

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 10/25/2024
NAME OF PROVIDER OR SUPPLIER Boyd Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 12100 Princeland Spur Ashland, KY 41102	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>28707</p> <p>Based on interview, record review, and review of facility's policy, the facility failed to treat each resident with respect and dignity and care in a manner that promoted maintenance of his or her quality of life for 1 of 1 sampled residents (Resident (R) 62).</p> <p>R62's religious beliefs prohibited cutting of women's hair and R62 was given a haircut without consulting the resident's guardian.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Resident's Rights Policy, dated October 2019, revealed it was the responsibility of all staff members to recognize the rights of residents at all times to enable personal dignity, well-being, and proper delivery of care.</p> <p>Review of R62's Face Sheet found in the resident's electronic medical record (EMR) revealed the facility admitted R62 on 07/26/2021 with diagnoses to include vascular dementia unspecified, cognitive communication deficit, and generalized anxiety disorder.</p> <p>Review of R62's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/24/2022, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident had severe cognitive impairment.</p> <p>Review of a Care Team Member Corrective Action Form, dated 01/25/2022, revealed State Registered Nurse Aide (SRNA) 7 cut R62's hair after a shower, stating the resident had requested this. Further review of the form revealed SRNA7 was re-educated on resident rights, although she refused to sign, stating the resident had requested the haircut.</p> <p>During an interview with R62's daughter (Daughter 62), on 10/25/2024 at 9:41 AM, she stated when R62 was initially admitted to facility, she stressed to the admitting staff to please not cut the resident's hair as it was against her religion. She stated R62 had hair that hung way down her back on admission, and she had never known her mother to cut her hair. She stated she started crying when she came to the facility in late January of 2022 and saw her mother's hair was cut to the top of her shoulders. She believed staff may have cut R62's hair so they did not have to take care of it. She stated R62 never said anything about it, and did not appear to be affected negatively due to her confusion.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 185418	If continuation sheet Page 1 of 5

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>SRNA7 was no longer employed at the facility and could not be reached for interview.</p> <p>During an interview with SRNA4, on 10/24/2024 at 1:36 PM, she stated she remembered working with R62 and the resident had dementia and was confused. She stated R62's family was very religious, and the resident would always have to be in skirts and wear her hair long. SRNA4 stated she would sometime braid R62's hair, and the resident's hair would hang about to her waist. She stated she had never known the resident to cut her hair, but heard someone on night shift had cut her hair to about shoulder length. She stated the family was upset regarding this, although it did not appear to upset R62. SRNA4 stated everyone knew R62 did not cut her hair, and she remembered speaking with family who stated her hair could be braided or put into a ponytail.</p> <p>During an interview with SRNA5, on 10/24/2024 4:58 PM, she stated R62 had to wear skirts and her family would not allow her hair to be cut. She stated she was told by family when R62 arrived that she only wore skirts and not to cut her hair. SRNA5 could not remember a situation in which R62's hair was cut.</p> <p>During an interview with SRNA6, on 10/24/2024 at 7:40 PM, he stated he remembered taking care of R62. He described R62 as confused and she would holler out a lot. He stated she always had long hair, and it was never cut during the time she was on his hallway, that he was aware of.</p> <p>During an interview with Licensed Practical Nurse (LPN) 1, on 10/24/2024 at 3:00 PM, she stated she was not aware R62 wore her hair long for religious reasons and that it could not be cut, but heard about it after the fact. She stated R62 had hair past her shoulders, and after cutting it, her hair came down to her shoulders.</p> <p>During an interview with the Wound Nurse, on 10/24/2024 at 4:43 PM, she stated R62 had dementia. She further stated R62's family would come to visit, and although she was not certain which religion the resident and family belonged to, she remembered R62 always wore skirts and had long hair. She stated R62 would wear her hair pulled back and braided or in a bun, and that it would hang down to her mid back area. She stated she remembered something about the family being upset someone had cut R62's hair, and that it did look a little shorter to her.</p> <p>During an interview with the Regional Social Services (RSS), formerly the Social Services Director, on 10/24/2024 at 8:12 AM, she stated she did not remember any situation in which R62 had a haircut. She stated R62's family was very involved and came to visit often. The RSS described R62 as being a pleasantly confused resident who enjoyed being around activities to see what was going on.</p> <p>During an interview with the Director of Nursing Services (DNS), on 10/25/2024 at 8:42 AM, she stated she did not remember the circumstances behind why SRNA7 cut R62's hair, but remembered SRNA7 refused to sign a corrective action form, as she maintained R62 wanted her hair cut. The DNS stated she reviewed the resident's EMR and could not find anything regarding her preferences for no haircut. She stated she was uncertain whether or not staff knew not to cut the resident's hair. She further stated SRNA7 was disciplined as she was not a beautician, and was not authorized to cut R62's hair. The DNS stated the process would have been to put a resident on the beautician list for haircuts, as aides do not normally cut hair. She further stated she believed R62's sister was the one that complained after the haircut, and R62's family was very involved. She stated in cases where a resident was not their own responsible party, the guardian should be consulted before a haircut.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Executive Director (ED), on 10/25/2024 at 10:28 AM, he stated he was not employed at the facility at the time of the incident, and only knew R62 briefly. He stated his expectation for any resident with religious preferences stringent in dressing or hair style would be for staff to follow their wishes. He further stated the guardian should be contacted prior to doing anything.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49050</p> <p>Based on observation, interview, and review of facility's policy, the facility failed to follow an infection prevention and control policy to prevent the development and transmission of communicable diseases and infections for 1 of 8 sampled residents receiving blood glucose monitoring (Resident (R) 55).</p> <p>Observation on 10/23/2024 at 11:00 AM revealed Licensed Practical Nurse (LPN) 1 placed R55's glucometer on top of the treatment cart without a barrier prior to obtaining a blood glucose reading. Following the glucose reading, LPN1 cleaned the glucometer for two minutes and placed the glucometer on top of the treatment cart to dry without a barrier between the cart top and the glucometer.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Infection Prevention, dated March 2022, revealed it was the responsibility of nurses to practice aseptic technique when obtaining glucose readings and to follow the manufacturer's guidelines when performing cleaning of the glucometer.</p> <p>Review of the Validation Checklist for Glucometer Disinfection, undated, revealed the nurse is to perform the procedure in accordance with the facility's standard of practice. Further review revealed the following: Step 13 indicated to cleanse the glucometer with a disinfectant wipe; Step 14 revealed to discard the disinfectant wipe into the waste receptacle; and Step 15 revealed to allow the device to dry for five minutes or per the manufacturer's recommendation.</p> <p>Review of R55's Face Sheet revealed the facility admitted the resident on 07/09/2024 with diagnoses to include morbid obesity, type II diabetes with Insulin, and lower extremity weakness.</p> <p>Review of R55's initial Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/23/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had no cognitive impairment.</p> <p>During an interview with LPN1 on 10/23/2024 at 11:21 AM, she stated the way to clean the glucometer after each use was by using a prepackaged wipe. She further explained she used the prepackaged wipe to wipe all around the glucometer to be sure any blood products were not on it, and did so for two minutes. After the two minutes was over, the glucomter was placed on the cart to dry for five minutes, on a barrier.</p> <p>During an interview with the Assistant Director of Nursing Services (ADNS) on 10/23/2024 at 1:40 PM, she stated nurses were expected to place a barrier between the top of the treatment cart and the clean glucometer when preparing to obtain a glucose reading from a resident. She further stated after the cleaning of the glucometer, it should be placed on a barrier to dry and not set directly on the treatment cart.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing Services (DNS) on 10/24/2024 at 11:08 AM, she stated nursing staff were expected to follow guidelines outlined in the glucometer disinfection policy. She further stated nurses should use a protective barrier between the glucometer and any multi-use surface to prevent contamination and the spread of germs.</p> <p>During an interview with the Executive Director (ED) on 10/25/2024 at 10:29 AM, he stated his expectation was for nurses to properly follow the policies related to infection control and the cleaning of glucometers. He further stated it was important for nurses to clean glucometers to prevent the spread of infection from resident to resident.</p>		