

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

PRINTED: 02/23/2016
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 R 02/23/2016
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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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(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
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{F 000}	INITIAL COMMENTS	{F 000}		
	An offsite Revisit was conducted, and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance on 01/30/16 as alleged.			

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.

859 246 2307

Office Inspector General

02:22:42 p.m. 01-06-2016

7/44

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

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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 A Recertification Survey was initiated on 12/15/15 and concluded on 12/17/15, with deficiencies cited at the highest Scope and Severity of an "E".	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=E	483.13(c) DEVELOP/IMPLMENT 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 interview, record review and review of facility policy, it was determined the facility failed to implement written policies and procedures related to reporting misappropriation of resident property to the State Agencies, for one (1) of fifteen sampled residents (Resident #4), and four (4) unsampled residents (Unsampled Residents B, C, D, E). In addition, the facility failed to screen one (1) of four (4) sampled employees (Employee #3) for the appropriate licensing board or registry check, as per the facility's policy. The findings include: Review of the facility admissions document titled "Customer Concern Guidelines", dated 08/2014, revealed the facility would take ordinary precautions to protect property, but the resident and responsible party agree the facility would not	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Administrator

2-11-16

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.

859 246 2307

Office Inspector General

02:23:17 p.m. 01-06-2016

8/44

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F 226 Continued From page 1

be responsible or liable for loss or theft of personal property for any reason.

Review of the facility "Abuse Policy", dated 03/01/14, revealed it was the policy of the center to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property. The Policy stated, alleged violations were to be reported immediately to the Administrator. Such violations would also be reported to state agencies and law enforcement in accordance with existing law. The Administrator would direct a thorough investigation of each alleged violation. Per the Policy, the Administrator was responsible to report the results of all investigations to the state agencies as required by state and federal law.

1. Review of Unsampled Resident E's medical record revealed the facility readmitted the resident on 07/29/15 with diagnosis which included Altered Mental Status, Atrial Fibrillation, Urinary Tract Infection and Congestive Heart Failure. Further review revealed the resident was discharged on 09/15/15.

Review of Unsampled Resident E's Customer Concern Form dated 09/02/15, revealed the resident's prescription glasses were left on the residents' bed and were now missing. Further review revealed the resident's glasses were not found and the resident decided to purchase a new pair of glasses. Although an investigation was done, there was no documented evidence the state agencies were notified.

2. Review of Resident #4's medical record revealed the facility admitted the resident on

F 226 F226

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. Social Service Director discussed missing glasses with Resident E's wife on 09/01/15 at which time she stated the glasses were readers bought at local department store and were not prescription. She indicated she had already replaced them. Resident discharged 09/15/15. Resident #4 gowns replaced 01/12/16. Resident B discharged from facility 04/13/2015.

859 246 2307

Office Inspector General

02:23:48 p.m. 01-06-2016

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F 226 ; Continued From page 2

09/23/14 with diagnoses which included Congestive Heart Failure, Diabetes Mellitus and Muscle Weakness. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 11/11/15 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) Score of fifteen (15) out of fifteen (15) indicating the resident was cognitively intact.

Review of Resident #4's Customer Concern Form dated 06/21/15, revealed the resident had missing gowns which had not been found. Further review of the Form, revealed an investigation was completed; however, there was no documented evidence state agencies were notified.

Interview on 12/16/15 at 2:45 PM with Resident #4 revealed he/she had lost two (2) night gowns in the past year. Resident #4 stated he/she did report the missing gowns to the lady in laundry and was told by laundry they could not locate his/her night gowns. Resident #4 further stated he/she did not receive any replacement of the gowns and was not reimbursed.

3. Review of Unsampled Resident B's medical record revealed the facility admitted the resident on 03/13/15, with diagnoses which included Hypertension, Urinary Tract Infection and Hyperlipidemia. Further review revealed the resident was discharged on 04/13/15.

Review of Unsampled Resident B's Customer Concern Form dated 05/11/15, revealed an investigation was completed after receiving a call from the resident's daughter related to a missing book. Although an investigation was completed, there was no documented evidence the state agencies were notified.

F 226 :

Resident C discharged from facility 09/29/2015.
Resident D discharged from facility 08/26/15.
On 12/21/15 the Administrator and Social Service Director reviewed all complaint/concern forms within past ninety days to determine if any other residents were affected by deficient practice. No other reporting of misappropriation of resident property was found.
Regional Vice- President and the Administrator reviewed the facility "Abuse Policy" on 12/21/15 and found no changes needed.
The Regional Vice-President reviewed the facility "Abuse Policy" with the Administrator on 12/22/15 with additional education of what constitutes mistreatment, neglect, and abuse of residents and misappropriation of resident property and proper procedure in a thorough investigation of alleged violations and required reporting to the state agencies as required by state and federal law.

859 246 2307

Office Inspector General

02:24:19 p.m. 01-06-2016

10/44

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F 226 Continued From page 3

F 226:

4. Review of Unsampled Resident C's medical record revealed the facility admitted the resident on 01/05/09 and readmitted the resident on 07/17/15 with diagnoses which included Alzheimer's Disease, Hypertension and Contracture of the Hand. Further review of the record revealed the resident was discharged from the facility on 08/29/15.

Review of the Customer Concern Form dated 06/05/15, revealed Unsampled Resident C's daughter completed the Form related to three (3) missing gowns. Although an investigation was completed, there was no documented evidence the state agencies were notified.

5. Review of Unsampled Resident D's medical record revealed the facility readmitted the resident on 07/01/15 with diagnoses which included Congestive Heart Failure, and Chronic Kidney Disease. Further review revealed the resident was discharged on 08/26/15.

Review of Unsampled Resident D's Customer Concern Form dated 06/11/15, revealed an investigation was done related to missing items including a Daytona tee shirt, and three (3) pairs of black sweat pants. Per the investigation, Resident C's name was not on the missing items and the Daytona tee shirt, and three (3) pairs of black sweat pants were not found. Although an investigation was completed, there was no documented evidence the state agencies were notified.

Interview, on 12/17/15 at 9:45 AM, with Laundry Aide #1, revealed family and residents would tell her when there was missing clothing. She stated

Education regarding facility's Abuse, Neglect and Exploitation Policy was provided to all staff by the Staff Development Coordinator and Administrator on 01/26/2016 and will be completed by 01/28/2016. All staff are re-educated on the abuse policy at a minimum once a year by the Staff Development Coordinator utilizing Relias Learning, 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. All complaint/concerns are reviewed upon receipt by the Social Service Director.

R59 246 2307

Office Inspector General

02:24:50 p.m. 01-06-2016

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F 225 Continued From page 4
residents' clothing was hard to find if the resident's name was not written in the clothing. Further interview, revealed any concerns about missing resident items or clothing was reported to the Housekeeping Supervisor. Laundry Aide #1 stated, the laundry was searched and any clothing matching the description would be shown to the resident or family for identification. She further stated they encouraged residents and families to look through the lost and found.

Interview, on 12/17/15 at 9:55 AM, with the Housekeeping Supervisor, revealed the laundry staff searched for the missing items in laundry and in the lost and found. She stated the State Registered Nurse Aides (SRNAs), families and residents were asked to identify clothing. She further stated, the clothing did not always have the residents' name, but they tried to identify items by the size and description of the missing clothing.

Interview, on 12/17/15 at 10:00 AM, with SRNA #1, revealed staff looked for missing clothing in the wardrobes and other resident rooms. She stated, staff would usually find the clothing in the laundry or another residents' room. She further stated, they would tell the Housekeeping Supervisor when a resident's clothing was missing. Continued interview revealed when clothes were brought in, staff marked the resident's name on them with a permanent marker; however, at times families would bring clothes in and not tell staff and those clothes might not get labeled

Interview, on 12/17/15 at 10:02 AM, with Licensed Practical Nurse (LPN) #1 revealed family and residents would notify staff of missing items and

F 226. The Social Service Director will immediately give any complaint/ concern that falls within the definition of mistreatment, neglect, and abuse of residents and misappropriation of resident property per state and federal regulations to the Administrator. These concerns along with a final report within five days will be reported to the state agencies as required by state and federal law. All complaint/concerns will be reviewed daily Monday through Friday in the morning standup meeting to assure reporting is completed and follow-up report is completed timely. The monthly complaint/concern log will be reviewed each week for a period of 8 weeks then monthly thereafter by the Administrator and Regional Vice-President to assure all reportable complaint/concerns have been completed.

859 246 2307

Office Inspector General

02:25:22 p.m. 01-06-2016

12/44

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staff would check the rooms, and laundry for the items. LPN #1 further stated, the staff contacted Social Services concerning any missing resident items or clothing.

Interview, on 12/17/15 at 3:12 PM, with the Social Services/Admissions Coordinator (SSAC) revealed residents and family could fill out a concern form for missing items. She stated, the concern forms were located at the nurse's station, Social Services (SS) office and in the lobby.

Further interview, revealed a facility search was conducted in the resident's room, laundry and throughout the facility for resident missing items or clothing. She stated they also asked the residents and families to look through the laundry lost and found. The SSAC stated, residents and families were responsible for missing personal property and this was explained upon admission. Continued interview on 12/17/15 at 3:45 PM, revealed SS was responsible to investigate concern forms as they were received. She further stated each of the listed missing items was investigated, but she was not aware that missing items was to be reported to state agencies.

Interview, on 12/17/15 at 2:40 PM, with the Administrator, revealed not all items that were missing and investigated were reported to the State Agencies because upon admission the residents and families were notified the facility was not held responsible for the loss or theft of the residents' personal property. The Administrator further stated, she was not aware all incidents of residents' missing property should be reported to the State Agencies.

6. Review of the facility policy titled "Abuse Policy" dated 03/01/14, revealed all applicants for

F 226 Any results found of non-reported complaint/concerns that would constitute need of reported per state and federal regulations will immediately be followed up by the facility QAPI meeting by conducting a special called meeting of the committee consisting of members of Administrator, Director of Nursing, Medical Director, Pharmacy Consultant, Medical Records, MDS Coordinator, Dietary Manager, Activities Director, Social Service Director, Staff Development Coordinator, Housekeeping Supervisor and Maintenance Director. The committee will recommend action needed to assure continued compliance.
Employee #3 Kentucky Nurse Aide Abuse Registry was validated by the facility on 12/17/2015 by the facility Payroll Clerk. The Administrator instructed the Payroll Clerk to validate the Kentucky Nurse Aide Abuse Registry for all current facility employees. This was completed by 12/28/2015.

859 246 2307

Office Inspector General

02:25:55 p.m. 01-06-2016

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F 226 Continued From page 6
employment shall, at a minimum, have the appropriate licensing board or registry check.

Review of Employee #3's employee file revealed the employee was a dietary cook with a hire date of 09/24/15. Continued review revealed the registry check was not completed as per the facility's policy.

Interview with the Administrator, on 12/17/15 at 11:55 AM, revealed the corporate office completed the background checks and she would check with the office to see if they had a copy of the online validation of the abuse registry. She further stated, the facility was just now starting to check the online abuse registry validation on everyone and not just the nursing staff.

Interview with Accounts Payable/Payroll on 12/17/15 at 12:30 PM, revealed she was responsible for checking the Board of Nursing abuse registry for nursing employees. She further stated she did not know all employees needed abuse registry checks until she was notified by the Administrator during the survey.

F 226 All new facility applicants will have the appropriate licensing board of registry checked prior to hire by the facility Payroll Clerk beginning 12/18/15. The Administrator will check each new employee file for the appropriate licensing board registry validation prior to employee conducting any resident/patient care. A check sheet will be utilized to verify information was obtained by Payroll Clerk and Administrator checked for validation with date indicated check completed. An audit will be conducted monthly for period of six months by the Administrator to determine appropriate licensing board of registry validation has been completed. Any discrepancies will be immediately corrected and process will be reviewed by the monthly QAPI committee to determine required action to assure compliance. The QAPI committee consist of Administrator, Director of Nursing, Medical Director, Pharmacy Consultant, Medical Records, MDS Coordinator, Dietary Manager, Activities Director, Social Service Director, Staff Development Coordinator, Housekeeping Supervisor and Maintenance Director.

Completed 01/30/2016

F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
SS=E

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced

859 246 2307 Office Inspector General

02:26:23 p.m. 01-06-2016

14/44

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F 323 Continued From page 7

by:
Based on observation, interview and review of the facility's policy it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible. Observation revealed resident room doors were rough, chipped and broken.

The findings include:

Review of facility policy titled "Annual Building Inspections", effective date 09/01/14, revealed this inspection process was meant to improve the environment in which the residents live.

Review of facility form titled "Environmental Rounds Master List", undated, revealed doors were not listed as a part of the regular environmental rounds.

Observation, during the environmental tour of the facility on 12/16/15 at 10:10 AM, revealed fourteen (14) of fifty (50) bathroom doors and eleven (11) of twenty-six (26) resident room doors on the 100 and 200 hallways had rough splintered and sharp edges. This included; bathroom doors 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 202, 210 and resident room doors 101, 102, 103, 104, 105, 107, 108, 109, 110, 213, and 214

Interview, on 12/16/15 at 10:30 AM, with the Maintenance Supervisor, revealed it was a safety hazard for the residents of the facility to have sharp edges on the doors as this could cause skin tears. The Maintenance Supervisor stated at the beginning of his shift every morning he did a walk around environmental tour of the facility to identify any needed repairs. He revealed, during

F 323 F323

It is the policy of Boyd Nursing and Rehabilitation Center to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Regional Maintenance Director, Maintenance Director and Administrator inspected all resident entry doors and bathroom doors for needed repairs on 12/18/2015. It was decided to cover all resident entry doors and bathroom doors including those not identified as scarred and rough. Door protectors were reviewed and ordered 12/23/15 by the Administrator. Maintenance Department will place protectors on bathroom doors 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 202 and 210 and on resident room doors 101, 102, 103, 104, 105, 107, 108, 109, 110, 213 and 214 as of 01/22/16. Protectors will be placed on all remaining resident room doors and bathroom doors by Maintenance Department by 01/29/2016.

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Office Inspector General

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15 / 44

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F 323 Continued From page 8
his environmental tours he had not identified the doors as a concern.

Interview, on 12/16/15 at 10:41 AM, with the Regional Supervisor, revealed he agreed the rough, sharp edges on the doors presented a safety hazard to the residents of the facility. He revealed he was unaware of the sharp edges on the resident room doors and the bathroom doors. He further revealed he expected the needed maintenance repairs to be documented and scheduled on the maintenance log.

Interview, on 12/17/15 at 4:05 PM, with the Administrator, revealed her expectation was for the Maintenance Supervisor to make daily environmental rounds and complete maintenance reports weekly, to check for equipment, furnishings or items needing repaired or replaced. She stated the rough doors could be a potential for residents to develop skin tears.

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective

F 323 The Administrator educated Maintenance Director of the importance of maintaining a safe environment as free of accident hazards as possible on 12/18/2015. On 01/26/2016 education will be provided by the Administrator to all facility staff concerning the importance of maintaining a safe environment as free of accident hazards as possible by reporting any found safety concerns to supervisors and/or maintenance personnel immediately upon discovery. This education will be completed for all facility staff by 01/28/2016 by the Administrator. The Administrator revised the "Environmental Rounds Master List" to include checking of all resident doors both entry and bathroom doors for safety issues on 01/12/16. The Maintenance Director will use this form to conduct weekly environmental rounds hereafter. All issues will be identified and submitted to Administrator for review and required follow-up assigned.

859,246,2307

Office Inspector General

02:27:22 p.m. 01-06-2016

16/44

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

PRINTED: 01/06/2016
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 12/17/2015
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
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F 441 Continued From page 9
actions related to infections.

(b) Preventing Spread of Infection

- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
- (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
- (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This STANDARD is not met as evidenced by:

Based on observation, interview, record review and review of facility policy, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for three (3) of fifteen (15) sampled residents (Residents #3, #12 and #13) and one (1) unsampled resident (Unsampled Resident F).

Observation revealed Resident #3's tube feeding

F 441 Continue of F323

The audit findings will be reviewed monthly in the facility QAPI meeting for additional monitoring and recommendations.

This committee members consists of the Administrator, Director of Nursing, Medical Director, Pharmacy Consultant, Medical Records, MDS Coordinator, Dietary Manager, Activities Director, Social Service Director, Staff Development Coordinator, Housekeeping Supervisor and Maintenance Director.

Completed 01/30/2016

F441

It is the policy of Boyd Nursing and Rehabilitation Center to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Resident #12 and #13 oxygen tubing and nebulizer tubing/mouth piece were discarded on 12/15/2015 and new tubing obtained by LPN. Resident #3 tube feeding tubing was discarded on 12/15/2015 and new tubing obtained by LPN.

859 246 2307 Office Inspector General

02:27:51 p.m. 01-06-2016 17/44

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2015
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
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F 441 Continued From page 10
tubing was undated and was hanging on a tube feeding pole, uncapped and unbagged.

Observation revealed Resident #12's oxygen tubing was undated and was stored unbagged. Also, the nebulizer tubing and mouth piece was observed to be lying in the floor.

Observation revealed Resident #13's nasal cannula and oxygen tubing was undated and was lying partly on the chair and partly on the floor. Also, the resident's nebulizer tubing was undated and was in a bag in a chair with the tubing hanging out of the bag touching the Dycem (non slip material) in the chair.

In addition, observation revealed staff failed to properly disinfect the glucometer after using the glucometer to check Unsamped Resident F's fingerstick blood sugar.

Additionally, observation of meal service delivery to resident rooms, revealed the State Registered Nurse Aides (SRNA's) failed to wash or sanitize hands between delivering meal trays, and prior to obtaining meal trays from the meal cart. In addition, a SRNA attempted to place a soiled meal tray in the area of the meal cart where the clean meal trays were stored.

The findings include:

Review of the facility's Policy, entitled "Policies and Practices-Infection Control", dated 08/2007, revealed the facility's infection control policies and practices were intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage the transmission of diseases and infections. Standard Precautions

F 441: LPN #2 was re-educated on proper infection control techniques to prevent spread of infections while disinfecting the glucometer per the manufacturers recommendations for the disinfecting wipes by the Staff Development Coordinator on 12/18/2015.

SRNA #2 & #3 was re-educated on proper Handwashing Techniques to prevent the spread of infection during meal service on 12/18/2015 by the Staff Development Coordinator.

SRNA #1 was re-educated by the Staff Development Coordinator on proper disposal of dirty meal trays to prevent the spread of infection on 12/18/2015.

LPN #1 and LPN #2 was re-educated on proper procedure for dating/labeling/storing tube feeding tubing, oxygen/nebulizer tubing per the Staff Development Coordinator on 12/18/2015.

859 246 2307

Office Inspector General

02:28:21 p.m.

01-06-2016

18 /44

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

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FORM APPROVED
OMB NO 0938-0391

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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
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F 441 Continued From page 11

would be used in the care of all residents regardless of their diagnoses or suspected or confirmed infection control status and shall apply to the care of all residents in all situations. Hand hygiene refers to handwashing with soap or using alcohol based hand rubs that do not require access of water. Hands shall be washed when visibly soiled and in the absence of visible soiling of hands, alcohol based hand rubs are preferred for hand hygiene. Continued review revealed staff was to ensure reusable equipment was not used for the care of another resident until it had been appropriately cleaned and reprocessed.

1. Review of Resident #3's medical record revealed the facility re-admitted the resident on 06/12/15 with diagnoses which included Left Sided Weakness, Cognitive Impairment, Cerebral Infarct (Stroke), Dysphagia, and Percutaneous Endoscopic Gastrostomy (Peg) (medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate).

Observation, during initial tour on 12/15/15 at 11:10 AM, revealed Resident #3's tube feeding tubing was unbagged, uncapped without a date and hanging on the tube feeding pole.

Interview, on 12/17/15 at 10:40 AM, with Licensed Practical Nurse (LPN) #1 revealed the tube feeding tubing should have been dated, and should have been capped, and bagged while not in use.

Interview, on 12/17/15 at 4:15 PM, with the Staff Development Coordinator (SDC)/ Infection Control Nurse (ICN) revealed the tube feeding

F 441

All facility staff will be re-educated by Staff Development Coordinator on 01/26/2016 regarding the importance of proper hand washing procedures to help prevent the development and transmission of disease and infection. This education included hand hygiene protocol when delivery meal trays. All nursing staff will receive additional education on the proper procedures for dating/labeling/ storing tube feeding tubing and oxygen/ nebulizer tubing and the proper procedure for disposing of dirty meal trays. This education will be completed for all facility staff and/or nursing staff by the Staff Development Coordinator by 01/28/16.

All licensed nursing staff will be re-educated by the Staff Development Coordinantor on 01/26/16 regarding proper Infection Control Techniques in regards to manufactures recommendations for disinfecting the glucometer.

859 246 2307

Office Inspector General

02:28:52 p.m. 01-06-2016

19/44

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

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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 12/17/2015
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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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(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
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F 441 Continued From page 12
tubing should have been dated, and should have been capped, and stored in a plastic bag when not in use to prevent contamination. Continued interview revealed staff had been inserviced on the correct procedure for storing tube feeding tubing when not in use.

Interview, on 12/17/15 at 4:30 PM, with the Director of Nursing (DON) revealed it was her expectation for the tube feeding tubing to be dated, and capped and bagged while not in use. Continued interview revealed nursing staff had been trained on the correct storage of tubing while not in use in order to prevent contamination of the tubing.

2. Observation of Resident #12, on 12/17/15 at 9:40 AM, revealed the resident was sitting up in the recliner chair at bedside. An oxygen concentrator was in the room for as needed (PRN) oxygen, and the oxygen tubing was observed to be undated and unbagged. A nebulizer machine was sitting on the bedside table covered with a plastic bag, and the tubing and mouth piece was observed to be lying in the floor.

Interview with LPN #2, on 12/17/15 at 9:50 AM, who was assigned to Resident #12, revealed oxygen tubing was changed every two (2) weeks and should be bagged when not in use. She further stated she did not think the facility dated the oxygen tubing. Continued interview revealed the nebulizer tubing should be thrown away since it was in the floor, and this was an infection control issue.

3. Review of Resident #13's medical record revealed the resident was re-admitted on

F 441 Monitoring of tube feeding will be conducted on all residents receiving tube feedings to ensure the tubing is capped and bagged properly. This will be done daily Monday through Friday for four weeks then once weekly for eight weeks by the Director of Nursing Services, Staff Development Coordinator and RN supervisor utilizing the Tube Feeding Care audit tool (copy attached). Monitoring of oxygen tubing and nebulizer tubing is properly dated and bagged in the resident care areas will be conducted daily Monday through Friday for four weeks then weekly for eight weeks by the Director of Nursing, Staff Development Coordinator and RN Supervisor utilizing the Monitoring Compliance with Infection Control checklist (copy attached). Monitoring of the nursing staff to ensure proper protocol is followed for disinfecting the blood glucose monitors between resident use will be conducted on a minimum of five residents daily Monday through Friday for four weeks then five residents weekly for eight weeks by the Director of Nursing Services, Staff Development Coordinator and RN Supervisor utilizing the Blood Glucose Monitoring Audit tool (copy attached).

859 246 2307

Office Inspector General

02:29:23 p.m. 01-06-2016

20/44

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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 12/17/2015
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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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(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
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F 441 Continued From page 13
07/01/14 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Dementia, Hypoxemia and Anxiety.

Observation, on 12/17/15 at 10:30 AM, of Resident #13's room, revealed the nasal cannula and oxygen tubing was undated and was lying on the chair and on the floor. The nebulizer tubing was undated and was in a bag in a chair with the tubing hanging out of the bag touching Dycem (non slip material) in the chair.

Interview, with LPN #1 on 12/17/15 at 10:40 AM, revealed she was assigned to Resident #13, and she needed to throw away the nasal cannula and the oxygen tubing because it was not dated and was not bagged. Further interview revealed the nebulizer tubing should have been dated and completely bagged while not in use.

Interview, with the SDC/ICN, on 12/17/15 at 4:15 PM, revealed nasal cannulas, and oxygen and nebulizer tubing should be dated, and should be bagged while not in use to prevent contamination. Further interview revealed staff was trained on this at a minimum of yearly and upon hire.

Interview with the DON on 12/17/15 at 4:00 PM and 4:30 PM, revealed the night shift was responsible for dating and changing out the oxygen and nebulizer tubing per schedule, but the tubing should also be changed any time it was contaminated. She further stated respiratory tubing should be bagged when not in use. Continued interview revealed this was an infection control issue and all nursing staff were in-serviced on respiratory supplies and infection control on hire and at least annually.

F 441 Monitoring of meal service to ensure proper hand hygiene when delivering trays and to ensure proper disposal of dirty meal trays will be conducted daily Monday through Friday by rotating the three meals per day services. This will be done daily Monday through Friday for four weeks then weekly for eight weeks by the Director of Nursing Services, Staff Development Coordinator and the RN supervisor alternating monitoring resident rooms delivery service and dining room service utilizing the Meal Service Audit tool (copy attached). Any staff member deviating from proper protocols will be educated at that time. The Staff Development Coordinator will conduct weekly infection control/environmental compliance rounds thereafter utilizing the Monitoring Compliance with Infection Control checklist.

859 246 2307

Office Inspector General

02:29:54 p.m.

01-06-2016

21 /44

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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 441 Continued From page 14

4. Review of the Super Sani-Cloth's label revealed, to disinfect nonfood contact surfaces only: Use a wipe to remove heavy soil as needed. Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two (2) minutes. Further review of the label revealed, use additional wipes if needed to assure continuous two (2) minute wet contact time. Let air dry. Review of the Super Sani-Cloth's front label revealed, disinfects in two (2) minutes.

Observation, on 12/17/15 at 11:50 AM, revealed LPN #2 used the glucometer to check the blood sugar of Unsampled Resident F, and placed the glucometer on the top of the medication cart. LPN #2 then used a Super Sani-Cloth wipe to clean the glucometer; however, did not monitor the amount of time the glucometer stayed wet in order to disinfect correctly.

Interview with LPN #2, on 12/17/15 at 11:55 AM, revealed she was unaware the glucometer had to remain wet a full two (2) minutes in order to be correctly disinfected and thought she could just wipe the glucometer off and let it set to dry.

Interview, on 12/17/15 at 10:40 AM, with LPN #1, revealed she was unaware the Super Sani-Cloth's used to disinfect the glucometer's had to stay wet for a full two (2) minutes before the glucometer would be completely disinfected. Further interview revealed she would let the glucometer completely dry which seems to be about thirty (30) seconds but she did not time the disinfection process.

Interview, on 12/17/15 at 4:15 PM, with the SDC/INC revealed staff had been trained on the correct procedure for disinfecting glucometer's

F 441 The results will be forwarded to weekly Focus meeting (a subcommittee of the monthly QAPI committee) consisting of the Administrator, Director of Nursing Services, Staff Development Coordinator, MDSC, Health Information Medical Coordinator, RN Supervisor, Activity Director, and Social Service Director. The audit findings will then be reviewed monthly in the facility QAPI meeting for additional monitoring and recommendations. This committee members consists of the Administrator, Director of Nursing, Medical Director, Pharmacy Consultant, Medical Records, MDS Coordinator, Dietary Manager, Activities Director, Social Service Director, Staff Development Coordinator, Housekeeping Supervisor and Maintenance Director.

859 246 2307

Office Inspector General

02:30:26 p.m.

01-06-2016

22 /44

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

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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)

F 441 Continued From page 15
and expectations were to disinfect the glucometer every time before use and follow manufacturers recommendation for the disinfecting wipes.

Interview, on 12/17/15 at 4:30 PM, with the DON, revealed the staff had been trained on the correct procedure for disinfecting glucometer's and expectations were to disinfect the glucometer in between patient usage and the Super Sani-cloths were to remain wet on the surface for two (2) minutes.

5. Observation of meal service delivery to hallways, on 12/15/15 at 5:10 PM, revealed State Registered Nurse Aide (SRNA) #2 entered Room 108 with a meal tray, assisted the resident up in the bed, set the tray up for the resident, and left the room without washing or sanitizing her hands. SRNA #2 was then observed to take Room 106's tray from the cart and start to enter room 106; however, after surveyor intervention another tray was ordered for the resident in Room 106.

Interview with SRNA #2, on 12/15/15 at 6:00 PM, revealed she had received training on handwashing and knew she should wash her hands after any resident care and before leaving a resident's room. SRNA #2 further stated, she could spread infections by not washing her hands.

Observation of meal service delivery to hallways, on 12/16/15 at 12:15 PM, revealed SRNA #3 took the food tray into Room 104-B, and while setting up the tray up she kept touching her hair and putting her hair behind her ears. Further observation, revealed SRNA #3 left the room and went to the meal cart without washing her hands and was attempting to open the door of the food

F 441 Based on the results of the Infection Control audits the QAPI committee will determine the need and the frequency of additional audits related to Infection control procedures.

Completed 01/30/16

859 246 2307

Office Inspector General

02:30:57 p.m. 01-06-2016

23 /44

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

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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 441 Continued From page 16
cart when the surveyor intervened.

F 441

Interview with SRNA #3, on 12/16/15 at 12:20 PM, revealed she had received training on handwashing and when to wash hands. She further stated she was pushing her hair out of her face while setting up the meal tray and this was an infection control issue. She further stated she did not wash or sanitize her hands prior to exiting Room 104 and was going to open the food cart to look for any extra butter. She revealed she should have washed or sanitized her hands after exiting the room and before attempting to open the door of the meal cart because this could and this could cause cross contamination, which could cause a resident to get an infection.

Observation of meal delivery to hallways on 12/16/15 at 12:22 PM, revealed SRNA #1 entered Room 106 with a meal tray, and the resident refused the tray. SRNA then picked the tray up from the bedside table and left the room returning to the food cart, and was attempting to place the soiled meal try in the food cart with the clean meal trays when the surveyor intervened.

Interview with SRNA #1, on 12/16/15 at 12:25 PM, revealed she had received training related to ensuring they did not place dirty meal trays in with clean meal trays on the meal cart, but she was just so nervous she wasn't thinking. SRNA #1 further stated this would cause cross contamination to put dirty meal trays in the meal cart with the clean meal trays.

Further interview with the DON on 12/17/15 at 4:30 PM, revealed staff should ensure they wash or sanitize hands prior to exiting resident rooms, and before serving meal trays. Continued

859 246 2307

Office Inspector General

02:31:29 p.m.

01-06-2016

24 /44

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

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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 12/17/2015
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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 441 . Continued From page 17
interview revealed staff should not place a dirty meal tray in with the clean meal trays on the meal cart.

F 441:

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 02/01/2016
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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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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 12/17/15 as alleged.	{K 000}		
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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.

859 246 2307

Office Inspector General

02:21:19 p.m. 01-06-2016

4/44

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195418	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B WING _____	(X3) DATE SURVEY COMPLETED 12/16/2015
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)

K 000 INITIAL COMMENTS

K 000

CFR: 42 CFR 483.70(a)

Building: 01

Survey under: NFPA 101 (2000 edition)

Facility type: SNF/NF

Type of structure: Type V (000)

Smoke Compartment: Three (3)

Fire Alarm: Full fire alarm (upgrade completed in 2009)

Sprinkler System: Full sprinkler system

Generator: Type II Diesel installed 1995

A Standard Life Safety Code Survey was conducted on 12/16/2015. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was fifty-six (56). The facility was licensed for sixty (60) beds.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at an "F" level.

K 144 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

K 144

Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99 3.4.4.1.

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.

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X4) DATE

[Signature]

Administrator

2-11-16

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.

859 246 2307

Office Inspector General

02:21:50 p.m. 01-06-2016

5/44

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

PRINTED: 01/06/2016
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2015
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
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K 144 ; Continued From page 1

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This STANDARD is not met as evidenced by:
Based on record review and interview, it was determined the facility failed to ensure the emergency generator was maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, sixty (60) residents, staff and visitors.

The findings included:

Record review of the monthly emergency generator testing records on 12/16/15 at 3:30 PM, with the Maintenance Director, revealed the emergency generator has been exercised monthly for fifteen (15) minutes instead of the required minimum of thirty (30) minutes during the months of July, August, September and October 2015. Interview with the Maintenance Director, revealed the emergency generator was set on an automatic timer and he was not aware that the timer was set for a run-time of fifteen (15) minutes instead of the required thirty (30) minutes.

The findings were acknowledged by the Administrator during the exit conference.

NFPA 110 (1999 Edition)

K 144

It is the policy of Boyd Nursing and Rehabilitation Center to maintain life and safety compliance according to the National Fire Protection Association Standards. On 12/16/15 the Maintenance Director reset the emergency generator automatic timer for a run-time of thirty minutes (30) as required by the National Fire Protection Association standards. The Regional Maintenance Supervisor educated the facility Maintenance Director on 2/17/15 on the proper procedure of completing generator monthly testing under the required minimum thirty minute (30) timeframe and properly recorded.

859 246 2307

Office Inspector General

02:22:17 p.m. 01-06-2016

6 / 44

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

PRINTED: 01/06/2016
FORM APPROVED
OMB NO. 0938-0391

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6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.

Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded.

6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of thirty (30) minutes, using one of the following methods:

(a) Under operating temperature conditions or at not less than thirty (30) percent of the EPS nameplate rating

(b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer

The date and time of day for required testing shall be decided by the owner, based on facility operations.

The Administrator will audit the generator testing records each month to assure the thirty minute (30) required testing time is exercised. Any discrepancies of these records will be taken to the monthly facility Safety Committee (members include Administrator, Director of Nursing Services, Medical Records, Payroll Clerk, Dietary Manager, Infection Control Coordinator, Activities Director and Maintenance Director) and forwarded to the Regional Maintenance Director for review and recommendations for improvement to meet required standards.

Completed 12/17/15