STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185418	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Boyd Nursing and Rehabilitation	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview, record review, and facility policy review, the facility failed to notify the physician when medications were not administered for 2 of 5 sampled residents reviewed for unnecessary medications, Resident (R) 4 and R20. The findings include: Review of the facility's policy titled, Medication Administration, dated 01/02/2024, revealed, 22. Physicians will be notified timely of medication omissions. 1. Review of R4's admission Record revealed the facility admitted R4 on 07/22/2024 with diagnoses to include hypertension, diabetes mellitus, major depressive disorder, psychotic disorder with hallucinations, and gastroesophageal reflux disease. Review of R4's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 09/08/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 3 out of 15, indicating the resident had severe cognitive impairment. Review of R4's medication administration record (MAR) for the timeframe 10/01/2025 through 10/31/2025, revealed the resident's medications ordered to be administered at 7:00 AM were not administered on 10/02/2025, 10/06/2025, 10/09/2025, 10/12/2025, 10/18/2025, 10/19/2025, 10/20/2025, 10/24/2025, 10/26/2025, and 10/31/2025, due to the resident being asleep. Review of R4's MAR for the timeframe 11/01/2025 through 11/30/2025, revealed the resident's medications ordered to be administered at 7:00 AM were not administered on 11/02/2025, 11/05/2025, 11/09/2025, and 11/14/2025 due to the resident being asleep. During an interview with the Medical Director on 11/21/2025 at 4:10 PM, who was R4's primary physician, she stated she was not aware R4 was not getting her medications because she was sleeping. The Medical Director stated she should be informed when the residents' medications were not administered. 2. Review of R20's admission Record revealed the facility admitted R20 on 12/22/2022 with diagnoses to include hypertension. Review of R20's quarterly MDS, with an ARD of 08/20/2025, revealed the facility assessed the resident to have a BIMS score of 3 out of 15, indicating the resident had severe cognitive impairment. Review of R20's MAR for the timeframe 10/01/2025 through 10/31/2025, revealed the resident was not administered amlodipine (a medication used to treat high blood pressure) and lisinopril (a medication used to treat high blood pressure) at 9:00 AM on 10/01/2025, 10/02/2025, 10/03/2025, 10/06/2025, (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/07/2025, 10/08/2025, 10/09/2025, 10/12/2025, 10/18/2025, 10/19/2025, 10/20/2025, 10/22/2025, 10/24/2025, 10/26/2025, 10/27/2025, and 10/31/2025. Further review of the MAR revealed R20 was not administered his Lopressor (a medication used to treat high blood pressure) as ordered by the physician on 10/01/2025, 10/02/2025, 10/03/2025, 10/06/2025, 10/07/2025, 10/08/2025, 10/09/2025, 10/12/2025, 10/18/2025, 10/19/2025, 10/20/2025, 10/22/2025, 10/24/2025, 10/26/2025, 10/27/2025, and 10/31/2025. Review of R20's MAR for the timeframe 11/01/2025 through 11/30/2025, revealed the resident was not administered amlodipine and lisinopril medication at 9:00 AM on 11/01/2025, 11/02/2025, 11/05/2025, 11/09/2025, 11/10/2025, 11/13/2025, 11/14/2025, and 11/17/2025. Further review of the MAR revealed R20 was not administered his Lopressor as ordered by the physician on 11/01/2025, 11/02/2025, 11/05/2025, 11/09/2025, 11/10/2025, 11/13/2025, 11/14/2025, and 11/17/2025. During an interview with the Medical Director on 11/21/2025 at 4:10 PM, who was R20's primary physician, she stated she was not aware R20 was not getting his medications. She stated she should be informed when the residents' medications were not administered. During an interview with the Director of Nursing (DON) on 11/21/2025 at 4:37 PM, she stated if a resident was sleeping when the qualified medication aide (QMA) administered their medication and the resident could not awaken, the QMA should notify the nurse, who should then notify the physician to see if the physician wanted the medication administered at a later time. During an interview with the Executive Director (ED) on 11/21/2025 at 5:15 PM, she stated staff should let the physician know if medication was not administered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, and facility policy review, the facility failed to ensure their medication error rate was not greater than 5 percent (%). There were seven errors out of 28 opportunities, which resulted in a mediation error rate of 25% for 2 of 3 residents observed for medication administration, Resident (R) 18 and R19.The findings include:Review of the facility's policy titled, Medication Administration, dated 01/02/2024, revealed, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.1. Review of R19's admission Record revealed the facility admitted the resident on 10/11/2023 with diagnoses to include major depressive disorder, type 2 diabetes mellitus, B-group vitamin deficiency, and hypokalemia.Review of R19's Order Summary Report, for active orders as of 11/19/2025, revealed the following: an order dated 10/11/2023, for Januvia 100 milligrams (mg) by mouth one time a day for diabetes mellitus; an order dated 03/28/2025, for escitalopram oxalate 15 mg one time a day for depression; an order dated 05/02/2024, for cyanocobalamin 500 micrograms (mcg) by mouth one time a day for supplement; and an order dated 09/03/2025, for potassium chloride extended release 20 milliequivalent (mEq) give 40 mEq one time a day for hypokalemia.During medication administration observation on 11/19/2025 at 8:21 AM, Qualified Medication Aide (QMA) 2 administered R19's medications to include escitalopram 5 mg instead of the 15 mg as ordered and potassium chloride 20 mEq instead of the 40 mEq as ordered by the physician. QMA2 failed to administer the Januvia 100 mg and cyanocobalamin 500 mcg to R19.During an interview with QMA2 on 11/19/2025 at 2:51 PM, she stated she did not administer R19's Januvia and cyanocobalamin that morning because those medications were on order. QMA2 stated she should have pulled the medications from backup. QMA2 further stated the escitalopram should have been three tablets to equal 15 mg, and she only gave one tablet. She stated she should have paid attention to the dose ordered, and she should have administered two tablets of potassium chloride. 2. Review of R18's admission Record revealed the facility admitted the resident on 07/22/2016 with diagnoses to include constipation, vitamin D deficiency, and seasonal allergic rhinitis.Review of R18's Order Summary Report, for active orders as of 11/19/2025, revealed the following: an order dated 05/14/2022, for polyethylene glycol 3350 powder administer 17 grams by mouth one time a day for constipation; an order dated 05/20/2022, for calcium 500 + D3 tablet 500 milligrams - 400 milligrams unit tablet by mouth two times day for supplement; and an order dated 08/27/2022, for fluticasone propionate suspension 50 micrograms per actuation spray one spray in each nostril one time a day for allergy relief.During medication administration observation on 11/19/2025 at 8:37 AM, QMA2 administered R18's medications; however, she did not administer the polyethylene glycol, calcium with Vitamin D, or the fluticasone propionate to R18.During an interview with QMA2 on 11/19/2025 at 2:51 PM, she stated she missed the polyethylene glycol, calcium with Vitamin D, and the fluticasone propionate when she administered R18 their medications on 11/19/2025. QMA2 stated she was just nervous, was going too fast, and overlooked them. QMA2 further stated she did not realize she missed the medications on R18's medication administration record (MAR) during medication administration.During an interview with the Director of Nursing (DON) on 11/21/2025 at 3:50 PM, she stated she expected staff to follow the rights of medication administration, and if it was a QMA who had a question, the QMA should notify the nurse.During a follow-up interview with the DON on 11/21/2025 at 4:35 PM, she stated the five rights of medication administration were the right resident, right time, right dose, right medication, and the right route. During an interview with the Executive Director (ED) on 11/21/2025 at 5:17 PM, she stated she expected medication to be administered per the physician orders and the five rights of (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication administration should be followed, because it could be detrimental to the resident if not followed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, record review, and facility policy review, the facility failed to ensure the route of medication administration was accurate for 1 of 14 sampled residents, Resident (R) 7. The findings include:Review of the facility's policy titled, Documentation in the Medical Record, dated 01/02/2024, revealed, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.Review of R7's admission Record revealed the facility admitted the resident on 01/29/2024 with diagnoses to include dysphagia (difficulty swallowing) and gastrostomy status. Review of R7's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 09/25/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 3 out of 15, indicating the resident had severe cognitive impairment. Further review revealed R7 had a feeding tube. Review of R7's Care Plan Report included a focus area, initiated 02/01/2024, that indicated the resident was at risk for complications due to requiring a feeding tube due to dysphagia and nothing by mouth (NPO) status.Review of R7's Order Recap Report revealed an order dated 09/23/2025 for an NPO diet and an order dated 09/11/2025, for Keppra (an anticonvulsant medication) oral solution 100 milligrams per milliliter (mg/ml), give 5 ml by mouth two times a day for seizures.Review of R7's Medication Administration Record [MAR], for the timeframe 11/01/2025 through 11/30/2025, revealed staff documented Keppra oral solution 100 mg/ml was administered by mouth.During an interview with Licensed Practical Nurse (LPN) 3 on 11/21/2025 at 9:19 AM, she stated R7 took all her medications by feeding tube and nothing by mouth. LPN3 stated the Keppra was liquid and given through the resident's feeding tube and not by mouth. She further stated the order needed to be changed, and R7's medical record was not accurate if it indicated the resident took their medication by mouth.During an interview with the Director of Nursing (DON) on 11/21/2025 at 4:37 PM, she stated the facility should have gotten an order to change the resident's Keppra medication from by mouth to by feeding tube. The DON stated when the staff documented the resident received the medication by mouth instead of by feeding tube, it made the resident's medical record not accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview, document review, and facility policy review, the facility failed to ensure health department recommendations were followed to test the facility water two times weekly for legionella. This deficient practice had the potential to affect all 57 residents who currently resided in the facility.The findings include:Review of the facility's policy titled, Water Management Policy, dated 05/01/2025, revealed, H. We will notify the local health department upon knowledge of any new presumptive or confirmed Legionella within 24 hours. We will make efforts to follow the guidance provided by health department officials and field experts.During an interview with the Maintenance Director on 11/21/2025 at 10:21 AM, he stated legionella water testing had been completed twice a week, and the results were being sent to the health department. The Maintenance Director stated there had been no failed test. He further stated the facility met with the health department, and they told him to test the dead-end areas and to run the water in the dead-end areas for three minutes. The Maintenance Director stated there had been one resident that tested positive for legionella.On 11/21/2025 at 11:16 AM, the Executive Director (ED) provided the surveyor with the facility Legionella Test log and stated she had been with the facility for three weeks and was told about legionella. The ED stated the facility did not have any test kits, and she ordered the test kits. She further stated the water had been tested twice since she started at the facility.Review of the Legionella Test log revealed test dates for 08/13/2025 through 08/15/2025, 11/17/2025 through 11/19/2025, and 11/19/2025 through 11/21/2025, with pass noted on each set of dates. There was no evidence of a test for the dead-end areas for three minutes or that the test was done as recommended by the local health department.During a telephone interview with the Registered Nurse (RN) Administrator with the local health department on 11/21/2025 at 11:55 AM, she stated she had been notified in April 2025 of a case of legionella at the facility.During a follow-up telephone interview with the RN Administrator with the local health department on 11/21/2025 at 12:36 PM, she stated the water samples at the facility were recommended to be tested twice a week for three months. She further stated the facility was told during the 08/13/2025 visit, and the results should show the actual twice a week testing result and the location of the water source. During further interview with the Maintenance Director on 11/21/2025 at 1:50 PM, he stated that starting in August 2025, he was supposed to test the water twice a week for three months. The Maintenance Director stated he informed the former administrator that he needed more test kits. He stated he had not completed any more tests since August 2025, until he began testing again on 11/17/2025.During an interview with the Assistant Director of Nursing (ADON) on 11/21/2025 at 12:43 PM, who also served as the Infection Preventionist, she stated a resident admitted to the facility was sent out to the hospital and diagnosed with legionella. The ADON stated the facility investigated and found the source of the resident's legionella was not from the facility. She stated the facility was supposed to do water tests two times a week for so many weeks then one a month for two months. The ADON stated the testing did not get done because the former administrator did not order more testing kits.During an interview with the Director of Nursing (DON) on 11/21/2025 at 3:42 PM, she stated she expected the water testing to be completed as recommended by the local health department.During a telephone interview with the Medical Director on 11/21/2025 at 4:01 PM, she stated she would expect the facility to test the water if the local health department recommended it.During an interview with the ED on 11/21/2025 at 5:15 PM, she stated it was her expectation that the water tests be done as the local health department recommended.