Based on interview, record review and facility policy review, it was determined the facility failed to ensure one (1) of fourteen (14) sampled residents was free from mistreatment and neglect (Resident #3). On 07/04/15, Resident #3 was hollering and complaining of pain related to a urinary indwelling catheter. Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1 failed to assess the resident; and failed to provide care to address the resident's catheter pain. RN #1 removed the resident's [MEDICAL CONDITION] voice valve for an unknown length of time to prevent the resident from hollering and voicing pain. At approximately 9:00 PM, RN #3 assessed the resident and identified the resident's voice valve had been removed; his/her bladder was distended; and, the resident had no urinary output in the Residents Affected - Few catheter bag.
RN #3 replaced the resident's voice valve and the resident immediately complained of pain and started hollering. RN #3 removed water from the catheter bulb, the catheter popped out and the resident had brown, bloody drainage. RN #3 sent the resident to the emergency room and the resident was identified as having a urinary tract infection.
In addition, RN #1 and LPN #1 failed to provide necessary care and services when they neglected to assess the resident's catheter pain; failed to ensure treatment was provided; and when they removed the resident's [MEDICAL CONDITION] voice valve, depriving him/her of the means to communicate his/her needs.
The facility's failure to ensure residents were free from mistreatment or needect has caused or is likely to cause serious. The facility's failure to ensure residents were free from mistreatment or neglect has caused or is likely to cause serious The facility's failure to ensure residents were free from mistreatment or neglect has caused or is likely to cause serious injury, harm, or impairment to a resident. Immediate Jeopardy was identified on 09/08/15 and determined to exist on 07/04/15. The facility was notified of the Immediate Jeopardy on 09/08/15. An acceptable Allegation of Compliance (AoC) was received on 09/17/15, and the State Survey Agency validated the Immediate Jeopardy was removed on 09/18/15, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (POC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy titled, Abuse Prohibition, dated 07/01/13, revealed the definition of abuse as the willful Review of the facility's policy titled, Abuse Prohibition, dated 07/01/13, revealed the definition of abuse as the willful infliction of physical pain, injury, or mental anguish, or the willful deprivation by a caretaker of services which are necessary to maintain physical or mental health. The policy further defined neglect as the failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness.

Record review revealed the facility admitted Resident #3 on 04/29/15 with [DIAGNOSES REDACTED]. Review of the Significant Change Minimum Data Set Assessment, dated 07/28/15, revealed the facility assessed Resident #3's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of eleven (11) which indicated the resident was interviewable. The facility coded the MDS as functional limitation on one side, upper and lower related to a [MEDICAL COMPTION] Review of the facility's Complaint Investigation Initial Report, dated 07/09/15, revealed Resident #3 alleged Licensed Practical Nurse (LPN) #1 neglected him/her when she refused to send the resident to the hospital when he/she was in pain on 07/04/15. Interview with Resident #3, on 08/04/15 at 9:10 AM; on 08/05/15 at 11:50 AM; and, on 08/06/15 at 9:30 AM, revealed he/she had been in pain all day on 07/04/15 and LPN #1 told him/her, that he/she had been medicated for pain already. Resident #3 stated he/she told staff he/she was hurting related to the catheter and staff would not send him/her to the hospital. stated nessite to that are lessed was nutring related to the caracter and start would not send infinite to the hospital. During further interview, Resident #3 stated when the night nurse (RN #3) came in that night, she called the ambulance and the resident was transported to the emergency room. Resident #3 stated he/she was unable to insert or remove his/her speaking valve by himself/herself. Review of the July 2015 Medication Administration Record (MAR) revealed on 07/04/15, Resident #3 received [MEDICATION] (anti-anxiety) 0.5 milligrams (mg) via feeding tube at 1:45 PM. However, there was no documented evidence the resident received any medication for pain Review of the Nursing Notes, dated 07/04/15, revealed there was no documented evidence staff addressed Resident #3's pain until 9:00 PM. until 9:00 PM.
Interview with State Registered Nurse Aide (SRNA) #3, on 08/04/15 at 11:40 AM, revealed she worked 7:00 AM to 3:00 PM on 07/04/15. She stated Resident #3 yells all the time and on this particular day he/she was complaining of pain where the catheter goes in. She said RN #1 was made aware of the resident's complaints of pain and the RN checked the catheter and the drainage bag and said the resident was fine, maybe a UTI. The SRNA stated she was giving the resident a bath and the resident continued to yell that he/she was hurting and burning in the penis area. SRNA #3 stated she checked the resident's catheter tubing and it was clear. She stated the resident stated he/she wanted to stay in the bed. catheter tubing and it was clear. She stated the resident stated ne/she wanted to stay in the bed. Interview with SRNA #1, on 08/04/15 at 5:10 PM, revealed she worked the 3:00 PM to 11:00 PM shift on 07/04/15. She stated when she came into work that day, Resident #3 was in a wheelchair in the lobby area with other residents. She stated the resident was irritated and yelling out. SRNA #1 stated RN #1 and LPN #1, reported that the resident had been yelling all day. The SRNA stated the resident was screaming as if he/she was in pain and his/her face was red. SRNA #1 said when she asked the resident where the pain was, the resident pointed downward to his/her private area and said pee pee. She stated the resident requested medication for pain and LPN #1 was made aware by her. Further interview revealed LPN #1 told her the

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

TITLE

resident had already been medicated and the resident was just trying to go out to the hospital. The SRNA stated she told LPN #1 she felt like the resident needed to be put to bed, and LPN #1 spun around and headed down the hallway with the

resident before she (SRNA #1) could even secure the lift. She stated the nurse acted as if she was irritated. The SRNA stated the resident was sweating while being transferred to the bed using the lift, and LPN #1 kept telling the resident, You are not going to the hospital. SRNA #1 stated when she entered the resident's room around 9:00 PM, the resident looked as if he/she was screaming but nothing was coming out. The SRNA stated she told RN #3 and the RN picked up the voice box

valve and inserted it and the resident went back to screaming. SRNA #1 stated when the resident's covers were pulled back, there was urine on the bed sheets and when the catheter came out, the urine kept coming out. The SRNA stated RN #3 sent the resident to the hospital.

Interview, on 08/04/15 at 5:40 PM, with SRNA #2, who worked the 3:00 PM to 11:00 PM shift on 07/04/15, revealed when RN #3

called him into the room, Resident #3 was complaining of hurting and was hollering loudly. SRNA #2 stated when RN #3 took the resident's catheter out, there was blood, urine and gooey pus and a lot of blood. SRNA stated the resident said that he/she wanted to go to the hospital. The SRNA stated the resident's skin was very clammy and cold to touch. SRNA #2 stated he did not know anything about the speaking valve, as the resident was speaking while he was in the room.

Facility ID: 185312

(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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YL1O11

If continuation sheet Page 1 of 20

	_			OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION	(X2) MULTIPLE CONSTRUCTI A. BUILDING B. WING	ON	(X3) DATE SURVEY COMPLETED 09/18/2015	
CORRECTION	NUMBER			09/18/2013	
NAME OF PROVIDER OF SU	185312 PPLIER	<u> </u>	STREET ADDRESS, CITY, STA	L ATE, ZIP	
BARKLEY CENTER			4747 ALBEN BARKLEY DRIV PADUCAH, KY 42001	VE .	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home			
(X4) ID PREFIX TAG		DEFICIENCIES (EACH DEFICIEN	NCY MUST BE PRECEDED BY	Y FULL REGULATORY	
F 0224	answer. A message was left requesting a return call.				
Level of harm - Immediate jeopardy					
Residents Affected - Few	hollering so she and LPN #1 place request to go to the hospital and t	I, with RN #1, who worked the 7:00 ed the resident back to bed. RN #1 he SRNA never reported the reside DN] care and removed the speaking	stated the resident did not complent wanted to go to the hospital.	lain of pain and/or RN #1 said she	
	shift change at 7:00 PM. Howeve	r, interview with RN #3, on 08/04/d the voice valve was on the table of	15 at 2:35 PM, revealed when sh	e entered the room at	
	presence of a indwelling urinary and the resident's skin was noted back it was noted that there was u	by RN #3, dated 07/04/15 at 9:54 catheter to a bedside drainage. RN to be cool and clammy and his/her trine on the sheets and the resident	#3 documented there was no urin face was red. The RN wrote who continued to yell stating it hurts	ne in the drainage bag en she pulled the covers down there where I	
	resident yelled louder with pain a catheter came out of the urethra a expressed the desire to go to the l	evealed the nurse took a syringe to nd stated, take out. The nurse docu nd the resident voided thick, brown ospital and then voided bright red	imented she deflated the bulb, the nish urine. RN #3 documented or	e resident yelled, the nce again the resident	
	RN #1 reported to her that Reside that he/she had a catheter and sho	5 at 2:35 PM, revealed she had wor ent #3 had complained all day long ouldn't be hurting. RN #3 said RN #	of having pain on urination and total told her they had taken Reside	was told by the nurse ent #3's speaking valve	
	she entered Resident #3's room, s side). RN #3 stated the resident w that he/she was in severe pain and	o much and the resident's roommate he noted the voice valve was on the vould normally refuse to have the val lept grabbing the catheter saying so she secured a syringe to flush th	e table on the resident's left side ( alve removed. She stated Resider that he/she couldn't pee. RN #3 s	([MEDICAL CONDITION] nt #3 kept telling her stated the resident's	
	water from the bulb and the resid substance coming out of the resid resident voided straight blood. The	so she secured a syringe to flush in ent's urethra. She stated she could the le RN stated at that time the resider sysician, but she was unable to reac	ter shot out. RN #3 stated there we tell the resident's bladder was dis nt was begging to be sent to the h	vas a brown, thick, stended and then the nospital so she	
	(ADON) and got permission to so was being admitted to the hospital Review of the Hospital History ar	and the resident to the hospital. She I for a Urinary Tract Infection [ME d Physical, dated 07/05/15 at 2:32]	e stated she learned later in the event EDICAL CONDITION].  AM, revealed Resident #3 was a	dmitted to the hospital	
	(IV) hydration. Review of the Ho [DATE].	Care on admission to the hospital is spital Discharge Summary revealed on 08/05/15 at 9:20 AM, revealed	d the resident was discharged bac	ck to the facility on	
	the emergency room because Res some relief. The ADON stated R resident to the emergency room . speaking valve on the bedside tal able to take the valve out and put related to the resident hollering a assessment of Resident #3. He sta stated that he would expect the st	ident #3 had no urine output. RN # N #3 reported the resident wanted the Further interview with the ADON ble when she entered the room. Furt it back in. She stated she thought the total the theory of the ADON reported he tied he thanked RN #3 for assessing aff to assess the resident for pain, a	43 stated the balloon had been deto o go to the hospital and she told revealed RN #3 reported she had ther interview with the ADON re he other nurses had left the valve e was not sure why LPN #1 didn' g the resident and putting his/her	flated and the resident had RN #3 to send the I found the resident's evealed the resident was out intentionally t do a more thorough safety first. The ADON	
	determine there was any mistreat clinical protocols for assessments	Director of Nursing, on 08/14/15 at ment/neglect of Resident #3. She st	tated the facility determined LPN	investigation did not I #1 failed to follow	
	1. Resident #1 was transferred to the hospital on [DATE] at 10:15 PM by RN #3 immediately upon assessment of the catheter in order to address Resident #3's complaints of pain.  2. Resident #1 was readmitted to the facility on [DATE] at 5:12 PM with no orders to remove the speaking valve. Resident #3				
	continued to have a urinary cathe 04/30/15.	ter due to [MEDICAL CONDITIO]  IDITION] was removed on 08/24/1	N] bladder as assessed by the Ph		
	<ol> <li>Resident #3's urinary catheter v date.</li> </ol>	vas discontinued by the physician o	on 08/10/15 and removed by the 1		
	issues relating to tracheostomies	esidents in the center with a [MED] at this time. ee (3) of seventy-eight (78) residen	-	•	
	three (3) residents on 08/25/15 for with a catheter was identified as 1	r signs/symptoms of a urinary tract naving pain. The physician was not (CNS) and antibiotic treatment was	t infection and assessed for pain. ified and new orders were obtain	One (1) resident ned for a urinalysis	
	7. On 08/21/15, the three (3) resid No concerns were identified.	ents utilizing catheters were review			
	Administration Record (TAR) reidentified.	l resident records (79 of 79) (censural elected daily pain monitoring, which	h included a care plan review. No	o concerns were	
	Management to validate a PRN (a plan review; no concerns were id		Sheet was present for each resid	lent which included a care	
	Twenty-two (22) of seventy-seve	esidents listed on a change of cond n (77) (census fluctuated) residents ain interventions were initiated upovere identified.	s were reviewed to determine if re	esidents were assessed	
	of the physician's orders [REDA0	h 09/03/15, an RN reviewed all res CTED]. Order clarification needs w These identified clarification needs	ere identified as requiring the sp	ecification of mild,	
	12. The Administrator and DON I The Administrator completed tra of Conduct related to meeting pro regarding how best to uphold eth resident satisfaction to confirm q	participated in Corporate sponsored ning on 07/07/15 and the DON cor offessional standards, complying wit ical behavior every day. In addition ality goals are met and focus and of	mpleted training on 09/02/15. The the regulatory guidance, and exerce, the code included measuring cl	is education was on the Code cise of good judgement linical outcomes and	
	Office Manager, Receptionist, Ad Maintenance Assistant, Therapy with a completion date of 09/17/1	ve solutions. d Service Director, Cooks, and Co- tivities Director, Admissions Director, Program Director, and Therapists p 5 (76 out of 110). On 09/17/15, this susekeepers. Staff not available on 0	ctor, Medical Records, Payroll, No participated in Corporate mandate is training will be completed with	Maintenance and ed Code of Conduct Training h the contracted	
	I				

			(V2) DATE CUDVEY		
STATEMENT OF DEFICIENCIES	(X1) PROVIDER / SUPPLIER / CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	IDENNTIFICATION	B. WING	09/18/2015		
CORRECTION	NUMBER				
NAME OF BROWINGS OF CH	185312	CTREET AD	DDECC CITY CTATE ZID		
NAME OF PROVIDER OF SU	PPLIER		DRESS, CITY, STATE, ZIP		
BARKLEY CENTER		4747 ALBEN PADUCAH,	N BARKLEY DRIVE KY 42001		
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing home or the state	survey agency.		
(X4) ID PREFIX TAG		DEFICIENCIES (EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY		
E 0224	OR LSC IDENTIFYING INFORMATION)				
F 0224  Level of harm - Immediate jeopardy	suspicions of abuse, and reporting of suspicions of abuse, to include the chain of command, and the abuse prevention coordinator. This was completed on 09/14/15. Staff not available during this time frame (33 of 110) will be provided re-education including competency and post-test by the NPE or RN with a pass rate of 100% prior to returning to work. The NPE and DON were reeducated by the Manager of Clinical Operations on 08/26/15 and then the NPE, Consulting Respiratory Therapist or Regional Risk Manager, who was also an RN began reeducation on 08/26/15 through 09/04/15 with all licensed nurses which included RN #1 and RN #3, were provided with all reeducation. Twenty-three (23) of twenty-seven (27) RNs and LPNs were provided with the reeducation. RNs and LPNs not available during this timeframe will be provided the re-education including competency and post-test by the NPE or RN with a pass rate of 100% prior to returning to work. The above re-education included the following:				
Residents Affected - Few					
	A. Abuse and Neglect Policy which covered removing a Passey Muir speaking valve with return demonstration. All nurses educated verbalized and signed that they understood the removal of the valve to prevent a resident to speak is considered abuse.  B. [MEDICAL CONDITION] policy and procedure.  C. Timely review, revision and implementation of care plans and care cards to reflect response to care and changing needs and goals; a post test was used to validate learning.  D. Pain assessment and administering mediation and treatments as prescribed by the physician and/or Nurse Practitioner, and/or per the care plan. Monitoring effectiveness, side effects, and non-verbal signs/symptoms of pain. Completion of pain assessment regarding PRN pain medication administration when receiving communication from another staff member who si a resident may be in pain. Learning was validated with a post-test.  E. Ensuring assessment initiated for appropriate treatment and services to identify complications of an indwelling catheter related to UT1 to include signs and symptoms of pain, assessing for discoloration and urine flow in the tubing and an attempt to find the root cause for the pain and take appropriate action. Learning was validated with post-test.  On 109/17/15, all SRNA's will be provided with re-education on recognizing symptoms of any pain but specifically related to tracheostomics or urinary catheters, observations for discoloration of urine in urinary catheter or changes in urinary output related to catheters who to report these observations, when to report these observations, and what action to take if their concerns were not addressed. Learning will be validated via post-test graded by the NPE, DON, or RN with a 100% pas rate. SRNAs not available during this timeframe will be provided re-education including competency and post-test by the NF or RN with a pass rate of 100 % prior to returning to work.  13. The DON, NPE, or Licensed Nurse will observe licensed nurse providing all aspects of [MEDICAL CONDITION] care in				
	Director, Payroll, Receptionist, For across all shifts to determine if the they have witnessed any other res	instrator, Social Service Director, Business Offi ood Service Director, DON, NPE, or Licensed Ney feel if a staff member abused them, to includ ident being abused daily times fourteen (14) day ks then as determined by the Quality Improvem	Nurse will interview five (5) residents le all forms of abuse or neglect, of if ys to include weekends, then three (3)		
	17. Beginning 09/17/15, the Admi Director, Payroll, Receptionist, Fo across all shifts to determine if the fourteen (14) days to include wee	nistrator, Social Service Director, Business Offi ood Service Director, DON, NPE, or Licensed Ney know or suspect any resident being abused the kends, then three (3) times per week times two	Nurse will interview three (3) staff members nat they have not reported daily times		
	including care of five (5) resident	Iministrator, DON, NPE, RN Supervisor or Lice s to visually determine that the care plan is bein ree (3) times per week times two (2) weeks ther	g followed daily times fourteen (14)		
	The State Survey Agency validate 1. On 09/18/15, review of Resider [DATE] at 10:15 PM via ambular 2. On 09/18/15, review of Resider	d the corrective actions taken by the facility as I t #3's Nurse's Notes revealed the resident was to ce. The resident was admitted with a [DIAGN0 t #3's readmission orders [REDACTED]. There	ransported to the emergency roiagnom on OSES REDACTED].		
	4. On 09/18/15, review of Resident 5. Interviews on 09/18/15 with the	at #3's physician's orders [REDACTED].  DON at 12:52 PM and the NPE at 1:09 PM, re			
[MEDICAL CONDITION] residents. However, the facility reviewed to including following physician's orders [REDACTED].  6. On 09/18/15, review of documentation by the DON revealed the DO urinary catheter in the facility. She assessed the residents for signs and of the residents had symptoms of a UTI. The Physician was notified a antibiotic ordered. Interviews on 09/18/15 with the DON at 12:52 PM were assessed for Urinary Tract Infection symptoms and one (1) reside			ed three (3) residents with an indwelling s of an UTI and pain. She identified one were received for a Urinalysis and C&S with PE on 1:09 PM, revealed three (3) residents		
	completed.  7. On 09/18/15, review of documentation by the DON revealed on 08/21/15 an RN reviewed three (3) residents with catheters to validate the physician's orders [REDACTED]. The MAR contained instructions to assess every shift for presence of pain. A Care Plan review was also completed. All with no concerns noted.  8. On 09/18/15, review of check sheets on 09/18/15 revealed the DON reviewed all seventy-nine (79) (census flucturesidents medical records to ensure the MAR and TAR reflected daily pain management. The Manager of Clinical Cassisted with this and it was completed on 08/21/15. Interviews on 09/18/15 with the DON, at 12:52 PM and the Maximum and t				
	ensured the MAR/TAR and care 19. On 09/18/15, review of a check Director of Health Information va 10. On 09/18/15, review of docum records for a change of condition concern that was identified. Interchange of condition were comple 11. On 09/18/15, review of an Orc	on 08/28/15. A total of twenty-five (25) change views on 09/18/15 with the DON at 12:52 PM a ted and if there was a change of condition, a hea er Listing Report, revealed all PRN (as needed)	Information at 1:09 PM revealed the a pain management sheet on 08/27/15. who is an RN) and the DON reviewed all resident of conditions were identified, none had a nd the NPE at 1:09 PM, revealed audits for ad to toe assessment was completed. pain medications were reviewed to validate		
		iews on 09/18/15 with the DON at 12:52 PM an	LD, MODERATE or SEVERE was included on the ad the NPE at 1:09 PM, revealed orders were		

PRINTED:4/20/2016 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING \_\_\_\_ 09/18/2015 185312 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP 4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001 BARKLEY CENTER For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG (continued... from page 3)
12. On 09/18/15, review of the Code Of Conduct Signature Sheets verified that mandated education via computer independent training was completed on 07/07/15 by the Administrator and by the DON on 09/02/15. The training included Code of Conduct, how it related to staff positions, all were expected to meet Professional Standards, comply with Regulatory guidance and exercise judgement on how to best uphold ethical behavior every day. The Code also included measuring clinical outcomes, patient satisfaction to confirm goals are met. Additionally, it included focused discipline on improving the Quality of Care, creativity and innovation to develop effective solutions. Interviews on 09/18/15 with the DON at 12:52 PM and the Administrator at 12:04 PM verified they received this training.

On 09/18/15, review of the acknowledgement signature forms revealed facility staff except housekeeping, (who is contract) completed the Code of Conduct computer training on 09/17/15, except for ten (10) staff that have not completed the training and those staff will complete the training before returning to work. All housekeeping staff completed the inservices manually on 09/17/15 and signed acknowledgement forms. Further review of signature validation sheets and post tests revealed all facility staff received education by the NPE on the facility's Abuse/Neglect policy and procedure to include the forms of abuse and neglect, when to report, and including following the chain of command from 09/08/15-09/14/15. On 09/14/15, there were thirty-three (33) staff remaining to be educated and they will complete the training before being F 0224 Level of harm - Immediate jeopardy Residents Affected - Few 09/14/15, there were thirty-three (33) staff remaining to be educated and they will complete the training before being allowed to care for residents. allowed to care for residents.

On 09/18/15, review of signature validation sheets and post tests validated the NPE and the DON were re-educated by the Manager of Clinical Operations on 08/26/15. Further review of the signature validation sheets revealed the NPE, Consulting Respiratory Therapist or Regional Risk Manager also reeducated all licensed nurses on 09/02/15 related to the Passey-Muir speaking valve, the Abuse/Neglect policy, [MEDICAL CONDITION] care policies and procedures, following MD orders, timely review of revision of Care Plan implementation and care cards, pain assessments and medication, treatments, and assessments related to complications of indwelling urinary catheters. Post-tests and return demonstrations were completed by staff to ensure understanding. Twenty-three (23) of twenty-seven (27) licensed staff received the education with the remaining to complete on return to work. Interview with the DON, on 09/18/15 at 12:52 PM, revealed all nurses were educated regarding Abuse and Neglect, [MEDICAL CONDITION], the speaking valve, [MEDICAL CONDITION], care plans and care cards and all training was completed by 09/17/15. was complete by 09/17/15.
On 09/18/15, review of signature validation sheets and post tests revealed SRNAs were educated by the NPE and DON on 09/17/15 on recognizing the signs and symptoms of any kind of pain, especially related to residents who have a [MEDICAL CONDITION] or indwelling urinary catheter. Twenty-nine (29) out of thirty (30) SRNAs were education with the one (1) remaining to complete the training upon return to work.

Interview with the NPE, on 09/18/15 at 1:09 PM, revealed there was a Code of Conduct training presented by Corporate Staff and the NPE assisted with training of facility staff. She stated the Respiratory Therapist provided education to her and she then provided education to the facility staff which included a return demonstration. She stated the education covered she then provided education to the factify staff which included a fettin definishation. She stated the education covered the revision of Care Plans, care cards, signs and symptoms and non-verbal indicators of pain, pain assessment, PRN pain medications, indwelling catheter care, recognizing pain symptoms for SRNAs and who they should report it to. She stated post tests were completed by all and were graded by the Regional Risk Manager and the NPE. Abuse and Neglect education to include reporting was completed on 09/14/15. She stated she was responsible to make sure that all staff received education F 0280 Allow the resident the right to participate in the planning or revision of the resident's care plan.
\*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* Level of harm - Minimal \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*
Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the care plan was reviewed and revised for two (2) of fourteen (14) sampled residents (Resident #2 and Resident #8).

On 07/21/15 at approximately 8:50 PM, Resident #2, whom the facility had assessed to have severe cognitive impairment and wandered throughout the facility in a wheelchair, entered Resident #1's room. Resident #2 was rummaging in Resident #1's personal belongings. Resident #1 attempted to get the assistance of staff by yelling out repeatedly and utilizing the call harm or potential for actual Residents Affected - Few light, but staff failed to respond timely. Resident #1 called by phone to the nursing station requesting assistance to get Resident #2 out of his/her room. Resident #2 was noted to have a superficial abrasion to his/her right forehead area after Resident #2 out of his/her room. Resident #2 was noted to have a superficial abrasion to his/her right forehead area after he/she was removed from Resident #1's room. Resident #2 had a history of [REDACTED]. The facility failed to revise Resident #2's care plan to address the resident's behavior to prevent reoccurrence.

On 04/29/15, Resident #8 sustained a fall and the facility's corrective action was to ensure if the resident was going to be up in wheelchair unattended, he/she should be placed in the common area to be visible by staff; however, the facility failed to revise the care plan to include the new intervention. In addition, on 08/13/15, Resident #8's was found unsupervised in the facility courtyard area by the Resident's Daughter who became upset because the resident was outside alone and the wheel on the wheelchair was stuck in the mud. Further review of the care plan revealed the facility failed to revise the care plan to address supervision of the resident while in the courtyard after being made aware of the daughter's concerns. The findings include:

The findings include:
Review of the facility's policy titled, Care Plans, last revised 01/02/14, revealed the purpose was to provide necessary care and services to attain or maintain the resident's highest practicable physical, mental and psychosocial well being.
The policy included that the comprehensive care plan should be reviewed and revised a minimum of quarterly and, as needed to reflect response to care and changing needs and goals.
Record review revealed the facility admitted Resident #2 on 07/01/12 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/26/15, revealed the facility assessed Resident #2's cognition as severely impaired. The resident was not able to complete a Brief Interview of Mental Status examination, which indicated the resident was not interviewable. The facility assessed Resident #2 to be non ambulatory and required the extensive assistance with all activities of daily living (ADLs). Resident #2 was mobile via wheel chair when up out of bed.
Review of Resident #2's Comprehensive Care Plan for Anxiety, Depression and Dementia with Behavior Disturbance which included ineffective coping and motor agitation, biting, physical aggression, i.e. pushing others, revealed the care plan was last reviewed 06/15/15. Further review revealed interventions for staff to maintain a safe environment (initiated 05/08/14) and place resident at arms length away from other residents so he/she could participate in activities. If the resident expressed or demonstrated agitation (initiated 03/12/15) staff would divert the resident by giving him/her alternative objects or activity.

resident expressed or demonstrated agitation (initiated 03/12/15) staff would divert the resident by giving him/her alternative objects or activity.

Interviews on 08/03/15 with Licensed Practical Nurse (LPN) #3 at 4:45 AM, State Registered Nurse Aide (SRNA) #5 at 4:45 AM, SRNA #3 at 5:00 PM, SRNA #4 at 5:15 AM, and SRNA #9 at 5:30 AM, revealed Resident #2 was usually confused, wandered about and would go into other residents' rooms at times and could be combative when redirected. However, review of the resident's Comprehensive Care Plan, last updated 06/15/15, revealed there were no revisions to the care plan to address Resident #2's behavior of entering other residents' rooms.

Interviews conducted on 08/03/15 with Registered Nurse (RN) #4 at 7:25 PM and SRNA #7 at 9:20 AM, revealed Resident #1 had called the nurses' station by telephone on 07/21/15 to report Resident #2 had been in his/her room for thirty (30) minutes.

RN #4 stated she paged for staff to go to the resident's room. SRNA #7 stated when she came out of the dining room to answer the page, Resident #1's and another resident's call light were blinking which meant the lights had been on for at least a few minutes. SRNA #7 stated she found Resident #2 in his/her wheelchair in Resident #1's room. RN #4 and SRNA #7 stated she found Resident #2 in his/her wheelchair in Resident #1's room. RN #4 and SRNA #7 stated she found Resident #2 in his/her wheelchair in Resident #1's room. RN #4 and SRNA #7 stated she found Resident #2 in his/her wheelchair in Resident #1's room. RN #4 and SRNA #7 stated she found Resident #2 in his/her wheelchair in Resident #1's room. RN #4 and SRNA #7 stated she found Resident #2 in his/her wheelchair in Resident #1's room.

stated Resident #2 resided on a different hall than Resident #1.

Interviews on 08/03/15 with RN #3 at 4:20 AM, and LPN #2, at 1:00 PM, revealed on 07/21/15, they observed Resident #2 with Interviews on 60/03/13 with RN #3 at 4:20 AM, and LFIA #2, at 1:00 FM, revealed on 07/21/13, they observed resident #2 with an area that was not raised and had minor bleeding over the eyebrow area when she was removed from Resident #1's room. Further review of Resident #2's Comprehensive Care Plan, last revised 06/15/15 revealed there was no documented evidence the resident's care plan had been reviewed or revised after the 07/21/15 incident related to entering Resident #1's room. Interview with the Social Service Director (SSD), on 08/03/15 at 6:20 AM, revealed she initiated an investigation on 07/21/15 after she was notified of the incident. She stated there were no revisions made to Resident #2's care plan after the incident and to her knowledge, Resident #2 was not sent out for evaluation. The SSD stated there was no action taken related to Resident #2 behavior of wandering into other residents' rooms repeatedly.

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PRINTED:4/20/2016 FORM APPROVED

			OMB NO. 0938-0391
STATEMENT OF (X1) PROVE DEFICIENCIES / CLIA AND PLAN OF IDENNTIFI CORRECTION NUMBER	À. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/18/2015
185312			
NAME OF PROVIDER OF SUPPLIER	•	STREET ADDRESS CITY ST	ATE 7IP

BARKLEY CENTER

4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG OR LSC IDENTIFYING INFORMATION)

F 0280

Level of harm - Minimal

harm or potential for actual

Residents Affected - Few

2. Record review revealed the facility admitted Resident #8 on 11/04/14 with [DIAGNOSES REDACTED]. Review of the Quarterly MDS Assessment, dated 07/24/15, revealed the facility assessed Resident #8's cognition as moderately impaired with a BIMS score of eight (8) which indicated the resident was interviewable. In addition, the facility assessed Resident #8 to be non-ambulatory and to require extensive assistance of one (1) staff for locomotion on the unit and total dependence of one (1) staff for locomotion off the unit.

Review of the Quarterly MDS Assessment, dated 07/24/15, revealed the facility assessed Resident #8's cognition as moderately

Review of the Quarterly MDS Assessment, dated 07/24/15, revealed the facility assessed Resident #8's cognition as moderately impaired with a BIMS score of eight (8) which indicated the resident was interviewable. In addition, the facility assessed Resident #8 to be non-ambulatory and to require extensive assistance of one (1) staff for locomotion on the unit and total dependence of one (1) staff for locomotion off the unit. Review of the Comprehensive Care Plan, dated 11/12/15, revealed Resident #8 was at risk for falls with interventions for a bed and chair alarm, and not to leave resident unattended in his/her wheelchair in room.

Interview with Resident #8's daughter, on 09/09/15 at 1:00 PM, revealed she came into the facility on [DATE] around 3:00 PM and when she arrived the resident was not in his/her assigned room. The daughter stated she went to look for the resident.

and when she arrived the resident was not in his/her assigned room. The daughter stated she went to look for the resident and found the resident outside alone in the courtyard area with his/her wheelchair wheel off of the pavement and stuck in the mud. The daughter said she was not sure if she would be able to get the chair wheel out of the mud by herself, but was finally able to get it out of the mud. The daughter reported when the resident was taken back into the facility, she noted the resident's forehead and scalp were pink in color. The daughter stated another resident informed her when she reentered the building that the resident had taken him/herself out into the courtyard area with no assistance. The daughter stated she took the resident back to his/her room and assisted the resident to bed; however, no staff came to assist her. The daughter stated the facility Administrator was notified of the incident by the family on 09/08/15 and the DON was notified shortly after the incident.

Further review of the Comprehensive Care Plan, dated 11/12/14, revealed there was no revisions to the care plan to address

Further review of the Comprehensive Care Plan, dated 11/12/14, revealed there was no revisions to the care plan to address the resident going out into the courtyard without staff supervision even though the resident was a high risk for falls and the resident's daughter was upset he/she was out there without supervision and the resident's wheel was stuck in the mud. Interview with Resident #8, on 09/09/15 at 1:15 PM, revealed he/she did not remember who let him/her out into the courtyard, and he/she was unsure how he/she got outside. Interviews with SRNA #11 on 09/09/15 at 4:15 PM and SRNA #12 on 09/15/15 at 4:36 PM, revealed they were working on day shift recently and Resident #8's daughter was bringing the resident into the building from the courtyard area yelling and asking, who took her out there? The SRNA's stated any resident may go out into the courtyard area and staff monitor the courtyard area from inside the building as they go by doors and windows and when they go outside to smoke. The SRNA's stated, It is everyone's responsibility to know to check on any resident's in the courtyard area. SRNA #12 said she has seen Resident #8 self propel in the wheelchair but has never seen the resident opening the door to go outside.

Interview with RN #1, on 09/10/15 at 10:22 AM, revealed Resident #8s daughter was noted to be bringing the resident back into the building from the courtyard area. SR stated she was unsure of the date, but knew it was a weekend, as she only works weekend shifts. RN #1 revealed the daughter reported to her the resident was found outside alone in the courtyard

into the building from the courtyard area. She stated she was unsure of the date, but knew it was a weekend, as she only works weekend shifts. RN #1 revealed the daughter reported to her the resident was found outside alone in the courtyard area and the wheel of the wheelchair had gotten caught in a crack in the sidewalk. RN #1 reported that it was everyone's responsibility to keep an eye on the courtyard. RN #1 stated the staff watch the courtyard area to make sure there isn't a resident out there that should not be, such as a resident that is confused or a high fall risk. RN #1 stated she did not make any revisions to the resident's care plan related to the incident.

Interview with the DON, on 09/09/15 at 3:35 PM, revealed she was informed, as well as the Administrator of the incident in the courted with Posiciont #8 on 00/09/15 by the developers. The DON tends it was reported to her the resident was found.

the courtyard with Resident #8 on 09/08/15 by the daughters. The DON stated it was reported to her the resident was found in the courtyard alone, and the wheelchair wheel was stuck in the mud. She also reported that another resident with a BIMS score of fifteen (15), told her they saw Resident #8 propel self out into the courtyard area. The DON does not feel like there was any reason to make a change in the resident's Care Plan related to the incident in the courtyard because it was reported to the nurse. She stated any resident in the facility has the right to go out into the courtyard as this is their home. Further interview with the DON, on 09/17/15 at 9:36 AM, revealed Resident #8 attempted to self transfer on 04/21/15 in the room and experienced a fall. The resident was attempting to transfer from the wheelchair to the bed. The DON stated intervention related to the resident not being left unattended in room in wheelchair did not apply when in the courtyard because the resident's bed was not in the courtyard, therefore there was no risk for a fall. Furthermore, the DON revealed they had no validation that the wheelchair wheel had gone into the mud as the wheelchair was not muddy nor was there dirt evident on the chair. She stated she would not have expected the nurse to update or revise the Care Plan related to this reported incident, there was no adverse problem. She stated she feels the Courtyard is considered a common area and staff should look outside regularly to see who is in the courtyard as it is visible from all the windows and the dining rooms. Interview with the Administrator, on 09/10/15 at 8:15 AM and 1:20 PM, revealed she was unaware of the incident with Resident #8's wheelchair getting stuck in the mud. She stated no particular staff member was responsible to know the whereabouts of a resident at all times. She feels that the courtyard is a safe environment for all residents at the facility as the courtyard is monitored by staff as they look outside or walk through the courtyard to access other halls.

F 0281

Make sure services provided by the nursing facility meet professional standards of

Level of harm - Immediate jeopardy

Residents Affected - Few

quality.
\*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*
Based on interview, record review, facility policy review, review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #14, and review of the Hospital History and Physical, it was determined the facility failed to provide services, in accordance with acceptable standards of practice, for one (1) of fourteen (14) sampled residents (Resident #3). On 07/04/15, Resident #3 was hollering and complaining of pain related to an indwelling urinary catheter most of the day. Licensed Practical Nurse (LPN) #1 and Registered Nurse (RN) #1 failed to follow the physician's orders [REDACTED]. At 9:00 PM, Registered Nurse #3 assessed the resident and identified the resident had a distended bladder and no urine output was in the catheter bag. When RN #3 deflated (removed water) the catheter bulb, the catheter popped out and the resident had brown, bloody drainage. RN #3 sent the resident to the emergency room. The resident was admitted to the hospital and was identified as having a urinary tract infection, resulting in intravenous (IV) antibiotic therapy and hydration therapy.

hydration therapy.

The facility's failure to provide services in accordance with acceptable standards of practice has caused or is likely to cause serious injury, harm, or impairment to a resident. Immediate Jeopardy was identified on 09/08/15 and determined to exist on 07/04/15. The facility was notified of the Immediate Jeopardy on 09/08/15. An acceptable Allegation of Compliance (AoC) was received on 09/17/15, and the State Survey Agency validated the Immediate Jeopardy was removed on 09/18/15, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (POC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The findings include:

Review of the KBN AOS #14, Patient Care Orders, last revised 10/2010, revealed licensed nurses were responsible for administering medication and treatments as prescribed by the Physician or Advanced Practice Registered Nurse (APRN). Record review revealed the facility admitted Resident #3 on 04/29/15 with [DIAGNOSES REDACTED]. The resident also had [DIAGNOSES REDACTED]. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 07/28/15, revealed

the facility assessed Resident #3's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of laterity assessed resident was organized as inoderately impaired with a block line for the lateral state of the day of pain on 07/04/15. Interviews with Resident #3, on 08/04/15 at 9:10 AM, revealed he/she complained most of the day of pain on 07/04/15.

Resident #3 stated he/she told staff he/she was hurting down at the urinary catheter and staff would not send him/her to the hospital. Resident #3 stated when the night nurse (RN #3) came in that night, she called the ambulance and he/she was

transported to the emergency room.

Review of the July 2015 physician's orders [REDACTED]. However, review of the July 2015 Medication Administration Record (MAR) revealed there was no documented evidence the resident received Tylenol for pain on 07/04/15.

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(X3) DATE SURVEY (X1) PROVIDER / SUPPLIER STATEMENT OF (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING \_\_\_\_ 09/18/2015 185312 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP BARKLEY CENTER 4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG (continued... from page 5)
Review of Nursing Notes, dated 07/04/15, revealed there was no documented evidence by Registered Nurse (RN) #1 or Licensed Practical Nurse (LPN) #1 that Resident #3 had any complaints of pain or was administered pain medication from 7:00 AM through 7:00 PM. However, interviews with State Registered Nurse Aide (SRNA) #3 who worked 7:00 AM-3:00 PM on 07/04/15, on 08/04/15 at 11:40 AM; and, SRNA #1 who worked 3:00 PM to 11:00 PM shift on 07/04/15, on 08/04/15 at 5:10 PM; revealed Resident #3 complained of catheter pain most of the day on 07/04/15. SRNA #1 said she made LPN #1 aware the resident was complaining of pain and requesting pain medication on her shift and the LPN told her the resident had already been medicated. F 0281 Level of harm - Immediate jeopardy Residents Affected - Few medicated.

Interview with LPN #1, on 08/05/15 at 12:48 PM, revealed she was unable to talk at that time; she stated she would return the call to the surveyor. An attempt was made to reach LPN #1, on 08/06/15 at 12:08 PM, but there was no answer, a message was left requesting a return call.

Interview with RN #1, on 08/04/15 at 3:15 PM, revealed Resident #3 was hollering so she and LPN #1 placed the resident back to bed. RN #1 stated the resident did not state he/she was in pain and/or wanted to go to the hospital and the SRNA never reported the resident was in pain and wanted to go to the hospital. However, interview with SRNA #3, who worked 7:00 AM-3:00 PM on 07/04/15, on 08/04/15 at 11:40 AM, revealed she told RN #1 that Resident #3 was in pain and she stated the resident was fine, maybe a UTI. resident was fine, maybe a UTI.
Review of a Nursing Note, dated 07/04/15 at 9:54 PM and 10:00 PM, and interview on 08/04/15 at 2:35 PM, with RN #3 who worked 7:00 PM to 7:AM on 07/04/15, revealed Resident #3 complained of pain with urination related to his/her indwelling urinary catheter. RN #3 stated she observed the resident's skin was cool and clammy and his/her face was red. The resident continued to yell stating it hurts down there and when asked to clarify, the resident stated that it hurt, Where I pee. RN #3 stated she took a syringe to check for proper placement of the catheter and the resident yelled louder with pain and stated, Take out. When the urinary catheter bulb deflated, the resident yelled and the catheter came out of the urethra. The resident continued to yell and voided thick, brownish urine. The resident then voided bright red blood. RN #3 was unable to contact the physician so she called the Assistant Director of Nursing (ADON) and the resident was sent to the emergency room.

Review of the Hospital History and Physical, dated 07/05/15 at 2:32 AM, revealed Resident #3 was admitted to the hospital with [REDACTED]. The plan on admission to the hospital included the antibiotic [MEDICATION NAME] and intravenous (IV) hydration.
Interview with the former ADON, on 08/05/15 at 9:20 AM, revealed he expected the licensed staff to assess the resident's pain, administer medications as ordered and if that was not helpful to contact the physician.
Interview with the Director of Nursing (DON), on 08/06/15 at 2:39 PM, revealed her expectation was that licensed staff should administer medications according to the physician's orders [REDACTED].
Interview with the Physician/Medical Director, on 08/07/15 at 8:21 AM, revealed he expected the facility staff to provide pain medication according to the physician's orders [REDACTED].
\*\*The facility implemented the following actions to remove the Immediate Jeopardy:
1. Resident #1 was transferred to the hospital on [DATE] at 10:15 PM by RN #3 immediately upon assessment of the catheter in order to address Resident #3's complaints of pain.
2. Resident #1 was readmitted to the facility on [DATE] at 5:12 PM with no orders to remove the speaking valve. Resident #3 continued to have a urinary catheter due to [MEDICAL CONDITION] bladder as assessed by the Physician related to a stroke on 04/30/15.
3. Resident #3's [MEDICAL CONDITION] was removed on 08/24/15 by the Respiratory Therapist. 3. Resident #3's [MEDICAL CONDITION] was removed on 08/24/15 by the Respiratory Therapist.
4. Resident #3's urinary catheter was discontinued by the physician on 08/10/15 and removed by the licensed nurse on that 5. As of 08/27/15, there were no residents in the center with a [MEDICAL CONDITION]; therefore, no potential exists for issues relating to tracheostomies at this time.
6. On 08/25/15, the center had three (3) of seventy-eight (78) residents who utilized a catheter. The DON assessed these 6. On 08/25/15, the center had three (3) of seventy-eight (78) residents who utilized a cameter. The DON assessed these three (3) residents on 08/25/15 for signs/symptoms of a urinary tract infection and assessed for pain. One (1) resident with a catheter was identified as having pain. The physician was notified and new orders were obtained for a urinalysis (UA) and culture and sensitivity (CNS) and antibiotic treatment was based on the preliminary analysis. The antibiotic therapy was completed on 08/31/15. 7. On 08/21/15, the three (3) residents utilizing catheters were reviewed by a RN to validate physician's orders [REDACTED]. No concerns were identified. 8. On 08/21/15, a RN reviewed all resident records (79 of 79) (census fluctuated) to validate the MAR and/or Treatment Administration Record (TAR) reflected daily pain monitoring, which included a care plan review. No concerns were 9. On 08/27/15, all resident records (78 of 78) (census fluctuated) were reviewed by the Director of Health Information Management to validate a PRN (as needed) Pain Management Flow Sheet was present for each resident which included a care plan review; no concerns were identified.

10. On 08/28/15, a RN reviewed residents listed on a change of condition report for the period between 08/07/15-08/28/15. Twenty-two (22) of seventy-seven (77) (census fluctuated) residents were reviewed to determine if residents were assessed for the presence of pain; and, if pain interventions were initiated upon the identified change of condition, which included a care plan review; no concerns were identified.

11. Beginning on 08/28/15 through 09/03/15, an RN reviewed all residents receiving PRN pain medication to validate accuracy of the physician's orders [REDACTED]. Order clarification needs were identified as requiring the specification of mild, moderate, or severe indications. These identified clarification needs were reviewed with the Physician with corrective moderate, or severe indications. These identified clarification needs were reviewed with the Physician with corrective action initiated upon discovery.

12. The Administrator and DON participated in Corporate sponsored mandated reeducation via independent computer training. The Administrator completed training on 07/07/15 and the DON completed training on 09/02/15. This education was on the Code of Conduct related to meeting professional standards, complying with regulatory guidance, and exercise of good judgement regarding how best to uphold ethical behavior every day. In addition, the code included measuring clinical outcomes and resident satisfaction to confirm quality goals are met and focus and discipline on improving quality of care. Creativity and innovation to develop effective solutions. and innovation to develop effective solutions.

13. All facility staff including Food Service Director, Cooks, and Cook Aides, SRNAs, LPNs, RNs, Social Services, Business Office Manager, Receptionist, Activities Director, Admissions Director, Medical Records, Payroll, Maintenance and Maintenance Assistant, Therapy Program Director, and Therapists participated in Corporate mandated Code of Conduct Training with a completion date of 09/17/15 (76 out of 110). On 09/17/15, this training will be completed with the contracted Housekeeping Supervisor and Housekeepers. Staff not available on 09/17/15 will be provided reeducation including competency and post-test by the Nurse Practice Educator (NPE) or RN with a pass rate of 100% prior to returning to work. In addition on 09/08/15, all were re-educated by the NPE on identification of all forms of abuse, including neglect, when to report suspicions of abuse, and reporting of suspicions of abuse, to include the chain of command, and the abuse prevention coordinator. This was completed on 09/14/15. Staff not available during this time frame (33 of 110) will be provided re-education including competency and post-test by the NPE or RN with a pass rate of 100% prior to returning to work.

The NPE and DON were reeducated by the Manager of Clinical Operations on 08/26/15 and then the NPE, Consulting Respiratory Therapist or Regional Risk Manager, who was also an RN began reeducation on 08/26/15 through 09/04/15 with all licensed nurses which included RN #1 and RN #3, were provided with all reeducation. Twenty-three (23) of twenty-seven (27) RNs and LPNs were provided with the reeducation. RNs and LPNs not available during this timeframe will be provided the re-education included the following:

A. Abuse and Neglect Policy which covered removing a Passey Muir speaking valve with return demonstration. All nurses A. Abuse and Neglect Policy which covered removing a Passey Muir speaking valve with return demonstration. All nurses educated verbalized and signed that they understood the removal of the valve to prevent a resident to speak is considered B. [MEDICAL CONDITION] policy and procedure.
C. Timely review, revision and implementation of care plans and care cards to reflect response to care and changing needs and goals; a post test was used to validate learning.

Facility ID: 185312

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCT	TON	(X3) DATE SURVEY COMPLETED		
DEFICIENCIES AND PLAN OF CORRECTION	/ CLIA IDENNTIFICATION NUMBER	A. BUILDING B. WING		09/18/2015		
	185312					
NAME OF PROVIDER OF SU BARKLEY CENTER	PPLIER		STREET ADDRESS, CITY, STA			
DARKLET CENTER			4747 ALBEN BARKLEY DRIV PADUCAH, KY 42001	/ E		
	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 0281	(continued from page 6) D. Pain assessment and administering mediation and treatments as prescribed by the physician and/or Nurse Practitioner,					
Level of harm - Immediate jeopardy	and/or per the care plan. Monitoring effectiveness, side effects, and non-verbal signs/symptoms of pain. Completion of pain assessment regarding PRN pain medication administration when receiving communication from another staff member who suspects a resident may be in pain. Learning was validated with a post-test.					
Residents Affected - Few  Residents Affected - Few  E. Ensuring assessment initiated for appropriate treatment and services to identify complications of an indwelling related to UTI to include signs and symptoms of pain, assessing for discoloration and urine flow in the tubing and						
	attempt to find the root cause for	the pain and take appropriate action	on. Learning was validated with p	ost-test.		
	On 09/17/15, all SRNA's will be p tracheostomies or urinary cathete		ognizing symptoms of any pain bu of urine in urinary catheter or chai			
			o report these observations, and w ost-test graded by the NPE, DON			
		this timeframe will be provided re	e-education including competency			
	13. The DON, NPE, or Licensed N	Nurse will observe licensed nurse	providing all aspects of [MEDICAL	AL CONDITION] care including		
	facility. This will include speaking to do so and following the plan of	g valve treatment and orders, abuse care. This will be completed acro	or if resident with a [MEDICAL of se related to removing it when not cost all shifts times fourteen (14) do as determined by the Quality Impr	t specifically ordered ays to include		
	corrective action upon discovery.  14. The DON, NPE, or Licensed N					
	and following the care plan relate	d to urinary catheter use. This wil	l be completed across all shifts tir. (2) weeks then as determined by t	mes fourteen (14)		
	Committee with corrective action	upon discovery.	•			
	assessment that the change of cor to include weekends, then three (	15. The DON, NPE, or RN Supervisor or Charge Nurse will review residents with a change of condition and audit by head to toe assessment that the change of condition is accurately documented and followed up on timely daily times fourteen (14) days to include weekends, then three (3) times per week times two (2) weeks then as determined by the Quality Improvement Committee with corrective action upon discovery.				
	16. Beginning 09/17/15, the Admi Director, Payroll, Receptionist, Fo	nistrator, Social Service Director,				
	across all shifts to determine if th	ey feel if a staff member abused the	hem, to include all forms of abuse urteen (14) days to include weeke	or neglect, of if		
	times per week times two (2) week		lity Improvement Committee with			
	discovery.  17. Beginning 09/17/15, the Admir					
	across all shifts to determine if th	ey know or suspect any resident b	or Licensed Nurse will interview being abused that they have not rep	ported daily times		
	fourteen (14) days to include wee Improvement Committee with co	rrective action upon discovery.				
	18. Beginning on 09/17/15, the Adincluding care of five (5) resident	s to visually determine that the ca	re plan is being followed daily tin	nes fourteen (14)		
	days to include weekends, then the Committee with corrective action		(2) weeks then as determined by t	he Quality Improvement		
	The State Survey Agency validate 1. On 09/18/15, review of Resider	d the corrective actions taken by t		nergency roiagnom on		
	[DATE] at 10:15 PM via ambular 2. On 09/18/15, review of Resider	nce. The resident was admitted wi	th a [DIAGNOSES REDACTED]	].		
	valve. 3. On 09/18/15, review of Resider	_	_			
	4. On 09/18/15, review of Resider	t #3's physician's orders [REDAC	TED].			
	5. Interviews on 09/18/15 with the [MEDICAL CONDITION] reside	ents. However, the facility reviews				
	including following physician's o 6. On 09/18/15, review of docume	ntation by the DON revealed the				
			and symptoms of an UTI and pain ed and orders were received for a V			
	of the residents had symptoms of a UTI. The Physician was notified and orders were received for a Urinalysis and C&S with antibiotic ordered. Interviews on 09/18/15 with the DON at 12:52 PM and the NPE on 1:09 PM, revealed three (3) residents were assessed for Urinary Tract Infection symptoms and one (1) resident was started on an antibiotic which has since been					
	completed. 7. On 09/18/15, review of docume	3 1				
	catheters to validate the physician presence of pain. A Care Plan rev	i's orders [REDACTED]. The MA	AR contained instructions to assess			
	8. On 09/18/15, review of check s	heets on 09/18/15 revealed the DC	ON reviewed all seventy-nine (79)			
		oleted on 08/21/15. Interviews on	09/18/15 with the DON, at 12:52	PM and the Manager of		
	Clinical Operations at 1:09 PM re ensured the MAR/TAR and care	plan reflected daily pain managen	nent.			
	9. On 09/18/15, review of a check Director of Health Information va					
	10. On 09/18/15, review of docum records for a change of condition	entation revealed the Regional Ri	isk Manager (who is an RN) and t	he DON reviewed all resident		
		views on 09/18/15 with the DON a	at 12:52 PM and the NPE at 1:09	PM, revealed audits for		
	11. On 09/18/15, review of an Ord	ler Listing Report, revealed all PR	N (as needed) pain medications w	vere reviewed to validate		
		iews on 09/18/15 with the DON a	addition, MILD, MODERATE of at 12:52 PM and the NPE at 1:09 F			
	reviewed for accuracy. No concert 12. On 09/18/15, review of the Co	de Of Conduct Signature Sheets v				
	training was completed on 07/07/ how it related to staff positions, a		ne DON on 09/02/15. The training onal Standards, comply with Regu			
	exercise judgement on how to be	st uphold ethical behavior every da	ay. The Code also included measured focused discipline on improvir	uring clinical outcomes,		
		develop effective solutions. Inter	views on 09/18/15 with the DON			
	On 09/18/15, review of the acknown	wledgement signature forms revea				
		training before returning to work.	All housekeeping staff completed	I the inservices		
	revealed all facility staff received	education by the NPE on the faci	review of signature validation she lity's Abuse/Neglect policy and pr	rocedure to include		
	the forms of abuse and neglect, w	hen to report, and including follow	wing the chain of command from d and they will complete the train	09/08/15-09/14/15. On		
	allowed to care for residents. On 09/18/15, review of signature	. ,				
			signature validation sheets reveal			

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185312 If continuation sheet Page 7 of 20

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED:4/20/2016 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

(X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING \_\_\_\_ 09/18/2015 185312

NAME OF PROVIDER OF SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP

BARKLEY CENTER

4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG

F 0281

Level of harm - Immediate jeopardy

Residents Affected - Few

(continued... from page 7)
Respiratory Therapist or Regional Risk Manager also reeducated all licensed nurses on 09/02/15 related to the Passey-Muir speaking valve, the Abuse/Neglect policy, [MEDICAL CONDITION] care policies and procedures, following MD orders, timely review of revision of Care Plan implementation and care cards, pain assessments and medication, treatments, and assessments related to complications of indwelling urinary catheters. Post-tests and return demonstrations were completed by staff to ensure understanding. Twenty-three (23) of twenty-seven (27) licensed staff received the education with the remaining to complete on return to work. Interview with the DON, on 09/18/15 at 12:52 PM, revealed all nurses were educated regarding Abuse and Neglect, [MEDICAL CONDITION], the speaking valve, [MEDICAL CONDITION], care plans and care cards and all

was completed by 09/17/15

On 09/18/15, review of signature validation sheets and post tests revealed SRNAs were educated by the NPE and DON on 09/17/15 on recognizing the signs and symptoms of any kind of pain, especially related to residents who have a [MEDICAL CONDITION] or indwelling urinary catheter. Twenty-nine (29) out of thirty (30) SRNAs were education with the one (1)

CONDITION of modwelling urinary catheter. I wenty-nine (29) out of thirty (30) SRNAs were education with the one (1) remaining to complete the training upon return to work.

Interview with the NPE, on 09/18/15 at 1:09 PM, revealed there was a Code of Conduct training presented by Corporate Staff and the NPE assisted with training of facility staff. She stated the Respiratory Therapist provided education to her and she then provided education to the facility staff which included a return demonstration. She stated the education covered the revision of Care Plans, care cards, signs and symptoms and non-verbal indicators of pain, pain assessment, PRN pain medications, indwelling catheter care, recognizing pain symptoms for SRNAs and who they should report it to. She stated post tests were completed by all and were graded by the Regional Risk Manager and the NPE. Abuse and Neglect education to include reporting was completed on 09/14/15. She stated she was responsible to make sure that all staff received education before they returned to work. before they returned to work

Interviews on 09/18/15 with RN #5 at 1:41 PM, RN #6 at 2:26 PM, LPN #2 at 2:41 PM, LPN #4 at 1:25 PM, LPN #5 at 1:33 PM, LPN

He at 1:39 PM, revealed they received recent training on [MEDICAL CONDITION], speaking valves and the care of the valve, Care Plan revisions and implementation, pain assessment and the administration of pain medications, communication, catheters, UTI signs and symptoms, abuse and neglect and Code of Conduct, accuracy of orders, and pain to be identified as mild, moderate or severe. They stated staff was required to complete post tests.

Interviews on 09/18/15 with SRNA #14 at 1:56 PM, SRNA #15 at 1:58 PM, SRNA #16 at 2:01 PM, SRNA #17 at 2:03 PM, SRNA

2:06 PM, SRNA #21 at 2:09 PM, SRNA #22 at 2:12 PM, SRNA #23 at 2:14 PM, SRNA #20 at 1:52 PM, SRNA #19 at 2:38 PM, Certified

Occupational Therapy Assistant (COTA) #1 at 1:54 PM, COTA #2 at 2:30 PM, Physical Therapy Assistant (PTA) #1 at 2:32 PM, and PTA #2 at 2:33 PM revealed they had received inservice training by the NPE on Abuse/Neglect, catheters, reporting of pain, care cards, and reporting of concerns to the DON. They stated post tests were provided after the training.

Interviews on 09/18/15 with the Activities Director at 1:46 PM, the Dietary Director at 1:48 PM, the Social Services Director at 1:49 PM, the Maintenance Man at 2:15 PM, the Health Information Coordinator at 1:36 PM, the Payroll and Benefits Coordinator at 1:43 PM, the Business Office Manager at 2:23 PM, the Admissions/Marketing Director at 2:18 PM, a Receptionist at 2:05 PM, the Hairdresser at 2:21 PM, Housekeeper #2 at 2:35 PM revealed inservice training was provided by the NPE regarding the abuse/neglect policy and the types of abuse as well as the signs and symptoms and reporting. They also received education on the chain of command and the reporting of pain. They were required to take a test after completion.

13. Review of the Roster Sample Matrix revealed as of 09/18/15, revealed there were no residents with a [MEDICAL CONDITION] in the building.

14. Interviews on 09/18/15 with the DON at 12:52 PM and the NPE at 1:09 PM revealed they were observing residents with indwelling catheters daily for signs of pain and ensuring staff was following the Plan of Correction.

15. Interviews on 09/18/15 with the DON at 12:52 PM and the NPE at 1:09 PM revealed they were completing head to toe skin assessments and documenting daily on any resident identified as having a change of condition daily.

16. Interview with the DON, on 09/18/15 at 12:52 PM, revealed five (5) residents were being interviewed daily regarding

Abuse/Neglect. 17. Interview with the DON, on 09/18/15 at 12:52 PM, revealed three (3) staff members were being interviewed daily regarding

17. Interview with the DON, on 09/18/13 at 12:52 PM, revealed three (3) staff memoers were being interviewed daily regard. Abuse/Neglect and the proper procedures to follow.

18. Interview with the DON, on 09/18/15 at 12:52 PM, revealed Administration and various staff were watching interactions between staff and residents daily.

F 0282

Level of harm - Immediate

Residents Affected - Few

Provide care by qualified persons according to each resident's written plan of care.
\*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*

Based on interview, record review and facility policy review, it was determined the facility failed to carry out interventions in accordance to the written plan of care for two (2) of fourteen (14) sampled residents (Resident #1 and

Resident #3 was care planned for staff to record urinary output; monitor output for odor, color, consistency and amount; monitor for signs and symptoms of infection and report to physician; medicate the resident as ordered for pain; monitor for effectiveness and monitor for side effects; report to physician as indicated and monitor for non-verbal signs/symptoms of

pain and medicate as ordered.

On 07/04/15, Resident #3 was hollering and complaining of pain related to a catheter most the day. Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1 failed to administer pain medication, and monitor the resident's urinary output which included the odor, color, consistency and amount according to the care plan after the resident expressed catheter pain and

discomfort.
At 9:00 PM, RN #3 assessed the resident and identified the resident was complaining of severe pain, his/her bladder was distended and there had been no output in the catheter bag. RN #3 removed water from the catheter pulb, the catheter popped out and the resident had brown, bloody drainage. RN #3 sent the resident to the emergency room and the diagnosed with

out and the resident had brown, bloody dramage. RN #3 sent the resident to the emergency from and the diagnosed with [REDACTED].

In addition, on 07/21/15 at approximately 8:50 PM, Resident #2 was rummaging in Resident #1's personal belongings; however, when Resident #1 yelled out for help and pushed the call light, the staff failed to respond. Resident #1 called the nurses' station via the public telephone line and reported to the staff that Resident #2 had been in his/her room for approximately thirty (30) minutes and somebody needed to come get him/her out. State Registered Nurse Aide (SRNA) #7 entered Resident #1's room, and observed Resident #2 was in the room in his/her wheelchair and she removed Resident #2 from the room. #1's from, and observed Resident #2 was in the from in from. The facility's failure to provide services in accordance with each resident's written plan of care has caused or is likely to cause serious injury, harm, or impairment to a resident. Immediate Jeopardy was identified on 09/08/15 and determined to exist on 07/04/15. The facility was notified of the Immediate Jeopardy on 09/08/15. An acceptable Allegation of Compliance (AoC) was received on 09/17/15, and the State Survey Agency validated the Immediate Jeopardy was removed on 09/18/15, as alleged. The Scope and Severity was lowered to a D while the facility develops and implements the Plan of Correction (POC); and, the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.

and, the facility's Quanty Assurance (QA) monitors the effectiveness of the systemic changes. The findings include:
Review of the facility's policy titled, Care Plans, dated 01/02/14, revealed a comprehensive, individualized care plan should be developed by the interdisciplinary team for each resident. The care plan should include measurable objectives to meet resident needs and goals as identified by the assessment process. The purpose of the Care Plan was to provide necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial

Record review revealed the facility admitted Resident #3 on 04/29/15 with [DIAGNOSES REDACTED]. Review of the Significant Change Minimum Data Set Assessment, dated 07/28/15, revealed the facility assessed Resident #3's cognition as moderately impaired with a Brief Interview for Mental Status (BIMS) score of eleven (11) which indicated the resident was interviewable and did not have pain.
Review of the Comprehensive Care Plan for alteration in comfort, dated 05/05/15, revealed interventions for staff to

medicate the resident as ordered for pain; monitor for effectiveness and monitor for side effects; report to physician as indicated and also to monitor for non-verbal signs/symptoms of pain and medicate as ordered. Interview with Resident #3, on 08/04/15 at 9:10 AM, on 08/05/15 at 11:50 AM, and on 08/06/15 at 9:30 AM, revealed he/she had

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YL1O11

Facility ID: 185312

If continuation sheet Page 8 of 20

STATEMENT OF DEFICIENCIES	/ CLÍA	(X2) MULTIPLE CONSTRUCT A. BUILDING	TION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION	IDENNTIFICATION NUMBER	B. WING		09/18/2015	
NAME OF PROVIDER OF SUP	185312 PPLIER		STREET ADDRESS, CITY, STA	ATE, ZIP	
BARKLEY CENTER			4747 ALBEN BARKLEY DRIV PADUCAH, KY 42001		
For information on the nursing h	nome's plan to correct this deficience				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM		ENCY MUST BE PRECEDED B	Y FULL REGULATORY	
F 0282	(continued from page 8) been in pain all day on 07/04/15 a	nd LPN #1 told him/her, he/she h	ad been medicated for pain alread	ly. Resident #3 stated	
Level of harm - Immediate jeopardy	he/she told staff he/she was hurtin Resident #3 stated when the night the emergency room.				
Residents Affected - Few	Interview on 08/04/15 at 11:40 AM revealed Resident #3 complained RN #1 aware of the resident's con resident was fine, maybe a UTI.	of pain in the catheter area and w	as hollering out most of the day. S	SRNA #3 stated she made	
	Interview with SRNA #1 who worked the 3:00 PM to 11:00 PM shift on 07/04/15, on 08/04/15 at 5:10 PM, revealed Resident #3 complained of pain in the catheter area and was hollering out most of the day. SRNA #1 said she also made LPN #1 aware the resident was complaining of pain and requesting pain medication on her shift and the LPN told her the resident had already been medicated.				
	Review of the July 2015 Physician (MAR)		•		
	and Nursing Notes for 07/04/15 re 07/04/15, as he/she should have, a	as per the care plan.	-		
	Review of the Comprehensive Car record output; monitor for signs a consistency and amount.				
	Review of the July 2015 Treatmen urinary output every shift for reter the boxes had a line drawn throug	ntion. Further review revealed no	documentation noted for 07/01/1:		
	Review of the Intake and Output d Resident #3 had 400 milliliter (ml documented with no amount on 0' Interview (Post Survey), on 08/14/ 07/04/15, revealed she looked for bag. She stated the catheters bags Resident #3's catheter bag around urine looked like. She said she rec piece of paper and give it to the nu	) output on 07/03-04/15, on the 1 7/04/15, 7:00 AM-3:00 PM; and 4/15 at 2:40 PM, with SRNA #3, w signs of irritation, discoloration it were emptied and the amount rec 2:00 PM on 07/04/15, but she dicorded IC on the flow sheet becau	1:00 PM-7:00 AM shift: J/C (indv 400 ml output on 07/04/15, 3:00 F tho had documented J/C for output in the urine and if there was urine orded at the end of the shift. SRN I not recall how much urine was it see they used to write the amount	welling catheter) was M-11:00 PM shift. t on 7:00 AM-3:00 PM shift on in the drainage (A #3 stated she emptied n the bag or what the of urine output on a	
	was supposed to document the am Interview with LPN #1, on 08/05/1 to the surveyor. An attempt was m	nount of urine emptied from the balls at 12:48 PM, revealed she was nade to reach LPN #1, on 08/06/1	ag. unable to talk at that time and she	e would return the call	
		5 at 3:15 PM, revealed Resident # staff should assess catheters each leted on a resident receiving an as und documented on the MAR. She ealed no documented evidence th 77/04/15 at 9:54 PM and 10:00 PM 4/15, revealed Resident #3 comp, s/her face was red. The resident or re I pee. RN #3 stated she took a s n pain and stated, take out. The bt ent continued to yell and voided t ontact the physician so she called	shift and document the findings of needed dose of pain medication of also stated residents were assesse resident received pain medication, and interview on 08/04/15 at 2: lained of pain with urination. RN ontinued to yell stating it hurts do syringe to check for proper placen lib was deflated, the resident yell whick, brownish urine. The resident	on the TAR. She stated one (1) hour after the ed for pain every shift. on on 07/04/15.  335 PM, with RN #3, who #3 stated the resident's wn there and the nent of the catheter ed and the catheter it then voided bright	
	red blood. RN #3 was unable to contact the physician so she called the Assistant Director of Nursing (ADON) and the resident was sent to the emergency room.  Review of the hospital History and Physical, dated 07/05/15 at 2:32 AM, revealed Resident #3 was admitted to the hospital with [REDACTED]. Plan on admission included the antibiotic [MEDICATION NAME] and intravenous (IV) hydration. Interview with the Director of Nursing, on 08/06/15 at 2:39 PM, revealed she would expect staff to implement the care plan and assess the resident's pain and attempt to find the root cause for the pain. She stated the staff would also need to notify the physician of any concerns identified. She stated the SRNAs were responsible for monitoring urinary output whe			nous (IV) hydration. nplement the care plan ld also need to	
	emptying drainage bags and shoul Interview (Post Survey) with the L enter output amounts on the flow noted in color, consistency and ch document when there had been a charted the care she provided for I and as needed per the plan of care	Director of Nursing (DON), on 08, sheet. She stated they should also hange in output amounts. She state change in condition for the resider Resident #3 on 07/04/15, and lice	/14/15 at 8:15 ÅM, revealed the S notify the nurse in charge on the ed licensed staff chart by exceptiont. She stated she would have exp	hall of any changes n and were required to ected LPN #1 to have	
	2. Record review revealed the faci. MDS Assessment, dated 06/26/15 fifteen (15) which indicated the remechanical lift and required assist	lity admitted Resident #1 on 11/2, revealed the facility assessed Resident was interviewable. Resident tance with all Activities of Daily I	esident #1's cognition as intact with th #1 required total assist with tra- Living (ADLs).	th a BIMS' score of nsfers, utilized a	
	Review of Resident #1's Comprehe the resident's call light within read Review of a Progress Note, dated (	ch at all times. 07/21/15 at 8:15 PM (Change in C	Condition) revealed the resident h	ad called, via telephone	
	for someone to get a resident (Res room. Interview with Resident #1, on 08/ up to Resident #2 at the foot of the but there wasn't anyone anywhere the bed and the over the bed table	03/15 at 11:45 AM, revealed on 0 e bed. He/she stated he/she turned. Resident #1 stated Resident #2 l	07/21/15 he/she was in bed asleep I on the call light and was repeate kept getting into his/her stuff and	around 9:00 PM and woke dly yelling for help had gotten stuck by	
	the bed and the over the bed table in the room about twenty (20) mir answered that Resident #2 had be Interview (phone) conducted on 08 07/21/15 and it was Resident #1. \$	nutes, so he/she (Resident #1) fina en in his/her room and somebody 8/03/15 at 7:25 PM with RN #4 re	ally got on the telephone and told needed to come get him/her. evealed she had answered the telephone	the person that phone on the evening of	
	minutes so she called the other nu Interview with State Registered Nt 11:00 PM shift. She stated she wa to go to Resident #1's room. She s Resident #2 into the hall in his/hei Resident #1's and another resident Interview with the Administrator, **The facility implemented the fol 1. Resident #1 was transferred to the	rse and then paged for someone to urse Aide (SRNA) #7, on 08/03/1 s sitting in the dining room with a tated she responded and found Re r wheelchair. SRNA #7 stated wh t's call light were blinking which to on 08/03/15 at 7:10 AM, revealed llowing actions to remove the Inn	o go to Resident #1's room immed 5 at 9:20 AM, revealed she worke another resident and heard an over esident #2 in Resident #1's room, en she came out of the dining roo meant the lights had been on for a l staff was expected to answer cal nediate Jeopardy:	liately. d 07/21/15 on the 3:00 PM to r head page for someone She stated she pushed m to answer the page, few minutes. I lights timely.	
	order to address Resident #3's con 2. Resident #1 was readmitted to the continued to have a urinary cathet 04/30/15.	nplaints of pain. he facility on [DATE] at 5:12 PM er due to [MEDICAL CONDITIO	with no orders to remove the spe DN] bladder as assessed by the Ph	aking valve. Resident #3	
	<ol> <li>Resident #3's [MEDICAL CON</li> <li>Resident #3's urinary catheter w date.</li> </ol>			licensed nurse on that	
	5. As of 08/27/15, there were no re	esidents in the center with a [MEI	DICAL CONDITION]; therefore,	no potential exists for	

STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY		
DEFICIENCIES AND PLAN OF CORRECTION	/ CLIA IDENNTIFICATION NUMBER	A. BUILDING B. WING	COMPLETED 09/18/2015		
	185312				
	AME OF PROVIDER OF SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP				
BARKLEY CENTER	4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001				
	g home's plan to correct this deficiency, please contact the nursing home or the state survey agency.				
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFORM	DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED MATION)	BY FULL REGULATORY		
F 0282	(continued from page 9) issues relating to tracheostomies at this time.				
Level of harm - Immediate jeopardy	6. On 08/25/15, the center had three (3) of seventy-eight (78) residents who utilized a catheter. The DON assessed these three (3) residents on 08/25/15 for signs/symptoms of a urinary tract infection and assessed for pain. One (1) resident with a catheter was identified as having pain. The physician was notified and new orders were obtained for a urinalysis				
Residents Affected - Few	(UA) and culture and sensitivity (therapy was completed on 08/31/7. On 08/21/15, the three (3) resid	CNS) and antibiotic treatment was based on the preliminary ana	lysis. The antibiotic		
		resident records (79 of 79) (census fluctuated) to validate the M lected daily pain monitoring, which included a care plan review			
	9. On 08/27/15, all resident record	is (78 of 78) (census fluctuated) were reviewed by the Director of its needed) Pain Management Flow Sheet was present for each respitited.	f Health Information sident which included a care		
	10. On 08/28/15, a RN reviewed r Twenty-two (22) of seventy-seventy-seventy for the presence of pain; and, if particles a care plan review; no concerns w	esidents listed on a change of condition report for the period bet n (77) (census fluctuated) residents were reviewed to determine ain interventions were initiated upon the identified change of con-	if residents were assessed adition, which included		
	of the physician's orders [REDAC moderate, or severe indications. T action initiated upon discovery.	CTED]. Order clarification needs were identified as requiring the hese identified clarification needs were reviewed with the Physical hese identified the physical hese identified clarification needs were reviewed with the Physical hese identified the physical hese identified hese identified hese identified hese identified hese identified hese identified hese identified hese identified hese	specification of mild, cian with corrective		
	The Administrator completed trai of Conduct related to meeting pro- regarding how best to uphold ethi resident satisfaction to confirm qu	participated in Corporate sponsored mandated reeducation via in ning on 07/07/15 and the DON completed training on 09/02/15. fessional standards, complying with regulatory guidance, and ex- cal behavior every day. In addition, the code included measurin, lality goals are met and focus and discipline on improving quality	This education was on the Code tercise of good judgement g clinical outcomes and		
	Office Manager, Receptionist, Ac	ve solutions. d Service Director, Cooks, and Cook Aides, SRNAs, LPNs, RN tivities Director, Admissions Director, Medical Records, Payrol Program Director, and Therapists participated in Corporate mand	l, Maintenance and		
	Housekeeping Supervisor and Ho and post-test by the Nurse Practic on 09/08/15, all were re-educated	5 (76 out of 110). On 09/17/15, this training will be completed usekeepers. Staff not available on 09/17/15 will be provided ree e Educator (NPE) or RN with a pass rate of 100% prior to return by the NPE on identification of all forms of abuse, including ne g of suspicions of abuse, to include the chain of command, and the	ducation including competency sing to work. In addition glect, when to report		
	coordinator. This was completed re-education including competent The NPE and DON were reeducat Therapist or Regional Risk Mana nurses which included RN #1 and	on 09/14/15. Staff not available during this time frame (33 of 11 by and post-test by the NPE or RN with a pass rate of 100% prioped by the Manager of Clinical Operations on 08/26/15 and then ger, who was also an RN began reeducation on 08/26/15 through IRN #3, were provided with all reeducation. Twenty-three (23) ducation. RNs and LPNs not available during this timeframe will	0) will be provided to returning to work. the NPE, Consulting Respiratory to 09/04/15 with all licensed of twenty-seven (27) RNs and		
	re-education included the following A. Abuse and Neglect Policy which educated verbalized and signed the	ist by the NPE or RN with a pass rate of 100% prior to returning ng: ch covered removing a Passey Muir speaking valve with return hat they understood the removal of the valve to prevent a residen	demonstration. All nurses		
	abuse. B. [MEDICAL CONDITION] po C. Timely review, revision and in and goals; a post test was used to	aplementation of care plans and care cards to reflect response to	care and changing needs		
	D. Pain assessment and administering mediation and treatments as prescribed by the physician and/or Nurse Practitioner, and/or per the care plan. Monitoring effectiveness, side effects, and non-verbal signs/symptoms of pain. Completion of pain assessment regarding PRN pain medication administration when receiving communication from another staff member who suspects				
	related to UTI to include signs an	g was validated with a post-test.  or appropriate treatment and services to identify complications of symptoms of pain, assessing for discoloration and urine flow it the pain and take appropriate action. Learning was validated wit	n the tubing and an		
	On 09/17/15, all SRNA's will be p tracheostomies or urinary catheter	provided with re-education on recognizing symptoms of any pair responsible to the symptoms of any pair responsible the symptoms of any pair responsible the symptoms of any pair report these observations, when to report these observations, and	but specifically related to changes in urinary		
	rate. SRNAs not available during or RN with a pass rate of 100% p	I. Learning will be validated via post-test graded by the NPE, DO this timeframe will be provided re-education including compete rior to returning to work. Surse will observe licensed nurse providing all aspects of [MED]	ncy and post-test by the NPE		
	observing for sign/symptoms of p facility. This will include speakin to do so and following the plan of	ain or discomfort during the care or if resident with a [MEDICA] g valve treatment and orders, abuse related to removing it when care. This will be completed across all shifts times fourteen (14 r week times two (2) weeks then as determined by the Quality II.	L CONDITION] enters into the not specifically ordered ) days to include		
	corrective action upon discovery.  14. The DON, NPE, or Licensed Mand following the care plan relate days to include weekends, then the	Nurse will observe for signs and symptoms of pain associated wid to urinary catheter use. This will be completed across all shifts ree (3) times per week times two (2) weeks then as determined by	th indwelling urinary catheters times fourteen (14)		
	assessment that the change of conto include weekends, then three (	visor or Charge Nurse will review residents with a change of condition is accurately documented and followed up on timely daily itimes per week times two (2) weeks then as determined by the	times fourteen (14) days		
	Director, Payroll, Receptionist, Fo across all shifts to determine if the they have witnessed any other restimes per week times two (2) week	upon discovery.  instrator, Social Service Director, Business Office Manager, Ad  ood Service Director, DON, NPE, or Licensed Nurse will interviey feel if a staff member abused them, to include all forms of ab  ident being abused daily times fourteen (14) days to include were  ks then as determined by the Quality Improvement Committee v	ew five (5) residents use or neglect, of if exends, then three (3)		
	Director, Payroll, Receptionist, Fe across all shifts to determine if the	nistrator, Social Service Director, Business Office Manager, Ad ood Service Director, DON, NPE, or Licensed Nurse will intervi- ey know or suspect any resident being abused that they have not kends, then three (3) times per week times two (2) weeks then a recetive action upon discovery.	ew three (3) staff members reported daily times		
	18. Beginning on 09/17/15, the Adincluding care of five (5) resident days to include weekends, then the Committee with corrective action	Iministrator, DON, NPE, RN Supervisor or Licensed Nurse will s to visually determine that the care plan is being followed daily tree (3) times per week times two (2) weeks then as determined l upon discovery.	times fourteen (14)		
	The State Survey Agency validate	d the corrective actions taken by the facility as follows:			

		OMB NO. 0938-0391		
(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NUMBER	B. WING	09/18/2015		
185312				
PPLIER	STREET ADDRESS, CITY, S'	ΓATE, ZIP		
	4747 ALBEN BARKLEY DR PADUCAH KV 42001	IVE		
home's plan to correct this deficien				
		BY FULL REGULATORY		
OR LSC IDENTIFYING INFORMATION)				
(continued from page 10) 1. On 09/18/15, review of Resident #3's Nurse's Notes revealed the resident was transported to the emergency rotation on				
[DATE] at 10:15 PM via ambulance. The resident was admitted with a [DIAGNOSES REDACTED].  2. On 09/18/15, review of Resident #3's readmission orders [REDACTED]. There was no order written to remove the speaking				
Residents Affected - Few  2. On 09/18/15, review of Resident #3's physician's orders [REDACTED]. There was no order written valve. 3. On 09/18/15, review of Resident #3's physician's orders [REDACTED]. #3's [MEDICAL CONDITIO 4. On 09/18/15, review of Resident #3's physician's orders [REDACTED]. 5. Interviews on 09/18/15 with the DON at 12:52 PM and the NPE at 1:09 PM, revealed as of 08/25/15 [MEDICAL CONDITION] residents. However, the facility reviewed their [MEDICAL CONDITION] including following physician's orders [REDACTED]. 6. On 09/18/15, review of documentation by the DON revealed the DON identified three (3) residents were urinary catheter in the facility. She assessed the residents for signs and symptoms of an UT1 and pain. So the residents had symptoms of a UT1. The Physician was notified and orders were received for a UT antibiotic ordered. Interviews on 09/18/15 with the DON at 12:52 PM and the NPE on 1:09 PM, reveal were assessed for Urinary Tract Infection symptoms and one (1) resident was started on an antibiotic were completed. 7. On 09/18/15, review of documentation by the DON revealed on 08/21/15 an RN reviewed three (3) reatheters to validate the physician's orders [REDACTED]. The MAR contained instructions to assess expresence of pain. A Care Plan review was also completed. All with no concerns noted. 8. On 09/18/15, review of check sheets on 09/18/15 revealed the DON reviewed all seventy-nine (79) (cresidents medical records to ensure the MAR and TAR reflected daily pain management. The Manager assisted with this and it was completed on 08/21/15. Interviews on 09/18/15 with the DON, at 12:52 PM Clinical Operations at 1:09 PM revealed they reviewed all seventy-nine (79) (census fluctuated) resider ensured the MAR/TAR and care plan reflected daily pain management. 9. On 09/18/15, review of a check sheet and interview with the Director of Health Information at 1:09 P Director of Health Information validated all resident records were complete with a pain management sl 10. On 09/18/15, review of				
the order accuracy and the Care I order to print on the MAR. Interveviewed for accuracy. No conce 12. On 09/18/15, review of the Ct training was completed on 07/07, how it related to staff positions, a exercise judgement on how to be patient satisfaction to confirm go Care, creativity and innovation to Administrator at 12:04 PM verifi On 09/18/15, review of the ackno completed the Code of Conduct and those staff will complete the manually on 09/17/15 and signed revealed all facility staff received the forms of abuse and neglect, w 09/14/15, there were thirty-three allowed to care for residents. On 09/18/15, review of signature Manager of Clinical Operations of Respiratory Therapist or Regiona speaking valve, the Abuse/Negle review of revision of Care Plan ir related to complications of indwe ensure understanding. Twenty-th complete on return to work. Inter Abuse and Neglect, [MEDICAL training	Plan was reviewed on 09/03/15. In addition, MILD, MODERATE views on 09/18/15 with the DON at 12:52 PM and the NPE at 1:05 rns were identified.  ode Of Conduct Signature Sheets verified that mandated education v15 by the Administrator and by the DON on 09/02/15. The training all were expected to meet Professional Standards, comply with Rest uphold ethical behavior every day. The Code also included mea als are met. Additionally, it included focused discipline on improve of develop effective solutions. Interviews on 09/18/15 with the DO ed they received this training.  wledgement signature forms revealed facility staff except housek computer training on 09/17/15, except for ten (10) staff that have retraining before returning to work. All housekeeping staff complete acknowledgement forms. Further review of signature validation at leducation by the NPE on the facility's Abuse/Neglect policy and when to report, and including following the chain of command from (33) staff remaining to be educated and they will complete the tra validation sheets and post tests validated the NPE and the DON work on 08/26/15. Further review of the signature validation sheets reveal Risk Manager also reeducated all licensed nurses on 09/02/15 reter policy, [MEDICAL CONDITION] care policies and procedures in the procession of the pr	or SEVERE was included on the PM, revealed orders were a via computer independent included Code of Conduct, gulatory guidance and issuring clinical outcomes, ving the Quality of N at 12:52 PM and the seeping, (who is contract) not completed the training ed the inservices sheets and post tests procedure to include in 09/08/15-09/14/15. On ining before being see re-educated by the aled the NPE, Consulting lated to the Passey-Muir s, following MD orders, timely reatments, and assessments completed by staff to a with the remaining to a were educated regarding		
On 09/18/15, review of signature 09/17/15 on recognizing the sign CONDITION] or indwelling urin remaining to complete the trainin Interview with the NPE, on 09/18 and the NPE assisted with trainin she then provided education to the revision of Care Plans, care c	s and symptoms of any kind of pain, especially related to resident tary catheter. Twenty-nine (29) out of thirty (30) SRNAs were edug upon return to work.  15 at 1:09 PM, revealed there was a Code of Conduct training prog of facility staff. She stated the Respiratory Therapist provided e the facility staff which included a return demonstration. She stated ards, signs and symptoms and non-verbal indicators of pain, pain	s who have a [MEDICAL cation with the one (1) esented by Corporate Staff ducation to her and the education covered		
		**		
Based on interview, record review	v, and policy review, it was determined the facility failed to provide	le the necessary care		
fourteen (14) sampled residents (	Resident #3).			
On 07/04/15, Resident #3 was hol Practical Nurse (LPN) #1 failed t determine what was causing the rassessed the resident and identific was requesting to go to the hospinad a brown, bloody drainage. RI diagnosed as having a urinary tra The facility's failure to to provide mental and psychosocial well-bei Immediate Jeopardy was identific Immediate Jeopardy on 09/08/15 Agency validated the Immediate while the facility develops and in monitors the effectiveness of the The findings include: Review of the facility's policy title part of the nursing assessment procondition or change in pain status providing a system to identify, as achieve an optimal balance between	llering and complaining of pain related to a catheter. Registered No assess Resident #1's pain and administer pain medication. RN #resident's pain to determine if further action was needed. At approved the resident was in pain, bladder was distended, had no urine in tal. RN #3 removed water from the catheter bulb, the catheter pop N #3 sent the resident to the emergency room and admitted to the ct infection.  the necessary care and services to attain or maintain the highest p ing has caused or is likely to cause serious injury, harm, or impaired on 09/08/15 and determined to exist on 07/04/15. The facility v. An acceptable Allegation of Compliance (AoC) was received on Jeopardy was removed on 09/18/15, as alleged. The Scope and Senplements the Plan of Correction (POC); and, the facility's Quality systemic changes.  ed, Pain Management, last revised 01/02/15, revealed residents shocess for the presence of pain upon admission/re-admission, quarts. The purpose is to maintain the highest possible level of comfort seess, treat and evaluate pain. In addition, the purpose is to design seen pain relief and preservation of function, in accordance with the	I and LPN #1 failed to ximately 9:00 PM, RN #3 at the catheter bag and ped out and the resident hospital. The resident was reacticable physical, ment to a resident. vas notified of the 09/17/15, and the State Survey everity was lowered to a D y Assurance (QA) ould be evaluated as erly, with change in for residents by a plan of care to e resident's directed		
	IDENNTIFICATION NUMBER  185312  PPLIER  INDENTIFICATION NUMBER  185312  PPLIER  INDENTIFICATION NUMBER  185312  PPLIER  INDENTIFICATION NUMBER  185312  PPLIER  INDENTIFICATION INDENTIFICATIO	Incennitification   R. Wing   R. W		

Facility ID: 185312

FORM CMS-2567(02-99) Previous Versions Obsolete

STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING	09/18/2015			
CORRECTION	NUMBER		05/10/2015			
VANCE OF PROVIDER OF ST	185312	ATTREET A DEPEND OF THE OTHER CONTRACTOR	A TIP. CITP.			
NAME OF PROVIDER OF SUI BARKLEY CENTER	PPLIER	STREET ADDRESS, CITY, ST. 4747 ALBEN BARKLEY DRI PADUCAH, KY 42001				
For information on the nursing	home's plan to correct this deficien	cy, 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 0309	(continued from page 11)					
Level of harm - Immediate jeopardy	or by observing for signs of pain. Documentation will be completed using the Pain Presence Monitor documentation tool. The Center's staff will report any observation or communication of pain to the nurse responsible for that resident. Review of the facility's policy titled, Assessment: Nursing, dated 01/02/14, revealed routine and focused assessments should be performed on an ongoing basis as needed. The purpose of the assessment is to determine a resident's condition and					
Residents Affected - Few	w clinical needs.  Record review revealed the facility admitted Resident #3 on 04/29/15 with [DIAGNOSES REDACTED]. Review of the Sign Change Minimum Data Set Assessment, dated 07/28/15, revealed the facility assessed Resident #3's cognition as moderately					
	interviewable and did not have pa					
Review of the Comprehensive Care Plan for alteration in comfort, dated 05/05/15, revealed interventions for stat medicate the resident as ordered for pain and monitor for effectiveness and monitor for side effects, and report physician, as indicated. Staff should also monitor for non-verbal signs/symptoms of pain and medicate as ordere Interview with Resident #3, on 08/04/15 at 9:10 AM, revealed he/she had been in pain all day on 07/04/15 and L			and report to the as ordered.			
	Review of Nursing Notes, dated 0 Practical Nurse (LPN) #1 that Re	n stating he/she had already been medicated.  7/04/15, revealed there was no documented evidence by Registerec sident #3 had any complaints of pain or was assessed for pain from esence Monitor form revealed there was no pain assessment docum	7:00 AM through 7:00 PM.			
	Review of a Nursing Note by RN	s the space was blank. n order [REDACTED].#3 was administered Tylenol for pain on 07. #3, dated 07/04/15 at 9:54 PM, revealed Resident #3 complained o the bedside drainage and no urine in the drainage bag. RN #3 docu	f pain with the presence of			
	skin was noted to have been cool temperature of 96.0 degrees Fahr blood sugar was documented to b	and clammy and his/her face was red. The resident vital signs were enheit orally (normal: 97.5) and was 98.6 degrees Fahrenheit under e 144 (normal: 80- 120 mg/dL), pulse was 78 (normal: 85), respira	e documented as a the arm. The resident's tions were 20 (normal: 19)			
	covers back it was noted that ther hurts down there where I pee. The	ormal range: 135/85). Further review of the Nursing Note revealed e was urine on the sheets. RN #3 documented the resident continue e nurse documented she took a syringe to check for proper placeme nd stated, take out. She documented she deflated the bulb, the resident	d to yell stating it nt of the catheter and the			
	catheter came out of the urethra. I expressed the desire to go to the I to contact the physician and the fa	RN #3 documented the resident continued to yell, voided thick, bro nospital and then voided bright red blood. RN #3 documented she learnly without success.	wnish urine, once again eft the room to attempt			
	Review of a Nursing Note, dated 07/04/15 at 10:00 PM, revealed RN #3 was unable to contact the physician and family of Resident #3. A phone call was placed to the Assistant Director of Nursing (ADON) in which she reported the situation to him and RN #3 was told to send the resident to the emergency room if he/she wanted to go. Emergency Medical Services (EMS) was notified regarding the need for transport to the emergency room.					
	Review of the Hospital History and Physical, dated 07/05/15 at 2:32 AM, revealed Resident #3 was admitted to the hospital with [REDACTED]. The plan on admission included the antibiotic [MEDICATION NAME] and intravenous (IV) hydration. Interview, on 08/04/15 at 11:40 AM, with State Registered Nurse Aide (SRNA) #3 who worked 7:00 AM-3:00 PM on 07/04/15, revealed Resident #3 complained of pain in the catheter area and was hollering out most of the day. She said RN #1 was made aware of the resident's complaints of pain and the RN looked at the catheter and the drainage bag and said the resident was					
	when she came into work that day and yelling out. SRNA #1 stated resident was screaming as if in pathe resident pointed downward to pain and LPN #1 was made aware Interview with LPN #1, on 08/05/	4/15 at 5:10 PM, revealed she worked the 3:00 PM to 11:00 PM shy, Resident #3 was in a wheelchair in the lobby area with other resi RN #1 and LPN #1, reported the resident had been yelling all day. in and his/her face was red. SRNA #1 said when she asked the resi his/her private area and said pee pee. She stated the resident reque by the SRNA and the LPN told her the resident had already been 15 at 12:48 PM, revealed she was unable to talk at that time and stetch LPN #1, on 08/06/15 at 12:08 PM, but there was no answer and	dents and was irritated The SRNA stated the dent where the pain was, sted medication for medicated. tted she would return the			
	requesting a return call.  Interview with RN #1, on 08/04/15 at 3:15 PM, revealed Resident #3 was hollering so she and LPN #1 placed the resident back to bed. RN #1 stated the resident did not complain of pain and did not request to go to the hospital. In addition, she said the SRNA never reported the resident was in pain and/or wanted to go to the hospital.					
	RN #1 reported to her in report the the nurse that he had a catheter are	5 at 2:35 PM, revealed she had worked on 07/04/15 on the 7:00 PM at Resident #3 had complained all day long of having pain on urina da shouldn't be hurting. RN #3 said RN #1 told her they had taken I ing too much and the resident's roommate was removed from the re	ation and was told by Resident #3's speaking			
	resident would normally refuse to severe pain and kept grabbing the	oom, she noted the voice valve was on the table on the resident's left of have the valve removed. RN #3 revealed Resident #3 kept telling catheter saying that he/she couldn't urinate. RN #3 stated the residence was the resident with the catheter. She study has the table the saying terminate to flight the catheter. She study has the saying the flight the saying the flight that the saying the flight the saying the flight that the saying t	her that he/she was in ent's catheter			
	the bulb and the resident screame coming out of the resident's ureth	ccured a syringe to flush the catheter. She stated she let out a little of d in pain and the catheter shot out. She revealed there was a brown ra. The nurse stated she could tell the resident's bladder was disten- te stated at that time the resident was begging to be sent to the hosp	, thick, substance ded and then the			
	attempted to reach the on call phy (ADON) and got permission to se was being admitted for a Urinary	visician, but she was unable to reach him so she phoned the Assistar and the resident to the hospital. She stated she learned later in the every Tract Infection [MEDICAL CONDITION].	at Director of Nursing evening the resident			
	him into the room and Resident # catheter out, there was blood, urin hospital. SRNA #2 said the reside	I, with SRNA #2, who worked the 3:00 PM to 11:00 PM shift on 0' 3 was complaining of hurting and was hollering loudly. SRNA #2 he and gooey pus and a lot of blood and the resident said that he/shent's skin was very clammy and cold to touch.	stated when RN #3 took the e wanted to go to the			
	emergency room because the resi hospital. The ADON stated she to to assess the resident for pain, add	on 08/05/15 at 9:20 AM, revealed RN #3 phoned saying she want dent was in pain, and had no urinary output and the resident was re old RN #3 to send the resident to the hospital, He revealed that he v minister medications as ordered and if not helpful to contact the ph	questing to go to the rould expect the staff ysician. Further			
	interview (Post Survey) with the former ADON, on 08/14/15 at 10:35 AM, revealed pain assessments should be completed daily and as needed; should be documented on the MAR; and should be conducted by licensed nurses.  Interview with the Physician/Medical Director of the facility, on 08/07/15 at 8:21 AM, revealed he would expect the facility staff to assess residents for pain and take the appropriate action. If staff were unable to reach the physician, it would be appropriate to send the resident to the emergency room. The Physician reported that complications from not assessing					
	Resident #3 was transferred to to order to address Resident #3's con	llowing actions to remove the Immediate Jeopardy: the hospital on [DATE] at 10:15 PM by RN #3 immediately upon a applaints of pain.				
	2. Resident #3 was readmitted to t continued to have a urinary cathe 04/30/15.	he facility on [DATE] at 5:12 PM with no orders to remove the speter due to [MEDICAL CONDITION] bladder as assessed by the Pl	eaking valve. Resident #3 nysician related to a stroke on			
	<ol> <li>Resident #3's urinary catheter w date.</li> </ol>	IDITION] was removed on 08/24/15 by the Respiratory Therapist. ras discontinued by the physician on 08/10/15 and removed by the esidents in the center with a [MEDICAL CONDITION]; therefore,				
	issues relating to tracheostomies		•			

STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
DEFICIENCIES AND PLAN OF CORRECTION	/ CLIA IDENNTIFICATION NUMBER	A. BUILDING B. WING	09/18/2015		
	185312				
NAME OF PROVIDER OF SUI	PPLIER	STREET ADDRESS, CITY, ST			
BARKLEY CENTER		4747 ALBEN BARKLEY DRI PADUCAH, KY 42001	VE		
For information on the nursing	home's plan to correct this deficience	cy, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED E MATION)	Y FULL REGULATORY		
F 0309	(continued from page 12)	u sions/overestours of a valinary tract infection and accessed for unin	One (1) resident		
Level of harm - Immediate jeopardy	three (3) residents on 08/25/15 for signs/symptoms of a urinary tract infection and assessed for pain. One (1) resident with a catheter was identified as having pain. The physician was notified and new orders were obtained for a urinalysis (UA) and culture and sensitivity (CNS) and antibiotic treatment was based on the preliminary analysis. The antibiotic therapy was completed on 08/31/15.				
Residents Affected - Few		ents utilizing catheters were reviewed by a RN to validate physicia	ın's orders [REDACTED].		
	8. On 08/21/15, a RN reviewed all	resident records (79 of 79) (census fluctuated) to validate the MA lected daily pain monitoring, which included a care plan review.	R and/or Treatment No concerns were		
	Management to validate a PRN (a plan review; no concerns were ide		dent which included a care		
	Twenty-two (22) of seventy-sever	esidents listed on a change of condition report for the period betw. n (77) (census fluctuated) residents were reviewed to determine if ain interventions were initiated upon the identified change of cond- rere identified.	residents were assessed		
	11. Beginning on 08/28/15 through of the physician's orders [REDAC moderate, or severe indications. T	h 09/03/15, an RN reviewed all residents receiving PRN pain med [TED]. Order clarification needs were identified as requiring the s [hese identified clarification needs were reviewed with the Physici	pecification of mild,		
	The Administrator completed trai of Conduct related to meeting pro	articipated in Corporate sponsored mandated reeducation via inde ning on 07/07/15 and the DON completed training on 09/02/15. T fessional standards, complying with regulatory guidance, and exe cal behavior every day. In addition, the code included measuring or	his education was on the Code rcise of good judgement		
	and innovation to develop effective	nality goals are met and focus and discipline on improving quality to solutions. d Service Director, Cooks, and Cook Aides, SRNAs, LPNs, RNs,	·		
	Maintenance Assistant, Therapy I with a completion date of 09/17/1	tivities Director, Admissions Director, Medical Records, Payroll, Program Director, and Therapists participated in Corporate manda 5 (76 out of 110). On 09/17/15, this training will be completed with usekeepers. Staff not available on 09/17/15 will be provided read.	ted Code of Conduct Training th the contracted		
	Housekeeping Supervisor and Housekeepers. Staff not available on 09/17/15 will be provided reeducation including competer and post-test by the Nurse Practice Educator (NPE) or RN with a pass rate of 100% prior to returning to work. In addition on 09/08/15, all were re-educated by the NPE on identification of all forms of abuse, including neglect, when to report suspicions of abuse, and reporting of suspicions of abuse, to include the chain of command, and the abuse prevention coordinator. This was completed on 09/14/15. Staff not available during this time frame (33 of 110) will be provided re-education including competency and post-test by the NPE or RN with a pass rate of 100% prior to returning to work. The NPE and DON were reeducated by the Manager of Clinical Operations on 08/26/15 and then the NPE, Consulting Respira Therapist or Regional Risk Manager, who was also an RN began reeducation on 08/26/15 through 09/04/15 with all licensed nurses which included RN #1 and RN #3, were provided with all reeducation. Twenty-three (23) of twenty-seven (27) RNs an LPNs were provided with the reeducation. RNs and LPNs not available during this timeframe will be provided the re-education including competency and post-test by the NPE or RN with a pass rate of 100% prior to returning to work. The above re-education included the following:  A. Abuse and Neglect Policy which covered removing a Passey Muir speaking valve with return demonstration. All nurses				
	abuse. B. [MEDICAL CONDITION] po	at they understood the removal of the valve to prevent a resident t licy and procedure.  plementation of care plans and care cards to reflect response to care.			
	and goals; a post test was used to D. Pain assessment and administe and/or per the care plan. Monitori	validate learning. ring mediation and treatments as prescribed by the physician and/ ng effectiveness, side effects, and non-verbal signs/symptoms of p	or Nurse Practitioner, pain. Completion of pain		
	a resident may be in pain. Learnin E. Ensuring assessment initiated f	nedication administration when receiving communication from and g was validated with a post-test. for appropriate treatment and services to identify complications of d symptoms of pain, assessing for discoloration and urine flow in	an indwelling catheter		
	attempt to find the root cause for On 09/17/15, all SRNA's will be p tracheostomies or urinary catheter output related to catheters who to their concerns were not addressed	the pain and take appropriate action. Learning was validated with rovided with re-education on recognizing symptoms of any pain be so, observations for discoloration of urine in urinary catheter or che report these observations, when to report these observations, and Learning will be validated via post-test graded by the NPE, DON	post-test.  ut specifically related to anges in urinary what action to take if J, or RN with a 100% pass		
	or RN with a pass rate of 100% pi 13. The DON, NPE, or Licensed N observing for sign/symptoms of p	Nurse will observe licensed nurse providing all aspects of [MEDIC ain or discomfort during the care or if resident with a [MEDICAL	CAL CONDITION] care including CONDITION] enters into the		
	to do so and following the plan of weekends, then three (3) times pe corrective action upon discovery.	g valve treatment and orders, abuse related to removing it when no care. This will be completed across all shifts times fourteen (14) or week times two (2) weeks then as determined by the Quality Imp	days to include provement Committee with		
	and following the care plan relate days to include weekends, then th Committee with corrective action		imes fourteen (14) the Quality Improvement		
	assessment that the change of con	visor or Charge Nurse will review residents with a change of condition is accurately documented and followed up on timely daily to 30 times per week times two (2) weeks then as determined by the Cappon discovery.	imes fourteen (14) days		
16. Beginning 09/17/15, the Administrator, Social Service Director, Business Office Manager, Director, Payroll, Receptionist, Food Service Director, DON, NPE, or Licensed Nurse will int across all shifts to determine if they feel if a staff member abused them, to include all forms of they have witnessed any other resident being abused daily times fourteen (14) days to include times per week times two (2) weeks then as determined by the Quality Improvement Committees.		nistrator, Social Service Director, Business Office Manager, Adm pod Service Director, DON, NPE, or Licensed Nurse will interviev sy feel if a staff member abused them, to include all forms of abus ident being abused daily times fourteen (14) days to include week	w five (5) residents be or neglect, of if ends, then three (3)		
	discovery.  17. Beginning 09/17/15, the Administrator, Social Service Director, Business Office Manager, Admission Director Director, Payroll, Receptionist, Food Service Director, DON, NPE, or Licensed Nurse will interview three (3) staff across all shifts to determine if they know or suspect any resident being abused that they have not reported daily to fourteen (14) days to include weekends, then three (3) times per week times two (2) weeks then as determined by Improvement Committee with corrective action upon discovery.		w three (3) staff members eported daily times determined by the Quality		
	including care of five (5) resident days to include weekends, then th Committee with corrective action		mes fourteen (14)		
	The State Survey Agency validate 1. On 09/18/15, review of Residen	d the corrective actions taken by the facility as follows: t #3's Nurse's Notes revealed the resident was transported to the e ice. The resident was admitted with a [DIAGNOSES REDACTEI			

STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCT	TION	(X3) DATE SURVEY COMPLETED		
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		09/18/2015		
CORRECTION	NUMBER 185312					
NAME OF PROVIDER OF SU			STREET ADDRESS, CITY, STA	ATE, ZIP		
BARKLEY CENTER			4747 ALBEN BARKLEY DRIV PADUCAH, KY 42001	VE		
For information on the nursing	FADUCAH, KY 42001  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 DOR LSC IDENTIFYING INFORM		ENCY MUST BE PRECEDED BY	Y FULL REGULATORY		
F 0309	(continued from page 13) 2. On 09/18/15, review of Residen	t #3's readmission orders [REDA	CTED1 There was no order writte	en to remove the speaking		
<b>Level of harm -</b> Immediate jeopardy	valve. 3. On 09/18/15, review of Residen	t #3's physician's orders [REDAC	CTED].#3's [MEDICAL CONDIT			
Residents Affected - Few	4. On 09/18/15, review of Resident #3's physician's orders [REDACTED].  5. Interviews on 09/18/15 with the DON at 12:52 PM and the NPE at 1:09 PM, revealed as of 08/25/15 there were no other [MEDICAL CONDITION] reviewer, the facility reviewed their [MEDICAL CONDITION] care policy and procedures.					
	[MEDICAL CONDITION] residents. However, the facility reviewed their [MEDICAL CONDITION] care policy and procedures, including following physician's orders [REDACTED].					
	6. On 09/18/15, review of documentation by the DON revealed the DON identified three (3) residents with an indwelling urinary catheter in the facility. She assessed the residents for signs and symptoms of an UTI and pain. She identified one of the griddents for symptoms of a UTI. The Physician was resident for a Urinal was and CAS with					
	of the residents had symptoms of a UTI. The Physician was notified and orders were received for a Urinalysis and C&S with antibiotic ordered. Interviews on 09/18/15 with the DON at 12:52 PM and the NPE on 1:09 PM, revealed three (3) residents were assessed for Urinary Tract Infection symptoms and one (1) resident was started on an antibiotic which has since been completed.					
	7. On 09/18/15, review of docume catheters to validate the physician					
	presence of pain. A Care Plan rev 8. On 09/18/15, review of check st	iew was also completed. All with	no concerns noted.	•		
	residents medical records to ensur assisted with this and it was comp	e the MAR and TAR reflected da	nily pain management. The Manag	ger of Clinical Operations		
	Clinical Operations at 1:09 PM re	vealed they reviewed all seventy-	nine (79) (census fluctuated) resid			
	ensured the MAR/TAR and care positive of the state of the	sheet and interview with the Dire	ector of Health Information at 1:09	PM revealed the		
	Director of Health Information va 10. On 09/18/15, review of docum	entation revealed the Regional Ri	isk Manager (who is an RN) and t	he DON reviewed all resident		
	records for a change of condition concern that was identified. Interv	views on 09/18/15 with the DON	at 12:52 PM and the NPE at 1:09	PM, revealed audits for		
	change of condition were comple 11. On 09/18/15, review of an Ord	ler Listing Report, revealed all PR	RN (as needed) pain medications v	vere reviewed to validate		
	the order accuracy and the Care P order to print on the MAR. Interv	iews on 09/18/15 with the DON a				
	reviewed for accuracy. No concer 12. On 09/18/15, review of the Co	de Of Conduct Signature Sheets v				
	training was completed on 07/07/ how it related to staff positions, a	Il were expected to meet Profession	onal Standards, comply with Regu	llatory guidance and		
	exercise judgement on how to be patient satisfaction to confirm goa	als are met. Additionally, it includ	led focused discipline on improvir	ng the Quality of		
	Care, creativity and innovation to Administrator at 12:04 PM verific	ed they received this training.				
	On 09/18/15, review of the acknown completed the Code of Conduct c	omputer training on 09/17/15, exc	cept for ten (10) staff that have no	t completed the training		
	and those staff will complete the manually on 09/17/15 and signed	acknowledgement forms. Further	review of signature validation sh	eets and post tests		
	revealed all facility staff received the forms of abuse and neglect, w	hen to report, and including follo	wing the chain of command from	09/08/15-09/14/15. On		
	09/14/15, there were thirty-three allowed to care for residents.	. ,	1			
	On 09/18/15, review of signature of Manager of Clinical Operations of					
	Respiratory Therapist or Regional speaking valve, the Abuse/Negleo	et policy, [MEDICAL CONDITION NOT NOT THE PROPERTY OF THE PROP	ON] care policies and procedures,	following MD orders, timely		
	review of revision of Care Plan in related to complications of indwe					
	ensure understanding. Twenty-thi complete on return to work. Inter-					
	Abuse and Neglect, [MEDICAL of training	CONDITION], the speaking valve	e,[MEDICAL CONDITION], care	e plans and care cards and all		
	was completed by 09/17/15. On 09/18/15, review of signature	validation sheets and post tests rev	vealed SRNAs were educated by t	he NPE and DON on		
	09/17/15 on recognizing the signs CONDITION] or indwelling urin	and symptoms of any kind of pa	in, especially related to residents v	who have a [MEDICAL		
	remaining to complete the training Interview with the NPE, on 09/18/	g upon return to work.				
	and the NPE assisted with training she then provided education to the	g of facility staff. She stated the R	Respiratory Therapist provided edu	ication to her and		
	the revision of Care Plans, care ca medications, indwelling catheter	ards, signs and symptoms and non	n-verbal indicators of pain, pain as	sessment, PRN pain		
	post tests were completed by all a include reporting was completed	nd were graded by the Regional I	Risk Manager and the NPE. Abuse	and Neglect education to		
	before they returned to work. Interviews on 09/18/15 with RN #		•			
	LPN #6 at 1:39 PM, revealed they rece					
	Care Plan revisions and implement catheters, UTI signs and sympton	ns, abuse and neglect and Code of	Conduct, accuracy of orders, and			
	mild, moderate or severe. They st Interviews on 09/18/15 with SRN.			SRNA #17 at 2:03 PM, SRNA		
	#18 at 2:06 PM, SRNA #21 at 2:09 PM,	SRNA #22 at 2:12 PM, SRNA #2	23 at 2:14 PM, SRNA #20 at 1:52	PM, SRNA #19 at 2:38 PM,		
	Certified Occupational Therapy Assistant (					
	and PTA #2 at 2:33 PM revealed pain, care cards, and reporting of Interviews on 09/18/15 with the A	they had received inservice training concerns to the DON. They stated	ng by the NPE on Abuse/Neglect, I post tests were provided after the	catheters, reporting of		
F 0315	Make sure that each resident wh	o enters the nursing home with	out a catheter is not given			
Level of harm - Immediate	a catheter, and receive proper s normal bladder function.	•				
jeopardy	**NOTE- TERMS IN BRACKET Based on interview, record review	, and facility policy review, it was	s determined the facility failed to	provide appropriate		
Residents Affected - Few	treatment and services to identify [MEDICAL CONDITION] for or	ne (1) of fourteen (14) sampled re	sidents (Resident #3).	•		
	On 07/04/15, Resident #3 was hol Nurse (RN) #1 and Licensed Prac	tical Nurse (LPN) #1 failed to ass	sess the resident's catheter and cath	heter pain. They failed		
	to assess the resident's urine outports and identified the resident					
1						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	FION	(X3) DATE SURVEY COMPLETED 09/18/2015
NAME OF PROVIDER OF SUF	PPLIER		STREET ADDRESS, CITY, STA	
			PADUCAH, KY 42001	
(X4) ID PREFIX TAG	nome's plan to correct this deficience SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM	EFICIENCIES (EACH DEFICIE		Y FULL REGULATORY
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFORM (continued from page 14) the catheter. RN #3 removed wate drainage. RN #3 sent the resident The facility's failure to provide ap catheter has caused or is likely to identified on 09/08/15 and determ 09/08/15. An acceptable Allegatic Immediate Jeopardy was removed develops and implements the Plar of the systemic changes. The findings include: Review of the facility's policy title abnormal findings should be repo abnormal findings should be repo abnormal findings and physician/ Review of the facility's policy title be performed on an ongoing basis clinical needs. Record review revealed the facilit' Change Minimum Data Set Asses impaired with a Brief Interview fi interviewable. The resident had a Review of the Comprehensive Car record output; monitor for signs a consistency and amount. Interview with Resident #3, on 08. catheter. The resident stated he/sh when the night nurse (RN #3) can room. Review of Nurses Notes, dated 07 indwelling urinary catheter relater Review of Surses Notes, dated 07 indwelling urinary catheter relater Review of the July 2015 Treatmen urinary output every shift for rete had a line drawn through with a n shift. Review of the Intake and Output do output on 07/03-04/15, on the 11: 07/04/15, 7:00 AM-3:00 PM; and Review of a Nursing Note, dated 0 with the presence of a indwelling and clammy and his/her face was that it hurt, Where I pee. The nurs louder with pain and stated, take of The resident continued to yell and unable to contact the physician so emergency room. Review of the Admission History chief complaint of hematuria (blo numerous to count (TNTC) (norm Negative), turbid, positive [MEDI Complete Blood Count revealed a damitted from the emergency roo Review of the Discharge Summar The resident would continue to re with the final dose to be administ Interview with SRNA #1, and 08/04/12 to bed. Further interview (Post Su discoloration in the urine was in of urine output on a piece of pape and a service of the Discharge Summar The resident would continue to r	DEFICIENCIES (EACH DEFICITMATION)  The first that the catheter bulb, the catheter to the emergency room and the repropriate treatment and services to the emergency room and the repropriate treatment and services to a services to a service of the catheter to the the catheter to the catheter of the cath	ne or the state survey agency.  ENCY MUST BE PRECEDED BY  The state survey agency.  ENCY MUST BE PRECEDED BY  The state survey agency.  The state survey agency.  The state survey agency.  The state survey agency.  The state survey agency are stated to a state survey and severity was lowered to a acility so Quality Assurance (QA) in acility's Quality Assurance of CA acility assessed Resident #3's eleven (11) which indicated in a resident (11) which indicated the resident (11) which indicated the resident of physician; and monitor out the had been in pain all day on 07/0 d he/she had been in pain all day on 07/0 d he/she had been medicated alreas abulance and the resident was transformed to a company and the resident acident evidence RN #1 and/or I for Resident #3 revealed staff was noted for 07/01/15, but the remains a cumented evidence RN #1 and/or I for Resident #3 revealed staff was noted for 07/01/15, but the remains and the resident get RN #3 observed that the resident elling catheter) documented with resident yelled and the catheter came he resident then voided bright red in the state of the catheter and the resident then voided bright red in the state of the catheter and the resident then voided bright red in the state of the catheter and the resident for or Nursing (ADON) and the resident ersident then voided bright red in the state of the state of the catheter and the resident for the state of the	ad a brown, bloody UTI.  welling urinary Jeopardy was te Jeopardy on urvey Agency validated the D while the facility nonitors the effectiveness  vealed that any nould include any sed assessments should nt's condition and  ED]. Review of the Significant cognition as moderately esident was  ntions for staff to out for odor, color,  04/15 related to his/her dy. The resident said sported to the emergency LPN #1 assessed Resident #3's to monitor the resident's der of the empty boxes heter assessment every 3 had 400 milliliter (ml) to amount indicated on ed of pain with urination, ent's skin was cool he resident clarified he resident yelled e out of the urethra. blood. RN #3 was lent was sent to the e emergency room with a lood Cells (WBC's) too is (4+) bacteria (normal: (normal: Negative). The er). The resident was the facility on [DATE]. m every twenty-four (24) hours and 7:00 AM to 3:00 PM on I was made aware of the lent was fine, maybe a the was hurting and ident requested to stay r signs of irritation, or ignes of irritatio
	shot out. She revealed there was a	brown, thick, substance coming	nd the resident screamed in pain an out of the resident's urethra and the ting to be sent to the hospital so the	en the resident

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STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY		
DEFICIENCIES	/ CLIA	A. BUILDING	COMPLETED		
AND PLAN OF CORRECTION	IDENNTIFICATION NUMBER 185312	B. WING	09/18/2015		
NAME OF PROVIDER OF SU		STREET ADDR	ESS, CITY, STATE, ZIP		
BARKLEY CENTER			ARKLEY DRIVE		
For information on the number	homes's alon to compet this deficien	PADUCAH, KY			
(X4) ID PREFIX TAG	•	cy, please contact the nursing home or the state sur DEFICIENCIES (EACH DEFICIENCY MUST BE	, , ,		
(A4) ID I KLI IA IAG	OR LSC IDENTIFYING INFORM		TREEDED DT TOLE REGULATORT		
F 0315  Level of harm - Immediate	(continued from page 15) to reach the on call physician but was unable to reach him so she phoned the Assistant Director of Nursing (ADON) and got permission to send the resident to the hospital. She stated she learned later in the evening the resident was being				
jeopardy	admitted for a Urinary Tract Infection [MEDICAL CONDITION].  Interview with the former Assistant Director of Nursing (ADON), on 08/05/15 at 9:20 AM, revealed RN #3 phoned saying she				
Residents Affected - Few	wanted to send Resident #3 to the deflated and the resident had relie to contact the physician. The ADO not sure why LPN #1 didn't do a n putting his/her safety first. The A Interview with the Director of Nu	emergency room. She stated RN #3 stated the rest; however, the resident continued to ask RN #3 to NN said he told RN #3 to send the resident to the emore thorough assessment of Resident #3, but than DON revealed he would expect the staff to assess trising (DON), on 08/06/15 at 2:39 PM, revealed she of find the root cause for the pain. The staff would a	ident had no output, the balloon was go to the hospital and she was unable mergency room. The ADON reported he was ked RN #3 for assessing the resident and the resident for pain/catheter. would expect staff to assess the		
	Interview with the Physician/Med staff to assess residents for pain a appropriate to send the resident to resident could be increased pain f	ical Director of the facility, on 08/07/15 at 8:21 AM nd take the appropriate action. If staff was unable to the emergency room. The physician reported that from a distended bladder. Illowing actions to remove the Immediate Jeopardy	to reach the physician, it would be tomplications from not assessing the		
	Resident #1 was transferred to t order to address Resident #3's cor	he hospital on [DATE] at 10:15 PM by RN #3 imn	nediately upon assessment of the catheter in		
	continued to have a urinary cather 04/30/15.	ter due to [MEDICAL CONDITION] bladder as as [DITION] was removed on 08/24/15 by the Respiration	ssessed by the Physician related to a stroke on		
	4. Resident #3's urinary catheter w date.	vas discontinued by the physician on 08/10/15 and the	removed by the licensed nurse on that		
	issues relating to tracheostomies a		1		
	6. On 08/25/15, the center had three (3) of seventy-eight (78) residents who utilized a catheter. The DON assessed these three (3) residents on 08/25/15 for signs/symptoms of a urinary tract infection and assessed for pain. One (1) resident with a catheter was identified as having pain. The physician was notified and new orders were obtained for a urinalysis (UA) and culture and sensitivity (CNS) and antibiotic treatment was based on the preliminary analysis. The antibiotic				
	therapy was completed on 08/31/7. On 08/21/15, the three (3) resid No concerns were identified.	<ol> <li>ents utilizing catheters were reviewed by a RN to v</li> </ol>	validate physician's orders [REDACTED].		
	8. On 08/21/15, a RN reviewed all resident records (79 of 79) (census fluctuated) to validate the MAR and/or Treatment Administration Record (TAR) reflected daily pain monitoring, which included a care plan review. No concerns were identified.				
	9. On 08/27/15, all resident records (78 of 78) (census fluctuated) were reviewed by the Director of Health Information Management to validate a PRN (as needed) Pain Management Flow Sheet was present for each resident which included a care plan review; no concerns were identified.				
	10. On 08/28/15, a RN reviewed residents listed on a change of condition report for the period between 08/07/15-08/28/15.  Twenty-two (22) of seventy-seven (77) (census fluctuated) residents were reviewed to determine if residents were assessed for the presence of pain; and, if pain interventions were initiated upon the identified change of condition, which included a care plan review; no concerns were identified.				
	11. Beginning on 08/28/15 throug of the physician's orders [REDAC moderate, or severe indications. T	h 09/03/15, an RN reviewed all residents receiving TED]. Order clarification needs were identified as hese identified clarification needs were reviewed v	requiring the specification of mild,		
	The Administrator completed trai of Conduct related to meeting pro- regarding how best to uphold ethi	narticipated in Corporate sponsored mandated reeduning on 07/07/15 and the DON completed training of dessional standards, complying with regulatory guical behavior every day. In addition, the code includability goals are met and focus and discipline on impressional control of the solution.	on 09/02/15. This education was on the Code idance, and exercise of good judgement ded measuring clinical outcomes and		
	13. All facility staff including Foo Office Manager, Receptionist, Ac Maintenance Assistant, Therapy I with a completion date of 09/17/1	d Service Director, Cooks, and Cook Aides, SRNA tivities Director, Admissions Director, Medical Re Program Director, and Therapists participated in Co 5 (76 out of 110). On 09/17/15, this training will b	ecords, Payroll, Maintenance and orporate mandated Code of Conduct Training be completed with the contracted		
	and post-test by the Nurse Practic on 09/08/15, all were re-educated suspicions of abuse, and reporting	usekeepers. Staff not available on 09/17/15 will be e Educator (NPE) or RN with a pass rate of 100% by the NPE on identification of all forms of abuse of suspicions of abuse, to include the chain of cor on 09/14/15. Staff not available during this time fra	prior to returning to work. In addition , including neglect, when to report mmand, and the abuse prevention		
	re-education including competency. The NPE and DON were reeducat Therapist or Regional Risk Mana nurses which included RN #1 and LPNs were provided with the reed	cy and post-test by the NPE or RN with a pass rate ed by the Manager of Clinical Operations on 08/26 ger, who was also an RN began reeducation on 08/ RN #3, were provided with all reeducation. Twen ducation. RNs and LPNs not available during this test by the NPE or RN with a pass rate of 100% prior.	of 100% prior to returning to work.  15 and then the NPE, Consulting Respiratory  26/15 through 09/04/15 with all licensed  ty-three (23) of twenty-seven (27) RNs and  imeframe will be provided the re-education		
		ng: ch covered removing a Passey Muir speaking valve tat they understood the removal of the valve to prev			
	B. [MEDICAL CONDITION] po C. Timely review, revision and in and goals; a post test was used to	nplementation of care plans and care cards to reflect validate learning.			
	and/or per the care plan. Monitori assessment regarding PRN pain n a resident may be in pain. Learnin		s/symptoms of pain. Completion of pain ication from another staff member who suspects		
	E. Ensuring assessment initiated the related to UTI to include signs an attempt to find the root cause for	or appropriate treatment and services to identify or d symptoms of pain, assessing for discoloration and the pain and take appropriate action. Learning was	d urine flow in the tubing and an validated with post-test.		
	tracheostomies or urinary cathete output related to catheters who to their concerns were not addressed rate. SRNAs not available during	rovided with re-education on recognizing sympton rs, observations for discoloration of urine in urinar report these observations, when to report these observations, when to report these observations will be validated via post-test graded by this timeframe will be provided re-education inclu	y catheter or changes in urinary servations, and what action to take if y the NPE, DON, or RN with a 100% pass		
	observing for sign/symptoms of p facility. This will include speakin	rior to returning to work.  Nurse will observe licensed nurse providing all aspe ain or discomfort during the care or if resident with g valve treatment and orders, abuse related to remo care. This will be completed across all shifts time.	h a [MEDICAL CONDITION] enters into the oving it when not specifically ordered		

(X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA IDENNTIFICATION NUMBER À. BUILDING B. WING \_\_\_\_ 09/18/2015 185312 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP BARKLEY CENTER 4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0315 (continued... from page 16) weekends, then three (3) times per week times two (2) weeks then as determined by the Quality Improvement Committee with weekends, then three (3) times per week times two (2) weeks then as determined by the Quality Improvement Committee with corrective action upon discovery.

14. The DON, NPE, or Licensed Nurse will observe for signs and symptoms of pain associated with indwelling urinary catheters and following the care plan related to urinary catheter use. This will be completed across all shifts times fourteen (14) days to include weekends, then three (3) times per week times two (2) weeks then as determined by the Quality Improvement Committee with corrective action upon discovery.

15. The DON, NPE, or RN Supervisor or Charge Nurse will review residents with a change of condition and audit by head to toe assessment that the change of condition is accurately documented and followed up on timely daily times fourteen (14) days to include weekends, then three (3) times per week times two (2) weeks then as determined by the Quality Improvement Committee with corrective action upon discovery. Level of harm - Immediate jeopardy Residents Affected - Few Committee with corrective action upon discovery.

16. Beginning 09/17/15, the Administrator, Social Service Director, Business Office Manager, Admission Director, Activities Director, Payroll, Receptionist, Food Service Director, DON, NPE, or Licensed Nurse will interview five (5) residents across all shifts to determine if they feel if a staff member abused them, to include all forms of abuse or neglect, of if they have witnessed any other resident being abused daily times fourteen (14) days to include weekends, then three (3) times per week times two (2) weeks then as determined by the Quality Improvement Committee with corrective action upon discovery.

17. Beginning 09/17/15, the Administrator, Social Service Director, Business Office Manager, Admission Director, Activities Director, Payroll, Receptionist, Food Service Director, DON, NPE, or Licensed Nurse will interview three (3) staff members across all shifts to determine if they know or suspect any resident being abused that they have not reported daily times fourteen (14) days to include weekends, then three (3) times per week times two (2) weeks then as determined by the Quality Improvement Committee with corrective action upon discovery.

18. Beginning on 09/17/15, the Administrator, DON, NPE, RN Supervisor or Licensed Nurse will observe staff interaction including care of five (5) residents to visually determine that the care plan is being followed daily times fourteen (14) days to include weekends, then three (3) times per week times two (2) weeks then as determined by the Quality Improvement Committee with corrective action upon discovery. Committee with corrective action upon discovery.

The State Survey Agency validated the corrective actions taken by the facility as follows:

1. On 09/18/15, review of Resident #3's Nurse's Notes revealed the resident was transported to the emergency roiagnom on [DATE] at 10:15 PM via ambulance. The resident was admitted with a [DIAGNOSES REDACTED].

2. On 09/18/15, review of Resident #3's readmission orders [REDACTED]. There was no order written to remove the speaking valve.
3. On 09/18/15, review of Resident #3's physician's orders [REDACTED].#3's [MEDICAL CONDITION] was removed on 08/24/15. 3. On 09/18/15, review of Resident #3's physician's orders [REDACTED]. 4. On 09/18/15, review of Resident #3's physician's orders [REDACTED]. 5. Interviews on 09/18/15 with the DON at 12:52 PM and the NPE at 1:09 PM, revealed as of 08/25/15 there were no other [MEDICAL CONDITION] residents. However, the facility reviewed their [MEDICAL CONDITION] care policy and procedures, including following physician's orders [REDACTED]. 6. On 09/18/15, review of documentation by the DON revealed the DON identified three (3) residents with an indwelling urinary catheter in the facility. She assessed the residents for signs and symptoms of an UTI and pain. She identified one of the residents had symptoms of a UTI. The Physician was notified and orders were received for a Urinalysis and C&S with antibiotic ordered. Interviews on 09/18/15 with the DON at 12:52 PM and the NPE on 1:09 PM, revealed three (3) residents were assessed for Urinary Tract Infection symptoms and one (1) resident was started on a antibiotic which has since been were assessed for Urinary Tract Infection symptoms and one (1) resident was started on an antibiotic which has since been were assessed of Ornary Tract Infection symptoms and one (1) resident was started on an antibiotic which has since been completed.

7. On 09/18/15, review of documentation by the DON revealed on 08/21/15 an RN reviewed three (3) residents with indwelling catheters to validate the physician's orders [REDACTED]. The MAR contained instructions to assess every shift for the presence of pain. A Care Plan review was also completed. All with no concerns noted.

8. On 09/18/15, review of check sheets on 09/18/15 revealed the DON reviewed all seventy-nine (79) (census fluctuated) residents medical records to ensure the MAR and TAR reflected daily pain management. The Manager of Clinical Operations assisted with this and it was completed on 08/21/15. Interviews on 09/18/15 with the DON, at 12:52 PM and the Manager of Clinical Operations to 1:00 PM revealed they reprint a plant with the DON, at 12:52 PM and the Manager of Clinical Operations to the complete of the presented by residents and the proposed by the property plant of the plant of the property plant of the plant o assisted with this and it was completed on 08/21/15. Interviews on 09/18/15 with the DON, at 12:52 PM and the Manager of Clinical Operations at 1:09 PM revealed they reviewed all seventy-nine (79) (census fluctuated) residents' records and ensured the MAR/TAR and care plan reflected daily pain management.

9. On 09/18/15, review of a check sheet and interview with the Director of Health Information at 1:09 PM revealed the Director of Health Information validated all resident records were complete with a pain management sheet on 08/27/15.

10. On 09/18/15, review of documentation revealed the Regional Risk Manager (who is an RN) and the DON reviewed all resident records for a change of condition on 08/28/15. A total of twenty-five (25) change of conditions were identified, none had a concern that was identified. Interviews on 09/18/15 with the DON at 12:52 PM and the NPE at 1:09 PM, revealed audits for change of condition were completed and if there was a change of condition, a head to toe assessment was completed.

11. On 09/18/15, review of an Order Listing Report, revealed all PRN (as needed) pain medications were reviewed to validate the order accuracy and the Care Plan was reviewed on 09/03/15. In addition, MILD, MODERATE or SEVERE was included on the order to print on the MAR. Interviews on 09/18/15 with the DON at 12:52 PM and the NPE at 1:09 PM, revealed orders were reviewed for accuracy. No concerns were identified.

12. On 09/18/15, review of the Code Of Conduct Signature Sheets verified that mandated education via computer independent 12. On 09/18/15, review of the Code Of Conduct Signature Sheets verified that mandated education via computer independent training was completed on 07/07/15 by the Administrator and by the DON on 09/02/15. The training included Code of Conduct, how it related to staff positions, all were expected to meet Professional Standards, comply with Regulatory guidance and exercise judgement on how to best uphold ethical behavior every day. The Code also included measuring clinical outcomes, patient satisfaction to confirm goals are met. Additionally, it included focused discipline on improving the Quality of Care, creativity and innovation to develop effective solutions. Interviews on 09/18/15 with the DON at 12:52 PM and the Administrator at 12:04 PM verified they received this training.

On 09/18/15, review of the acknowledgement signature forms revealed facility staff except housekeeping, (who is contract) completed the Code of Conduct computer training on 09/17/15, except for ten (10) staff that have not completed the training and those staff will complete the training before returning to work. All housekeeping staff completed the inservices manually on 09/17/15 and signed acknowledgement forms. Further review of signature validation sheets and post tests revealed all facility staff received education by the NPE on the facility's Abuse/Neglect policy and procedure to include the forms of abuse and neglect, when to report, and including following the chain of command from 09/08/15-09/14/15. On 09/14/15, there were thirty-three (33) staff remaining to be educated and they will complete the training before being allowed to care for residents.

On 09/18/15, review of signature validation sheets and post tests validated the NPE and the DON were re-educated by the On 09/18/15, review of signature validation sheets and post tests validated the NPE and the DON were re-educated by the Manager of Clinical Operations on 08/26/15. Further review of the signature validation sheets revealed the NPE, Consulting Respiratory Therapist or Regional Risk Manager also reeducated all licensed nurses on 09/02/15 related to the Passey-Muir speaking valve, the Abuse/Neglect policy, [MEDICAL CONDITION] care policies and procedures, following MD orders, timely review of revision of Care Plan implementation and care cards, pain assessments and medication, treatments, and assessments related to complications of indwelling urinary catheters. Post-tests and return demonstrations were completed by staff to ensure understanding. Twenty-three (23) of twenty-seven (27) licensed staff received the education with the remaining to complete on return to work. Interview with the DON, on 09/18/15 at 12:52 PM, revealed all nurses were educated regarding Abuse and Neglect, [MEDICAL CONDITION], the speaking valve, [MEDICAL CONDITION], care plans and care cards and all training training training was completed by 09/17/15.

On 09/18/15, review of signature validation sheets and post tests revealed SRNAs were educated by the NPE and DON on 09/18/15, review of signature validation sheets and post tests revealed SRNAs were educated by the NPE and DON on 09/18/15 on recognizing the signs and symptoms of any kind of pain, especially related to residents who have a [MEDICAL CONDITION] or indwelling urinary catheter. Twenty-nine (29) out of thirty (30) SRNAs were education with the one (1) remaining to complete the training upon return to work.

Interview with the NPE, on 09/18/15 at 1:09 PM, revealed there was a Code of Conduct training presented by Corporate Staff and the NPE assisted with training of facility staff. She stated the Respiratory Therapist provided education to her and she then provided education to the facility staff which included a return demonstration. She stated the education covered the revision of Care Plans, care cards, signs and symptoms and non-verbal indicators of pain, pain assessment, PRN pain

medications, indwelling catheter care, recognizing pain symptoms for SRNAs and who they should report it to. She stated

Facility ID: 185312

FORM CMS-2567(02-99) Previous Versions Obsolete

X3) DATE SURVEY STATEMENT OF (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION COMPLETED DEFICIENCIES AND PLAN OF CORRECTION CLIA
IDENNTIFICATION
NUMBER À. BUILDING B. WING \_\_\_\_ 09/18/2015 185312 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP BARKLEY CENTER 4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0315 post tests were completed by all and were graded by the Regional Risk Manager and the NPE. Abuse and Neglect education to include reporting was completed on 09/14/15. She stated she was responsible to make sure that all staff received education Level of harm - Immediate before they returned to work.

Interviews on 09/18/15 with RN #5 at 1:41 PM, RN #6 at 2:26 PM, LPN #2 at 2:41 PM, LPN #4 at 1:25 PM, LPN #5 at 1:33 PM, jeopardy Residents Affected - Few #6 at 1:39 PM, revealed they received recent training on [MEDICAL CONDITION], speaking valves and the care of the valve, Care Plan revisions and implementation, pain assessment and the administration of pain medications, communication, catheters, UTI signs and symptoms, abuse and neglect and Code of Conduct, accuracy of orders, and pain to be identified as mild, moderate or severe. They F 0323 Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents
\*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\* Level of harm - Minimal \*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\*

Based on interview, record review and facility policy review it was determined the facility failed to provide adequate supervision for two (2) of fourteen (14) sampled residents (Resident #2 and Resident #8).

On 07/21/15 at approximately 8:50 PM, Resident #2, who had severe cognitive impairment and wanders throughout the facility in a wheelchair, entered Resident #1's room. Resident #2 was rummaging in Resident #1's personal belongings; however, when Resident #1 yelled out for help and pushed the call light, the staff failed to respond. Resident #1 called the nursing desk via the public telephone line and reported to the staff that Resident #2 had been in his/her room for approximately twenty (20) minutes and somebody needed to come get him/her out. State Registered Nurse Aide (SRNA) #7 entered Resident #1's room, and observed Resident #2 was in the room in his/her wheelchair and she removed Resident #2 from the room. Further review revealed Resident #2 was a known wanderer who went into other resident's rooms repeatedly but staff failed to take any harm or potential for actual Residents Affected - Few and observed Resident #2 was a known wanderer who went into other resident's rooms repeatedly, but staff failed to take any action to ensure Resident #2 received adequate supervision to ensure his/her safety.

Resident #8 was assessed and care planned at high risk for falls with interventions for a bed and chair alarm. On 04/29/15, Resident #8 sustained a fall and the facility's corrective action to prevent further falls was to ensure if the resident was going to be up in wheelchair unattended, he/she should be placed in the common area to be visible by staff; however, the facility failed to revise the care plan to include the new intervention. On 08/13/15, Resident #8 was found unsupervised in the facility courtyard area by the resident's daughter who became upset because the resident was outside alone and the wheel on the wheelchair was stuck in the mud. Further review of the care plan revealed there were no revisions to the care plan to address the daughters concerns. In addition, the Surveyor determined the chair alarm was not audible in the building if it sounded out in the courtyard. The facility failed to have a system in place to ensure residents in the courtyard had adequate supervision to prevent accidents. The findings include: Review of the facility's policy titled, Call Lights, last revised 10/01/12, revealed residents will have a call light or alternative communication device within their reach at all times when unattended and staff will respond to call lights and communication devices promptly. The Purpose was To ensure safety and communication between staff and patients. Review of the facility's policy, Accidents/Incidents, last revised 05/15/14, revealed an accident was defined as any unexpected or unintentional incident which may result in injury or illness to a resident and an incident was defined as any occurrence not consistent with the routine operation of the Center or normal care of the resident. An incident can involve a visitor or staff member, malfunctioning equipment, or observation of a situation that poses a threat to safety or Record review revealed the facility admitted Resident #2 on 07/01/12 with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/26/15, revealed the facility assessed Resident #2's cognition as severely impaired and he/she was unable to complete a Brief Interview of Mental Status which indicated the resident was not interviewable. In addition, the resident was non ambulatory and required extensive assistance with all Activities of Daily Living (ADLs). Resident #2 was mobile via wheel chair when up.

Review of Resident #2's Comprehensive Care Plan, for Anxiety, Depression and Dementia with Behavior Disturbance which included ineffective coping and motor agitation, biting, and physical aggression, i.e. pushing others, was last reviewed 06/15/15. Interventions included for staff to maintain a safe environment (initiated 05/08/14) and place resident at arms length away from other residents so he/she could participate in activities. If he resident expressed or demonstrated agitation (initiated 03/12/15), staff should divert the resident by giving him/her alternative objects or activities. Review of a Nursing Note, dated 04/06/15 at 6:20 AM, revealed Resident #2 was found in another resident's room (room 202) and had slid out of his/her wheelchair. Review of an Event Summary Report, dated 04/06/15 at 6:20 AM, revealed the facility determined the resident was in another resident's room and attempted to stand from his/her wheel chair unassisted and slid to the floor with no injury sustained. An immediate intervention listed was When resident is restless take to commons area and provide diversional activity such as food, drink, baby doll as resident will tolerate.

Review of Nursing Note documented by RN #4, dated 07/21/15 at 9:52 PM, revealed Resident #2 was in another resident's room (Resident #1) and RN #4 sent an aide to redirect this resident from another resident's room. When the aide wheeled the resident to the nurse, Resident #2 was bleeding from an abrasion, which measured 3 centimeter (cm) by 3 cm on the right restaent to the nurse, Resident #2 was bleeding from an abrasion, which measured 3 centimeter (cm) by 3 cm on the right eyebrow area of the resident's face.

Interview with Resident #1 who is a BIMs of fifteen (15), on 08/03/15 at 11:45 AM, revealed on 07/21/15 he/she was in bed asleep around 9:00 PM and woke up to Resident #2 at the foot of the bed. He/she stated he/she turned on the call light and was repeatedly yelling for help but there wasn't anyone anywhere. Resident #1 revealed Resident #2 kept getting into his/her stuff and had gotten stuck by the bed and the over the bed table and they were wrestling for the table. Resident #1 further stated Resident #2 had been in the room about twenty (20) minutes and Resident #1 stated he/she finally got on the phone and told the person that answered that Resident #2 had been in his/her room and could have been outside and to the highway by now and somebody needed to come get him/her. Resident #1 revealed Resident #2 had been in his/her room many times and he/she would call for someone to get Pasident #3 at Pasident #1 revealed Resident #2 had been in his/her room many times and he/she would call for someone to get Pasident #3 at Pasident #1 revealed Resident #2 had been in his/her room many times and he/she would call for someone to get Pasident #3 at Pasident #1 revealed Resident #2 fraghear rowerd. phone and told the person that answered that Resident #2 had been in his/her room and could have been outside and to the highway by now and somebody needed to come get him/her. Resident #1 revealed Resident #2 had been in his/her room many times and he/she would call for someone to get Resident #2 out. Resident #1 stated he/she sprayed air freshener toward Resident #2 as being like a small child and didn't know any better but he/she did not hit Resident #1. Interview (phone) conducted on 08/03/15 at 7:25 PM with RN #4 revealed she had answered the phone on the evening of 07/21/15 and it was Resident #1. She stated the resident told her that Resident #2 had been in his/her room for twenty (20) minutes. She called the other nurse and then paged for someone to go to Resident #1's room immediately. She additionally stated Resident #2 resided on a different hall than Resident #1 and was very confused.

Interview with SRNA #7, on 08/03/15 at 9:20 AM, revealed she worked 07/21/15 on the 3:00 PM to 11:00 PM shift and Resident #1 was her responsibility that night. She stated she had put the resident to bed at about 6:00 PM. She stated she was sitting in the dining room with another resident and heard an over head page for someone to go to Resident #1's room. She stated she responded and found Resident #2 in Resident #1's room; she pushed Resident #2 into the hall in his/her wheelchair. She stated another SRNA had gone into Resident #1's room and was picking up stuff the resident said Resident #2 had knocked into the floor. SRNA #7 stated when she came out of the dining room to answer the page, Resident #1's and another resident's call light were blinking which meant the lights had been on for a few minutes. SRNA #7 described Resident #2 as usually in bed but would get up sometimes during the night and call for his/her Momma, Daddy and another family member. She stated Resident #2 would become upset sometimes. Further interview with SRNA #7 revealed she had observed the resident in other residents' rooms and has had to r

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stated Resident #2 was usually confused, was awake some nights and wandered about the facility, and goes into other residents' rooms at times. She stated Resident #2 could be combative when redirected. Interview with SRNA #3, on 08/03/15 at 5:00 AM, revealed Resident #2 was up sometimes when she reported for work at 11:00

			OMB NO. 0938-0391			
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
DEFICIENCIES	/ CLIA	A. BUILDING	COMPLETED			
AND PLAN OF	IDENNTIFICATION	B. WING	09/18/2015			
CORRECTION	NUMBER					
	185312					
NAME OF PROVIDER OF SU	JPPLIER	STREET ADDRE	ESS, CITY, STATE, ZIP			
BARKLEY CENTER		4747 ALBEN BA				
T 10 11 1	1 1 1	PADUCAH, KY				
	1	ncy, please contact the nursing home or the state surve				
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE F MATION)	PRECEDED BY FULL REGULATORY			
F 0323	(continued from page 18)	MITTON)				
1 0323		ld attempt to go into other residents' rooms and would	d call out for his/her mother			
Level of harm - Minimal	repeatedly. She further stated Resident #2 would become combative with redirection and would strike out, related to his/her confusion.  Interview with SRNA #4, on 08/03/15 at 5:15 AM, revealed Resident #1 would sit up at night so that he/she could sleep during					
harm or potential for actual harm						
Residents Affected - Few	dialysis during the day. SRNA #4 stated Resident #1 was not a problem if his/her needs were met; and the resident was not					
	aggressive. SRNA #4 revealed Resident #2 frequently went into Resident #1's room and ate the resident's snacks.  Interview with SRNA #9, on 08/03/15 at 5:20 AM, revealed Resident #1 was a loud mouth and had a problem with others coming in his/her room, but the resident was not physically aggressive. SRNA #9 stated Resident #2 mumbles and roams entering					
					Momma. She stated the resident was totally lost but w	
		sive Care Plan revealed even though staff was aware nto Resident #1's room on 07/21/15, there was no do				
	ever revised to address this behave	vior to ensure the appropriate amount of supervision				
	safety.	Director (SSD), on 08/03/15 at 6:20 AM, revealed sl	he was notified on 07/21/15 that there			
	would be an investigation and re-	port to be completed on Resident #1 and Resident #2	. The SSD stated she came into the			
	facility and saw Resident #2 on arrival. She said to her knowledge, Resident #2 was not sent out for evaluation. The SSD stated there was no action taken related to Resident #2's wandering into other resident's rooms repeatedly.					
		Interview with the Administrator, on 08/03/15 at 7:10 AM, revealed she did not come in on 07/21/15 when she was notified of				
	the incident. She stated on 07/22/15 she and the Director of Nursing (DON) interviewed Resident #1. The Administrator					
	stated she did not feel Resident #1 was at any risk due to Resident #2 as the resident could not have reached him/her and added Resident #2 could be combative. She stated Resident #2 should not have been in Resident #1's room.					
		cility admitted Resident #8 on 11/04/14 with [DIAGN				
	Minimum Data Set (MDS) Assessment, dated 07/24/15, revealed the facility assessed Resident #8's cognition as moderately impaired with a BIMS score of eight (8). The facility assessed Resident #8 to be non-ambulatory and he/she required					
	extensive assistance with all activities of daily living (ADL's). In addition, Resident #8 had two (2) falls with no injury and one (1) fall with minor injury, since 01/21/15 when there was a significant change MDS completed.					
	Review of Resident #8's Comprehensive Care Plan, dated 11/12/14 and in effect on 08/13/15, revealed the resident was at risk					
	for falls with interventions for a bed and chair alarm and the resident should not be left unattended in his/her wheelchair while in room.					
	Interview with Resident #8's daug	ghter, on 09/09/15 at 1:00 PM, revealed she came into				
		t was not in his/her assigned room. The daughter stat				
	and found the resident outside alone in the courtyard area with his/her wheelchair wheel off of the pavement and stuck in the mud. The daughter revealed she was not sure if she would be able to get the chair wheel out of the mud by herself, but was finally able to get it out of the mud. The daughter reported when the resident was taken back into the facility, she noted the resident's forehead and scalp were pink in color. The daughter stated another resident informed her when she reentered the building that the resident had taken himself/herself out into the courtyard area with no assistance. The daughter stated she took the resident back to his/her room and assisted the resident to bed; however, no staff came to assist her. The daughter stated the facility Administrator was notified of the incident by the family on 09/08/15 and the DON was notified shortly after the incident.					
					PM, revealed a SRNA was in the enclosed courtyard	area sounding a clip alarm. Attempts to
hear the alarm sounding from ins					side of the building by the State Agency Surveyor we to the courtyard and stepping into the courtyard.	re unsuccessful. The clip alarm was only
	Further review of the Comprehensive Care Plan, dated 11/12/14, revealed there was no revisions to the care plan to address					
	the resident going out into the courtyard without staff supervision even though the resident was at risk for falls and the resident's daughter was upset he/she was out there without supervision and the resident's wheel was stuck in the mud. Interview with Resident #8, on 09/09/15 at 1:15 PM, revealed he/she did not remember who let him/her out into the courtyard,					
				and he/she was unsure how he/she got outside.  Interview with SRNA #11, on 09/09/15 at 4:15 PM, revealed she was working on day shift recently and the resident's daughter		
		e building from the courtyard area. SRNA #11 stated				
	who took (him/her) out there? The SRNA revealed she attempted to help the daughter get the resident back into the room but the daughter went ahead pushing the resident up the hallway so she reported the incident to RN #1. The SRNA stated any resident may go out into the courtyard area and staff monitor the courtyard area from inside the building as they go by doors and windows. The SRNA stated, It is everyone's responsibility to know to check on any resident's in the courtyard					
	area. She also reported that if a resident is left outside, they could turn their wheelchair over, could get stung by a bee or have a heatstroke.					
	Interview with SRNA #12, on 09/	/15/15 at 4:36 PM, revealed she was unsure if the fac				
	courtyard area but staff are in and out of rooms and look outside if the blinds are open. SRNA #12 stated the staff also walk through the courtyard area when they go smoke and will often walk through the courtyard to get to other halls. SRNA					
	#12 revealed she was gone on break for ten to fifteen (10-15) minutes and when she returned from break the resident's					
	daughter was yelling, Who took outside on his/her own.	(him/her) outside? SRNA #12 stated two (2) other re-	sidents reported they saw the resident go			
	Interview with RN #1, on 09/10/1	5 at 10:22 AM, revealed Resident #8's daughter was				
		ard area. She stated she was unsure of the date, but knowled the daughter reported to her the resident was for				
	works weekend shifts. RN #1 revealed the daughter reported to her the resident was found outside alone in the courtyard area and the wheel of the wheelchair had gotten caught in a crack in the sidewalk. RN#1 stated she heard the resident say,					
	I always go out there. RN #1 reported there were no assignments made of staffing specifically to watch the courtyard area and revealed that it was everyone's responsibility to keep an eye on the courtyard. RN #1 stated the staff watch the					
	and revealed that it was everyone's responsibility to keep an eye on the courtyard. RN #1 stated the staff watch the courtyard area to make sure there wasn't a resident out there that should not be, such as a resident that is confused or a					
	high fall risk. RN #1 said she did	not make any revisions to the care plan after the inci	ident.			
		/14/15 at 5:52 PM, revealed some residents must have residents at risk for falls have to have someone to go				
	Interview with SRNA #20, on 09/	/18/15 at 9:33 AM, revealed she would not be able to				
	the resident was in the courtyard. Interviews on 09/18/15 with RN	#6 at 9:25 AM and SRNA #18 at 9:30 AM, revealed t	they did not recall ever hearing an alarm			
	sounding from the courtyard.					
	Interview with the DON, on 09/09/15 at 3:35 PM, revealed she was informed, as well as the Administrator of the incident in the courtyard with Resident #8 on 09/08/15 by the daughters. The DON stated it was reported to her the resident was found					
	in the courtyard alone, and the wheelchair wheel was stuck in the mud. She also reported that another resident with a BIMS					
	score of fifteen (15), told her they saw Resident #8 propel self out into the courtyard area. The DON stated the resident has a chair alarm and feels like it could be heard from inside the building if needed. She stated she did not feel like					
	there was any reason to make a change in the resident's Care Plan related to the incident in the courtyard because it was					
	reported to the nurse. She stated any resident in the facility has the right to go out into the courtyard as this is their home. Further interview with the DON, on 09/17/15 at 9:36 AM, revealed Resident #8 attempted to self transfer on 04/21/15					
	in the room and experienced a fall. The resident was attempting to transfer from the wheelchair to the bed. The DON stated					
	intervention related to the resident not being left unattended in his/her room in wheelchair did not apply when in the					
	courtyard because the resident's bed was not in the courtyard, therefore there was no risk for a fall. Furthermore, the DON revealed they had no validation that the wheelchair wheel had gone into the mud as the wheelchair was not muddy nor was					
	there dirt evident on the chair. She stated she would not have expected the nurse to update or revise the Care Plan related					
	to this reported incident, there was no adverse problem. She stated she feels the Courtyard is considered a common area and staff should look outside regularly to see who is in the courtyard as it is visible from all the windows and the dining					
	rooms.		C .			
	Interview with the Administrator,	on 09/10/15 at 8:15 AM and 1:20 PM, revealed she	was unaware of the incident with Resident			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED:4/20/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER / SUPPLIER (X2) MULTIPLE CONSTRUCTION CLIA IDENNTIFICATION NUMBER A. BUILDING B. WING \_\_\_\_ 09/18/2015 185312 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP 4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001 BARKLEY CENTER For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (X4) ID PREFIX TAG F 0323 (continued... from page 19)
#8's wheelchair getting stuck in the mud. She stated no particular staff member was responsible to know the whereabouts of a resident at all times. She felt that the courtyard was a safe environment for all residents at the facility as the courtyard was monitored by staff as they look outside or walk through the courtyard to access other halls. The Administrator revealed she has checked the courtyard area and felt that there were no physical hazards. She stated the facility has a two (2) hour check for residents and it is a minimum guideline. She also revealed the facility was responsible for the resident's safety but the staff was not aware every time a resident went out into the courtyard. She stated the facility was not considered a secure unit, but they did have systems in place when they need them. Level of harm - Minimal harm or potential for actual Residents Affected - Few

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