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

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BARKLEY CENTER	**4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001**

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.** **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 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 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 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 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 CONDITION]. 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. 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 NAME] (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. 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. 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 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.

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

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

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) Telephone interview with LPN #1, on 08/05/15 at 12:48 PM, revealed she was unable to talk at that time. LPN #1 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, on 08/04/15 at 3:15 PM, with RN #1, who worked the 7:00 AM to 7:00 PM shift on 07/04/15, 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/or request to go to the hospital and the SRNA never reported the resident wanted to go to the hospital. RN #1 said she provided [MEDICAL CONDITION] care and removed the speaking valve and put it down within the resident's reach just before shift change at 7:00 PM. However, interview with RN #3, on 08/04/15 at 2:35 PM, revealed when she entered the room at approximately 9:00 PM, she noted the voice valve was on the table on the resident's left side (the [MEDICAL CONDITION]) and out of the resident's reach. Review of a Nursing Note written by RN #3, dated 07/04/15 at 9:54 PM, revealed Resident #3 complained of pain with the presence of a indwelling urinary catheter to a bedside drainage. RN #3 documented there was no urine in the drainage bag and the resident's skin was noted to be cool and clammy and his/her face was red. The RN wrote when she pulled the covers back it was noted that there was urine on the sheets and the resident continued to yell stating it hurts down there where I pee. Further review of the Note revealed the nurse took a syringe to check for proper placement of the catheter and the resident yelled louder with pain and stated, take out. The nurse documented she deflated the bulb, the resident yelled, the catheter came out of the urethra and the resident voided thick, brownish urine. RN #3 documented once again the resident expressed the desire to go to the hospital and then voided bright red blood. RN #3 documented she left the room to attempt to contact the physician and the family without success. Interview with RN #3, on 08/04/15 at 2:35 PM, revealed she had worked on 07/04/15 on the 7:00 PM-7:00 AM shift. She stated RN #1 reported to her that Resident #3 had complained all day long of having pain on urination and was told by the nurse that he/she had a catheter and shouldn't be hurting. RN #3 said RN #1 told her they had taken Resident #3's speaking valve off because he/she was yelling too much and the resident's roommate was removed from the room as well. RN #3 stated when she entered Resident #3's room, she noted the voice valve was on the table on the resident's left side ([MEDICAL CONDITION] side). RN #3 stated the resident would normally refuse to have the valve removed. She stated Resident #3 kept telling her that he/she was in severe pain and kept grabbing the catheter saying that he/she couldn't pee. RN #3 stated the resident's catheter drainage bag was empty so she secured a syringe to flush the catheter. She stated she let out a little of the water from the bulb and the resident screamed in pain and the catheter shot out. RN #3 stated there was a brown, thick, substance coming out of the resident's urethra. She stated she could tell the resident's bladder was distended and then the resident voided straight blood. The RN stated at that time the resident was begging to be sent to the hospital so she attempted to reach the On Call Physician, but she 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 admitted to the hospital for a Urinary Tract Infection [MEDICAL CONDITION]. 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 of Care on admission to the hospital included the antibiotic [MEDICATION NAME] and intravenous (IV) hydration. Review of the Hospital Discharge Summary revealed the resident was discharged back to the facility on [DATE]. Interview with the former ADON, on 08/05/15 at 9:20 AM, revealed RN #3 phoned her saying she wanted to send Resident #3 to the emergency room because Resident #3 had no urine output. RN #3 stated the balloon had been deflated and the resident had some relief. The ADON stated RN #3 reported the resident wanted to go to the hospital and she told RN #3 to send the resident to the emergency room . Further interview with the ADON revealed RN #3 reported she had found the resident's speaking valve on the bedside table when she entered the room. Further interview with the ADON revealed the resident was able to take the valve out and put it back in. She stated she thought the other nurses had left the valve out intentionally related to the resident hollering all day long. The ADON reported he was not sure why LPN #1 didn't do a more thorough assessment of Resident #3. He stated he thanked RN #3 for assessing the resident and putting his/her safety first. The ADON stated that he would expect the staff to assess the resident for pain, administer medications as ordered and if these things didn't work, they should contact the physician. Interview (Post Survey) with the Director of Nursing, on 08/14/15 at 8:15 AM, revealed the facility's investigation did not determine there was any mistreatment/neglect of Resident #3. She stated the facility determined LPN #1 failed to follow clinical protocols for assessments and LPN #1 was terminated. **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. 4. Resident #3's urinary catheter was discontinued by the physician on 08/10/15 and removed by the licensed nurse on that date. 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 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 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 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 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. 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

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F 0224 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) 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 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 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 suspects 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 UTI 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 09/17/15, all SRNA's will be provided with re-education on recognizing symptoms of any pain but specifically related to tracheostomies 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% pass rate. SRNAs not available during this timeframe 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. 13. The DON, NPE, or Licensed Nurse will observe licensed nurse providing all aspects of [MEDICAL CONDITION] care including observing for sign/symptoms of pain or discomfort during the care or if resident with a [MEDICAL CONDITION] enters into the facility. This will include speaking valve treatment and orders, abuse related to removing it when not specifically ordered to do so and following the plan of care. 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. 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. 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. 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. 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 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 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.

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F 0224 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(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 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. 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 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 retu
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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** 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 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 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: 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. 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 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 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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	185312	A. BUILDING _____ B. WING _____	09/18/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BARKLEY CENTER	4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001

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F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) 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 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 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 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. 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 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 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **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. 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 eleven (11) which indicated the resident was interviewable. 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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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(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. 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. 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. 4. Resident #3's urinary catheter was discontinued by the physician on 08/10/15 and removed by the licensed nurse on that date. 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 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 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 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 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. 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 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 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.

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BARKLEY CENTER	**4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001**

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F 0281 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) 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 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 UTI 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 09/17/15, all SRNA's will be provided with re-education on recognizing symptoms of any pain but specifically related to tracheostomies 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% pass rate. SRNAs not available during this timeframe 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. 13. The DON, NPE, or Licensed Nurse will observe licensed nurse providing all aspects of [MEDICAL CONDITION] care including observing for sign/symptoms of pain or discomfort during the care or if resident with a [MEDICAL CONDITION] enters into the facility. This will include speaking valve treatment and orders, abuse related to removing it when not specifically ordered to do so and following the plan of care. 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. 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. 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. 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. 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 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 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 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 Manager of Clinical Operations on 08/26/15. Further review of the signature validation sheets revealed the NPE, Consulting

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	185312	A. BUILDING _____ B. WING _____	**09/18/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BARKLEY CENTER	**4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001**

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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 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 09/17/15 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 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. 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 #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 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 #18 at 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 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 jeopardy **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). 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 bulb, the catheter popped out and the resident had brown, bloody drainage. RN #3 sent the resident to the emergency room 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. 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. 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 well being. 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

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 8) been in pain all day on 07/04/15 and LPN #1 told him/her, he/she had been medicated for pain already. 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 . 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. SRNA #3 stated she made RN #1 aware of the resident's complaints of pain and the RN looked at the catheter and the drainage bag and said the resident was fine, maybe a UTI. 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 order [REDACTED]. However, review of the July 2015 Medication Administration Record (MAR) and Nursing Notes for 07/04/15 revealed there was no documented evidence the resident received Tylenol for pain on 07/04/15, as he/she should have, as per the care plan. Review of the Comprehensive Care Plan for the indwelling catheter, dated 05/07/15, revealed interventions for staff to record output; monitor for signs and symptoms of infection and report to the physician; monitor output for odor, color, consistency and amount. Review of the July 2015 Treatment Administration Record (TAR) for Resident #3 revealed staff was to monitor the resident's urinary output every shift for retention. Further review revealed no documentation noted for 07/01/15, but the remainder of the boxes had a line drawn through with a note stating, See ADL Book. Review of the Intake and Output document that was kept in the ADL Book, dated July 2015, revealed documentation that Resident #3 had 400 milliliter (ml) output on 07/03-04/15, on the 11:00 PM-7:00 AM shift; I/C (indwelling catheter) was documented with no amount on 07/04/15, 7:00 AM-3:00 PM; and 400 ml output on 07/04/15, 3:00 PM-11:00 PM shift. Interview (Post Survey), on 08/14/15 at 2:40 PM, with SRNA #3, who had documented I/C for output on 7:00 AM-3:00 PM shift on 07/04/15, revealed she looked for signs of irritation, discoloration in the urine and if there was urine in the drainage bag. She stated the catheters bags were emptied and the amount recorded at the end of the shift. SRNA #3 stated she emptied Resident #3's catheter bag around 2:00 PM on 07/04/15, but she did not recall how much urine was in the bag or what the urine looked like. She said she recorded IC on the flow sheet because they used to write the amount of urine output on a piece of paper and give it to the nurse so it could be recorded on the TAR. She stated she was not aware at the time she was supposed to document the amount of urine emptied from the bag. Interview with LPN #1, on 08/05/15 at 12:48 PM, revealed she was unable to talk at that time and 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 and the surveyor left a message 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 licensed staff should assess catheters each shift and document the findings on the TAR. She stated pain assessments should be completed on a resident receiving an as needed dose of pain medication one (1) hour after the administration of the medication and documented on the MAR. She also stated residents were assessed for pain every shift. However, review of the MAR revealed no documented evidence the resident received pain medication on 07/04/15. 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. RN #3 stated 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 the resident clarified 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. The bulb was 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]. 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 when emptying drainage bags and should alert the nurse of any concerns with the urinary output. Interview (Post Survey) with the Director of Nursing (DON), on 08/14/15 at 8:15 AM, revealed the SRNAs were responsible to enter output amounts on the flow sheet. She stated they should also notify the nurse in charge on the hall of any changes noted in color, consistency and change in output amounts. She stated licensed staff chart by exception and were required to document when there had been a change in condition for the resident. She stated she would have expected LPN #1 to have charted the care she provided for Resident #3 on 07/04/15, and licensed staff should assess catheters when providing care, and as needed per the plan of care. 2. Record review revealed the facility admitted Resident #1 on 11/24/14 with [DIAGNOSES REDACTED]. Review of the Quarterly MDS Assessment, dated 06/26/15, revealed the facility assessed Resident #1's cognition as intact with a BIMS' score of fifteen (15) which indicated the resident was interviewable. Resident #1 required total assist with transfers, utilized a mechanical lift and required assistance with all Activities of Daily Living (ADLs). Review of Resident #1's Comprehensive Care Plan for falls revealed an intervention that was initiated on 04/15/15, to place the resident's call light within reach at all times. Review of a Progress Note, dated 07/21/15 at 8:15 PM (Change in Condition) revealed the resident had called, via telephone for someone to get a resident (Resident #2) out of his/her room and an aide had been sent to get the resident out of the room. Interview with Resident #1, 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 stated 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, so he/she (Resident #1) finally got on the telephone and told the person that answered that Resident #2 had been in his/her room and somebody needed to come get him/her. Interview (phone) conducted on 08/03/15 at 7:25 PM with RN #4 revealed she had answered the telephone on the evening of 07/21/15 and it was Resident #1. She stated Resident #1 was saying Resident #2 had been in his/her room for twenty (20) minutes so she called the other nurse and then paged for someone to go to Resident #1's room immediately. Interview with State Registered Nurse Aide (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. 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 stated she pushed Resident #2 into the hall in his/her wheelchair. 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. Interview with the Administrator, on 08/03/15 at 7:10 AM, revealed staff was expected to answer call lights timely. **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. 4. Resident #3's urinary catheter was discontinued by the physician on 08/10/15 and removed by the licensed nurse on that date. 5. As of 08/27/15, there were no residents in the center with a [MEDICAL CONDITION]; therefore, no potential exists for

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F 0282 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 9) 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 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 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 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 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. 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 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 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 suspects 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 UTI 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 09/17/15, all SRNA's will be provided with re-education on recognizing symptoms of any pain but specifically related to tracheostomies 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% pass rate. SRNAs not available during this timeframe 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. 13. The DON, NPE, or Licensed Nurse will observe licensed nurse providing all aspects of [MEDICAL CONDITION] care including observing for sign/symptoms of pain or discomfort during the care or if resident with a [MEDICAL CONDITION] enters into the facility. This will include speaking valve treatment and orders, abuse related to removing it when not specifically ordered to do so and following the plan of care. 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. 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. 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. The State Survey Agency validated the corrective actions taken by the facility as follows:

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	185312	A. BUILDING _____ B. WING _____	09/18/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BARKLEY CENTER	4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0282 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(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 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. 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 at 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 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 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 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 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. 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 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 th
F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being for one (1) of fourteen (14) sampled residents (Resident #3). On 07/04/15, Resident #3 was hollering and complaining of pain related to a catheter. Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1 failed to assess Resident #1's pain and administer pain medication. RN #1 and LPN #1 failed to determine what was causing the resident's pain to determine if further action was needed. At approximately 9:00 PM, RN #3 assessed the resident and identified the resident was in pain, bladder was distended, had no urine in the catheter bag and was requesting to go to the hospital. RN #3 removed water from the catheter bulb, the catheter popped out and the resident had a brown, bloody drainage. RN #3 sent the resident to the emergency room and admitted to the hospital. The resident was diagnosed as having a urinary tract infection. The facility's failure to to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being 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, Pain Management, last revised 01/02/15, revealed residents should be evaluated as part of the nursing assessment process for the presence of pain upon admission/re-admission, quarterly, with change in condition or change in pain status. The purpose is to maintain the highest possible level of comfort for residents by providing a system to identify, assess, treat and evaluate pain. In addition, the purpose is to design a plan of care to achieve an optimal balance between pain relief and preservation of function, in accordance with the resident's directed goals. At a minimum of daily, residents should be evaluated for the presence of pain by making an inquiry of the resident

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 11) 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 clinical needs. 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 and monitor for effectiveness and monitor for side effects, and report to the physician, as indicated. Staff should also monitor for non-verbal signs/symptoms of pain and medicate as ordered. 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 LPN #1 would not give him/her anything for pain stating he/she had already been medicated. 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 assessed for pain from 7:00 AM through 7:00 PM. In addition, review of the Pain Presence Monitor form revealed there was no pain assessment documented on the tool for 07/04/15 per the facility policy, as the space was blank. Review of the July 2015 Physician order [REDACTED].#3 was administered Tylenol for pain on 07/04/15. Review of a Nursing Note by RN #3, dated 07/04/15 at 9:54 PM, revealed Resident #3 complained of pain with the presence of an indwelling urinary catheter to the bedside drainage and no urine in the drainage bag. RN #3 documented the resident's skin was noted to have been cool and clammy and his/her face was red. The resident vital signs were documented as a temperature of 96.0 degrees Fahrenheit orally (normal: 97.5) and was 98.6 degrees Fahrenheit under the arm. The resident's blood sugar was documented to be 144 (normal: 80- 120 mg/dL), pulse was 78 (normal: 85), respirations were 20 (normal: 19) and blood pressure was 128/84 (normal range: 135/85). Further review of the Nursing Note revealed when RN #3 pulled the covers back it was noted that there was urine on the sheets. RN #3 documented the resident continued to yell stating it hurts down there where I pee. The nurse documented she took a syringe to check for proper placement of the catheter and the resident yelled louder with pain and stated, take out. She documented she deflated the bulb, the resident yelled and the catheter came out of the urethra. RN #3 documented the resident continued to yell, voided thick, brownish urine, once again expressed the desire to go to the hospital and then voided bright red blood. RN #3 documented she left the room to attempt to contact the physician and the family without success. 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 fine, maybe a UTI. 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 and was irritated and yelling out. SRNA #1 stated RN #1 and LPN #1, reported the resident had been yelling all day. The SRNA stated the resident was screaming as if 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 the SRNA and the LPN told her the resident had already been medicated. Interview with LPN #1, on 08/05/15 at 12:48 PM, revealed she was unable to talk at that time and stated she would return the call. An attempt was made to reach LPN #1, on 08/06/15 at 12:08 PM, but there was no answer and the Surveyor left a message 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. Interview with RN #3, on 08/04/15 at 2:35 PM, revealed she had worked on 07/04/15 on the 7:00 PM-7:00 AM shift. She stated RN #1 reported to her in report that Resident #3 had complained all day long of having pain on urination and was told by the nurse that he had a catheter and shouldn't be hurting. RN #3 said RN #1 told her they had taken Resident #3's speaking valve off because he/she was yelling too much and the resident's roommate was removed from the room as well. RN #3 stated when she entered Resident #3's room, she noted the voice valve was on the table on the resident's left side and the resident would normally refuse to have the valve removed. RN #3 revealed Resident #3 kept telling her that he/she was in severe pain and kept grabbing the catheter saying that he/she couldn't urinate. RN #3 stated the resident's catheter drainage bag was empty so she secured a syringe to flush the catheter. She stated she let out a little of the water from the bulb and the resident screamed in pain and the catheter shot out. She revealed there was a brown, thick, substance coming out of the resident's urethra. The nurse stated she could tell the resident's bladder was distended and then the resident voided straight blood. She stated at that time the resident was begging to be sent to the hospital so the nurse attempted to reach the on call physician, but she 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 admitted for a Urinary Tract Infection [MEDICAL CONDITION]. 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 RN #3 called him into the room and Resident #3 was complaining of hurting and was hollering loudly. SRNA #2 stated when RN #3 took the catheter out, there was blood, urine and gooey pus and a lot of blood and the resident said that he/she wanted to go to the hospital. SRNA #2 said the resident's skin was very clammy and cold to touch. Interview with the former ADON, on 08/05/15 at 9:20 AM, revealed RN #3 phoned saying she wanted to send Resident #3 to the emergency room because the resident was in pain, and had no urinary output and the resident was requesting to go to the hospital. The ADON stated she told RN #3 to send the resident to the hospital, He revealed that he would expect the staff to assess the resident for pain, administer medications as ordered and if not helpful to contact the physician. 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 the resident could be increased pain from a distended bladder. **The facility implemented the following actions to remove the Immediate Jeopardy: 1. Resident #3 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 #3 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. 4. Resident #3's urinary catheter was discontinued by the physician on 08/10/15 and removed by the licensed nurse on that date. 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

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 12) 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 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 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 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. 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 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 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 suspects 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 UTI 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 09/17/15, all SRNA's will be provided with re-education on recognizing symptoms of any pain but specifically related to tracheostomies 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% pass rate. SRNAs not available during this timeframe 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. 13. The DON, NPE, or Licensed Nurse will observe licensed nurse providing all aspects of [MEDICAL CONDITION] care including observing for sign/symptoms of pain or discomfort during the care or if resident with a [MEDICAL CONDITION] enters into the facility. This will include speaking valve treatment and orders, abuse related to removing it when not specifically ordered to do so and following the plan of care. 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. 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. 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. 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].

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	185312	A. BUILDING _____ B. WING _____	09/18/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BARKLEY CENTER	4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 13) 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. 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 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 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 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 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. 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 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. 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 #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 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 #18 at 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 a
F 0315 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **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 appropriate treatment and services to identify complications of an indwelling urinary catheter related to a Urinary Tract Infection [MEDICAL CONDITION] 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 catheter most of the day. Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1 failed to assess the resident's catheter and catheter pain. They failed to assess the resident's urine output, the amount, color, consistency and odor of urine. At 9:00 PM, RN #3 assessed the resident and identified the resident had no urine output, his/her bladder was distended and was complaining of pain due to

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F 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 14) the catheter. RN #3 removed water from the catheter bulb, the catheter popped out and the resident had a brown, bloody drainage. RN #3 sent the resident to the emergency room and the resident was identified as having a UTI. The facility's failure to provide appropriate treatment and services to identify complications of an indwelling urinary catheter 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, Catheter: Indwelling Urinary - Care of, last revised 01/02/14, revealed that any abnormal findings should be reported to the nurse or physician/mid-level provider. Documentation should include any abnormal findings and physician/mid-level provider notification, if indicated. 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 clinical needs. 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 resident had an indwelling urinary catheter. Review of the Comprehensive Care Plan for the indwelling catheter, dated 05/07/15, revealed interventions for staff to record output; monitor for signs and symptoms of infection and report to physician; and monitor output for odor, color, consistency and amount. 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 related to his/her catheter. The resident stated he/she told LPN #1 and the LPN stated he/she had been medicated already. The resident said when the night nurse (RN #3) came in that night, she called the ambulance and the resident was transported to the emergency room . Review of Nurses Notes, dated 07/04/15, revealed there was no documented evidence RN #1 and/or LPN #1 assessed Resident #3's indwelling urinary catheter related to the catheter pain. Review of the July 2015 Treatment Administration Record (TAR) for Resident #3 revealed staff was to monitor the resident's urinary output every shift for retention. There was documentation noted for 07/01/15, but the remainder of the empty boxes had a line drawn through with a note to, See ADL Book. There was no documented evidence of a catheter assessment every shift. Review of the Intake and Output document, dated July 2015, revealed documentation that Resident #3 had 400 milliliter (ml) output on 07/03-04/15, on the 11:00 PM-7:00 AM shift; I/C (indwelling catheter) documented with no amount indicated on 07/04/15, 7:00 AM-3:00 PM; and, 400 ml output on 07/04/15, 3:00 PM-11:00 PM shift. Review of a Nursing Note, dated 07/04/15 at 9:54 PM and 10:00 PM, revealed Resident #3 complained of pain with urination, with the presence of a indwelling urinary catheter to bedside drainage. RN #3 observed that 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 the resident clarified that it hurt, Where I pee. The nurse took a syringe to check for proper placement of the catheter and the resident yelled louder with pain and stated, take out. The bulb was 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 Admission History and Physical , dated 07/05/15, revealed Resident #3 presented to the emergency room with a chief complaint of hematuria (blood in urine). Laboratory studies revealed a urinalysis with White Blood Cells (WBC's) too numerous to count (TNTC) (normal: Negative), Red Blood Cells TNTC (normal: Negative), four plus (4+) bacteria (normal: Negative), turbid, positive [MEDICATION NAME] (normal: Negative) and large leukocyte esterase (normal: Negative). The Complete Blood Count revealed an elevated reading of 11.39 (normal: 3.5 to 10.5 billion cells per liter). The resident was admitted from the emergency room with a [DIAGNOSES REDACTED]. Review of the Discharge Summary, dated 07/08/15, revealed Resident #3 was discharged to return to the facility on [DATE]. The resident would continue to receive intramuscular doses of [MEDICATION NAME] one (1) Gram every twenty-four (24) hours with the final dose to be administered at 9:00 PM on 07/14/15. 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 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. The SRNA stated she checked everything, the tubing was clear and the resident requested to stay in bed. Further interview (Post Survey) with CNA #3, on 08/14/15 at 2:40 PM, revealed she looks for signs of irritation, discoloration in the urine and if there was urine in the drainage bag. She revealed catheters were emptied and the amount recorded at the end of the shift. She stated she emptied Resident #3's catheter bag around 2:00 PM on 07/04/15, but she did not recall how much urine was in the bag. She said she recorded IC on the flow sheet because they used to write the amount of urine output on a piece of paper and give it to the nurse so it could be recorded on the TAR. She stated she was not aware at the time she was supposed to document the amount of urine emptied from the bag. 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 and was irritated and yelling out. SRNA #1 stated RN #1 and LPN #1 reported the resident had been yelling all day. The SRNA stated the resident was screaming as if 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 she made LPN #1 aware, but the LPN told her the resident had already been medicated and that the resident was just trying to go out to the hospital. The SRNA stated the resident was sweating while being transferred by lift, to the bed. She stated LPN #1 kept telling the resident, You are not going to the hospital. The SRNA revealed when she entered the resident's room around 9:00 PM, RN #3 pulled the resident's covers back and 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. Attempts at interviewing LPN #1, on 08/05/15 at 12:48 PM and on 08/06/15 at 12:08 PM, were unsuccessful. 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/or request to go to the hospital. She stated the SRNA never reported the resident was in pain and/or wanted to go to the hospital due to the resident's catheter. RN #1 revealed licensed staff should assess catheters each shift and as needed and document it on the TAR; however, further review of the July 2015 TAR revealed there was no documentation on the TAR that indicated Licensed staff had assessed Resident #3's catheter on 07/04/15. 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 RN #3 called him into the room around 9:00 PM and Resident #3 was complaining of hurting and was hollering loudly. SRNA #2 stated when RN #3 took the catheter out, there was blood, urine and gooey pus and a lot of blood and the resident said that he/she wanted to go to the hospital. SRNA #2 said the resident's skin was very clammy and cold to touch. Interview with RN #3, on 08/04/15 at 2:35 PM, revealed she had worked on 07/04/15 on the 7:00 PM-7:00 AM shift. She stated RN #1 reported to her that Resident #3 had complained all day long of having pain on urination and was told by the nurse that he had a catheter and shouldn't be hurting. RN #3 revealed she entered Resident #3's room and Resident #3 kept telling her that he/she was in severe pain and kept grabbing the catheter saying that he/she couldn't pee. RN #3 stated the resident's catheter drainage bag was empty and his/her bladder was distended so she secured a syringe to flush the catheter. She stated she let out a little of the water from the bulb and the resident screamed in pain and the catheter shot out. She revealed there was a brown, thick, substance coming out of the resident's urethra and then the resident voided straight blood. She stated at that time the resident was begging to be sent to the hospital so the nurse attempted

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F 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(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 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 wanted to send Resident #3 to the emergency room . She stated RN #3 stated the resident had no output, the balloon was deflated and the resident had relief; however, the resident continued to ask RN #3 to go to the hospital and she was unable to contact the physician. The ADON said he told RN #3 to send the resident to the emergency room . The ADON reported he was not sure why LPN #1 didn't do a more thorough assessment of Resident #3, but thanked RN #3 for assessing the resident and putting his/her safety first. The ADON revealed he would expect the staff to assess the resident for pain/catheter. Interview with the Director of Nursing (DON), on 08/06/15 at 2:39 PM, revealed she would expect staff to assess the residents for pain and to attempt to find the root cause for the pain. The staff would also need to notify the physician of any concerns identified. 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 was 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 the resident could be increased pain from a distended bladder. **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. 4. Resident #3's urinary catheter was discontinued by the physician on 08/10/15 and removed by the licensed nurse on that date. 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 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 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 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 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. 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 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 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 suspects 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 UTI 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 09/17/15, all SRNA's will be provided with re-education on recognizing symptoms of any pain but specifically related to tracheostomies 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% pass rate. SRNAs not available during this timeframe 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. 13. The DON, NPE, or Licensed Nurse will observe licensed nurse providing all aspects of [MEDICAL CONDITION] care including observing for sign/symptoms of pain or discomfort during the care or if resident with a [MEDICAL CONDITION] enters into the facility. This will include speaking valve treatment and orders, abuse related to removing it when not specifically ordered to do so and following the plan of care. This will be completed across all shifts times fourteen (14) days to include

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	185312	A. BUILDING _____ B. WING _____	09/18/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BARKLEY CENTER	4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001

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F 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 16) 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. 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. 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. 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 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 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 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 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. 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 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

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F 0315 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 17) 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. 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 #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 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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** 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 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 security. 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 the 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 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 Resident #2 out. Resident #1 stated he/she sprayed air freshener toward Resident #2 when he/she was in the room in an attempt to scare him/her away but it did not work. Resident #1 described Resident #2 as being like a small child and didn't know any better but he/she did not hit Resident #2. 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 redirect the resident, who becomes combative at times. Interview with RN #3, on 08/03/15 at 4:20 AM, revealed on 07/21/15, she was working on the back hall and Resident #1 had called on the main telephone line to the nurses' station and told RN #4 (no longer employed) that somebody needed to come get Resident #2 out of his/her room. RN #3 stated she observed Resident #2 a short while later with an area that was not raised and had minor bleeding over the eyebrow area. RN #3 stated Resident #2 normally propelled himself/herself in a wheel chair, was very confused; active, and goes about the facility and required frequent redirection. Interview with SRNA #5, on 08/03/15 at 4:45 AM revealed she came in on the 11:00 PM to 7:00 AM shift on 07/21/15. SRNA #5 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

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F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 18) PM. She stated Resident #2 would attempt to go into other residents' rooms and would call out for his/her mother 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 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 other residents' rooms hollering Momma. She stated the resident was totally lost but was easily redirected. Further review of the Comprehensive Care Plan revealed even though staff was aware Resident #2 wandered into other residents' rooms repeatedly and into Resident #1's room on 07/21/15, there was no documented evidence the care plan was ever revised to address this behavior to ensure the appropriate amount of supervision was provided to ensure the resident's safety. Interview with the Social Service Director (SSD), on 08/03/15 at 6:20 AM, revealed she was notified on 07/21/15 that there would be an investigation and report 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. 2. Record review revealed the facility admitted Resident #8 on 11/04/14 with [DIAGNOSES REDACTED]. Review of the quarterly 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 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 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. Observation on 09/17/15 at 3:00 PM, revealed a SRNA was in the enclosed courtyard area sounding a clip alarm. Attempts to hear the alarm sounding from inside of the building by the State Agency Surveyor were unsuccessful. The clip alarm was only audible after opening the door into the courtyard and stepping into the courtyard. 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 was bringing the resident into the building from the courtyard area. SRNA #11 stated the daughter was yelling and asking, 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 facility has policies related to the 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 (him/her) outside? SRNA #12 stated two (2) other residents reported they saw the resident go outside on his/her own. Interview with RN #1, on 09/10/15 at 10:22 AM, revealed Resident #8's daughter was noted to be bringing the resident back 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 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 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 incident. Interview with SRNA #13, on 09/14/15 at 5:52 PM, revealed some residents must have someone with them when they go outside in the courtyard. SRNA #13 stated residents at risk for falls have to have someone to go with them into the courtyard area. Interview with SRNA #20, on 09/18/15 at 9:33 AM, revealed she would not be able to hear an alarm from inside the building if 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 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. 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

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

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(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.