consent form revealed a phone consent was obtained from the legal representative five (5) days after the restraint device was applied. The phone consent was dated 10/01/13.</p> <p>Resident #2 was admitted by the facility on 04/17/08 with diagnoses which includes Alzheimer's disease, Psychosis, Depressive Disorder, Osteoporosis and a personal history of falls. Review of Resident #2's Admission MDS, dated 08/30/13, revealed a cognitive score for daily decision making to be a three (3) indicating severely impaired.</p> <p>Review of Resident #2's medical record revealed a Physician's order for a geri chair with a utility tray dated 07/18/13. Review of the consent form revealed a consent was obtained from the legal</p>	F 221	<p>The Geri-Chair with utility tray for Resident #2 was re-assessed by the IDCPT on October 15, 2013. All required documentation including, but not limited to assessments, physician order, consent, risk and benefits, and care planning were completed by the MDSC on October 15, 2013.</p> <p>Any Resident utilizing a device that could potentially meet the criteria of a restraint was reviewed by the DON and MDSC on October 15, 2013. Any device deemed to be a restraint was reviewed by the DON and the MDSC on October 15, 2013 to ensure that all documentation including, but not limited to assessments, physician order, consent, risk and benefits, and care planning were documented in the medical record.</p> <p>The IDCPT and all licensed nursing staff received additional education by the Director of Nursing no later than October 17, 2013 regarding the RAI criteria utilized to determine what constitutes a restraint and the documentation requirements that must be included in the medical record prior to initiating any type of restraining device. Additional education regarding the resident's right to be free from any physical restraint imposed for the purposes of discipline or convenience; and not required to treat the resident's medical symptoms was also addressed at this time.</p>	
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F 221 Continued From page 2
representative forty-four (44) days after the restraint was implemented. The consent was obtained by phone on 08/30/13 for a geri chair. Further review revealed no documented evidence a consent was given by the legal representative for a utility tray to be attached to the geri chair. Continued review revealed Resident #2 was ordered to have a seat belt restraint on 11/14/12 and consent was not obtained from the legal representative until ten (10) days after the device was applied. The consent was signed by the legal representative on 11/24/12.

Interview with the MDS coordinator, also responsible for obtaining restraint consents, on 10/02/13 at 4:40 PM, revealed there was a consent for an activity tray for Resident #1, dated 12/04/12; however, no consent was obtained for a utility tray. Further interview revealed the consent for the geri chair for Resident #2 was dated 08/30/13 and the restraint device was implemented prior to the consent. Further interview revealed Resident #1's activity tray restraint was applied prior to the phone consent give by the legal representative. Further Interview revealed the consents were occasionally mailed to the representative.

Interview with the Director of Nursing, on 10/02/13 at 2:56 PM, revealed her expectation would be for staff to obtain consent from the legal representative prior to a restraint device being applied to the resident.

F 221 The DON or MDSC will conduct audits weekly for four weeks on all residents utilizing a restraint to ensure that the required documentation is included in the medical record. The DON or MDSC will audit any new restraint to ensure that appropriate and timely documentation is included in the medical record.

The results of these audits will be forwarded to the Weekly Focus meeting (a sub-committee of Continuous Quality Improvement committee-CQI) to determine that all appropriate documentation is recorded and follow-up in place. The results will be forwarded to the monthly CQI Committee for further monitoring and continue compliance.

F 280 SS=D 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
The resident has the right, unless adjudged incompetent or otherwise found to be

F 280 It is the policy of Boyd Nursing and Rehabilitation Center to ensure residents have a right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in
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F 280 Continued From page 3
incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system to ensure a Comprehensive Care Plan was revised with individual interventions to reflect the facility's implementation of a restraining device for one (1) of three (3) sampled residents (Resident #1). Resident #1 was placed in a physical restraint on 09/27/13 with no reference and update to the comprehensive care plan until 10/01/13.

The findings include:

F 280 planning of care and treatment or changes in care and treatment.

Care plan for Resident #1 has been reviewed and revised by the IDCPT on October 1, 2013 to include accurate individualized interventions to reflect current needs of the resident.

The IDCPT will review and revise all care plans by October 31, 2013 to ensure accurate, individualized interventions that are reflective of current needs of the resident.

The IDCPT was re-educated October 17, 2013 by the DON regarding the importance of reviewing and revising resident status on a daily basis to ensure that resident needs are recorded accurately and completely on the current plan of care.

The DON/Designee will review four (4) care plans each month for four months, then four (4) quarterly for one year to determine that the care plans are accurate and reflective of current resident needs.

The results of these audits will be forwarded to the weekly Focus Meeting (a Sub-committee of Continuous Quality Improvement committee---CQI) to determine that the care plans are accurate and reflective of current resident needs. The results will be forwarded to the monthly CQI Committee for further monitoring and continue compliance.

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F 280 Continued From page 4

Review of the facility's policy titled Comprehensive Plan of Care and effective 08/01/12, revealed the Comprehensive Plan of Care will be updated to reflect the resident's current condition at least every ninety (90) days, or whenever significant changes occur.

Review of the facility's policy titled "Restraints - Physical" with an effective date of 08/01/12, revealed the plan of care for the restricted resident must detail when the restraint is to be used, how long it is to be used, plans for alternative measures, periodic re-evaluation of reduction of the restraint and continued need for the restraint.

Observation during Initial tour on 10/01/13 revealed Resident #1 in a wheel chair with an activity tray attached to the wheel chair.

Record review revealed Resident #1 was admitted by the facility on 08/12/13 with diagnoses which included Altered Mental Status, Muscle Weakness - Generalized, Difficulty in Walking, Dementia with Behavior Disturbances, and Generalized Anxiety Disorder. Review of Resident #1's Re-Entry Minimum Data Set (MDS) dated 08/16/13, revealed a Brief Interview for Mental Status (BIMS) score of 02/15, indicating cognitive impairment.

Review of Resident #1's medical record revealed a Physician's order for an activity tray to be attached to the resident's wheel chair dated 09/27/13. Review of the Comprehensive Care Plan revealed the care plan was updated to include the application of the restraint five (5) days after the restraint device was applied. The

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F 280	<p>Continued From page 5 restraint care plan was initiated on 10/01/13.</p> <p>Interview with the MDS Coordinator, who was also responsible for updating care plans, on 10/02/13 at 4:40 PM, revealed the care plan should be updated when the restraint is applied.</p> <p>Interview with the Director of Nursing, on 10/02/13 at 2:56 PM, revealed her expectation of staff would be to implement and/or update the care plan with the physician's order for the restraint device.</p>	F 280		
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