| 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 _____ | **02/13/2016** |

| 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 0155<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Let the resident refuse treatment or refuse to take part in an experiment and formulate advance directives.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, record review, review of facility policies, and review of the Emergency Medical System (EMS) records and hospital records, it was determined the facility failed to honor the explicit Advance Directive wishes of one (1) of twelve (12) sampled residents (Resident #1).<br>Resident #1 had an Advanced Directive which specified he/she desired to be provided Cardio [MEDICAL CONDITION] Resuscitation (CPR) if cardiac or respiratory arrest occurred. However, on [DATE], Registered Nurse (RN) #1 and RN #2 failed to provide CPR for Resident #1 when he/she was found unresponsive and a Code Blue was called.<br>911 was called and the Emergency Medical Service (EMS) arrived to Resident #1's room at 6:16 PM finding the resident alone, unresponsive and no staff present. Paramedic #1 located RN #1 at the nursing station and requested the resident's code status and RN #1 revealed Resident #1 was a full code. CPR was initiated and the resident was transferred to the hospital. Resident #1 was pronounced dead at the hospital.<br>The facility's failure to ensure residents' Advance Directives were honored has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance (AoC) was received on [DATE], and the State Survey Agency validated the Immediate Jeopardy was removed on [DATE], 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.<br>The findings include:<br>Review of the facility's policy titled, Cardiac and/or Respiratory Arrest, last revised [DATE], revealed the facility supports the right of every resident to accept or decline cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest. The Center will perform CPR on all residents, except in certain limited circumstances, unless there is a written physician's orders [REDACTED]. The policy also stated if a resident does not have a DNR order, CPR/Automated External Defibrillator (AED) certified staff will initiate CPR/AED and emergency medical services will be activated. The purpose of the policy was to ensure residents' wishes were followed in the event of [MEDICAL CONDITION].<br>Review of the facility's policy titled, Cardiac and/or Respiratory Arrest, last revised [DATE], revealed an un-witnessed arrest for residents without a DNR (Do Not Resuscitate), if there are no conclusive signs of death, to initiate actions for witnessed arrest which include: CPR/AED certified staff will initiate CPR/AED application. Call 911 and notify the primary physician. Designate an individual to record events on the CPR/AED Flow sheet. Continue CPR until one of the following occurs: Restoration of effective, spontaneous circulation; Care is transferred to a team providing advanced life support (EMS); The rescuer is unable to continue because of exhaustion, the presence of dangerous environmental hazards, or because continuation of the resuscitation efforts places others in jeopardy; or if State regulation allows licensed nurse to pronounce/certify death, for reliable and valid criteria indicating irreversible death are met, criteria of obvious death are identified, or criteria for termination of resuscitation are met; When EMS personnel arrive, they assume responsibility. Treatment will be directed by EMS personnel; Notify the family/health care decision maker of the patient's status.<br>Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set (MDS) Assessment, dated [DATE], revealed the facility assessed Resident #1 with severe cognitive impairment and required total assistance with all activities of daily living.<br>Further review of the record revealed there was no Advanced Directive in the record. However, the resident's record had a green sticker that indicated the resident was a full code and review of the Comprehensive Care Plan, dated [DATE], revealed the resident desired to be a full code (perform CPR and and activate 911) in the event respiratory or [MEDICAL CONDITION] occurred. The intervention was Activate resident's Advanced Directive as indicated.<br>Review of Nurses' Notes, dated [DATE] at 6:01 PM, and interviews with Registered Nurse (RN) #1 on [DATE] at 1:50 PM, RN #2 on [DATE] at 10:12 AM, Certified Nurse Aide (CNA) #1 on [DATE] at 3:00 PM, and CNA #2 on [DATE] at 10:50 AM, revealed on [DATE] at approximately 6:01 PM, CNA #1 and #2 found Resident #1 unresponsive. The CNAs called RN #1 who initiated a Code Blue by announcing Code Blue on the intercom and calling 911 (Emergency Medical System) at 6:06 PM, for an ambulance. RN #1 returned to Resident #1's room where RN #2 had arrived to respond to the code. RN #1 and RN #2 discussed Resident #1's full code status, but felt the resident had expired and they (Registered Nurses) did not initiate rescue ventilations or chest compressions. RN #2 then returned to her workstation located by the ,[DATE] Hall and RN #1 went to the 100 Hall nursing station to make notifications.<br>Interview with Paramedic #1, on [DATE] at 11:55 AM, and review of the EMS run report, dated [DATE], revealed EMS arrived to the resident's room at 6:16 PM finding the resident alone, unresponsive, not breathing, and there was no staff present. Paramedic #1 located RN #1 at the nursing station and requested the resident's code status. RN #1 informed the EMS the resident was a full code. Paramedic #1 asked why CPR was not being performed on the resident and RN #1 replied the code was stopped due to the resident not having a pulse. RN #1 walked away from Paramedic #1 without response when he asked who authorized the code to be stopped. Paramedic #1 returned to Resident #1 where he and Emergency Medical Technicians (EMT) #1 and #2 initiated CPR. The resident's airway was patent and clear, breathing and pulses were absent and there was a long capillary refill time. The resident's skin was warm, pale and pupils were non reactive. Extremities were flaccid. Resident #1 was transported to the emergency room via ambulance. EMS staff initiated Intravenous (IV) treatment enroute to the emergency room ; and [MEDICATION NAME] (for cardiac stimulation) was administered three (3) times. Sodium [MEDICATION NAME] (alkalinizing agent used for [MEDICAL CONDITION]) was administered one (1) time prior to arrival to the hospital.<br>Review of hospital records, dated [DATE], revealed Resident #1 was admitted to the Emergency Department (ER) on [DATE] at 6:48 PM. The ER record revealed CPR continued with an additional [MEDICATION NAME] injection given at 6:48 PM, and noted the resident's pacemaker was firing at a rate of 110 beats per minute, however, the resident was pronounced dead at 6:51 PM.<br>Further interview with RN #1, on [DATE] at 1:50 PM, revealed when she entered Resident #1's room, Resident #1's tongue was to the side, pupils were big and in her heart she knew Resident #1 was dead. She stated after calling the code and 911, she returned to the room and RN #2 stated, Do you really want to do this to (him/her)? (meaning CPR). RN #1 stated she picked up the resident's hand and it was dark and discolored with no capillary refill so she and RN #2 looked at their watches and agreed the time of death was 6:08 PM. RN #1 stated when EMS arrived the Paramedic asked why CPR was not being done on the resident and stated she did not think she answered because there was no pulse, but thinks that is what the Paramedic said she said. RN #1 stated the Paramedic asked a second time why the CPR was stopped and she didn't have an answer for him. RN |

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.

| 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 _____ | 02/13/2016 |

| 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 0155<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 1)<br>#1 stated, I regret walking out of the room, I know in my mind if I brought (him/her) back, (he/she) would have nothing in (his/her) mind.<br>Interview with RN #2, on [DATE] at 10:12 AM, revealed the resident was blue around the mouth and felt cold when she touched the resident's chest when she checked for breathing. She stated when RN #1 returned from calling 911 and checking to see if the resident was a full code, she and RN #1 discussed CPR. RN #2 stated she asked RN #1, Are we doing this because (he/she) is gone. RN #2 stated there was nothing they could do. She stated RN #1 said No, let (him/her) be. She (RN #2) stated, You have to make a decision about the quality of (his/her) life. RN #2 stated Resident #1 had no respirations, no pulse, was cyanotic around the mouth, and was stiff with rigor when they rolled him/her to place him/her on the back board, and the resident rolled all together like a log.<br>Interview with CNA #1, on [DATE] at 3:00 PM, revealed RN #1 and RN #2 discussed the resident's code status and RN #2 asked RN #1 Do you really want to crack the ribs? It's obvious (he/she) is dead. She stated RN #1 and RN #2 did not start rescue ventilations or chest compressions.<br>Interview with CNA #2, on [DATE] at 10:50 AM, revealed she opened Resident #1's eyes and they were not moving and the pupils were big. She stated Resident #1's skin was warm and she told RN #1 to call a Code Blue. CNA #2 stated RN #2 asked RN #1 who was going to do compressions and they discussed CPR and one of the RNs said Let's agree that we did the CPR and be done with it. CNA #2 stated she had touched Resident #1's chest and it felt warm and the resident's tongue was not sticking out and the resident was slobbering.<br>Further review with Paramedic #1, on [DATE] at 11:55 AM, revealed Resident #1 was not cold. The resident was warm and pale and he did not see any cyanosis. He stated there was no rigor in the resident and no lividity (bluish discoloration).<br>Interview with the Administrator, conducted on [DATE] at 1:25 PM, revealed RN #1 and RN #2 did not initiate chest compressions or rescue ventilations because they determined there was an indication of irreversible death and they pronounced Resident #1 dead. She stated RN #1 worked the 100 Hall where Resident #1 resided and was not current in CPR certification. RN #2 worked the ,[DATE] Hall on the opposite side of the building, and was current in CPR certification. The Administrator felt the nurses did not provide CPR because they felt there were signs of irreversible death and RN #1 had documented pupils dilated, fixed, tongue displaced and skin cool to touch and hands mottled (discolored).<br>The facility implemented the following actions to remove the Immediate Jeopardy:<br>1. All residents had the potential to be affected. All resident records were audited (76 of 76) by a licensed nurse and/or the Director of Social Services on [DATE] to determine that the resident had the right to formulate an advanced directive and the code status was clearly documented and consistently located in the resident's medical record for Cardiopulmonary Resuscitation (CPR) or Do Not Initiate Cardiopulmonary Resuscitation (CPR) as per the resident, responsible person (s) or Medical POA wishes. No concerns were identified.<br>2. All resident care plans (76 of 76) were audited by a licensed nurse or Social Service Director (SSD) on [DATE] and [DATE] to determine that resident code status was on the resident's plan of care. Care Plans were updated by a licensed nurse upon discovery if corrective action was required.<br>3. The facility's policy revealed that CPR certified staff would be on duty at all times. Beginning on [DATE] and ending on [DATE], all facility staff personnel files (82 of 82) were reviewed by the Payroll Benefits Coordinator to identify and track who held a current CPR certification as indicated by a current CPR card. Contract staff including housekeeping, laundry and therapy were not considered to meet this requirement. Corrective action included contacting the employee to determined if he/she had a current CPR certification with proof to be provided and placed in the certification book.<br>The Payroll Benefits Coordinator, Center Nurse Executive (CNE), Center Executive Director (CED), Assistant Director of Nursing (ADON), Nurse Practice Educator (NPE) or Receptionist will obtain a copy of the employee's CPR card to verify active dates and place in the certification book and/or personnel file.<br>Beginning on [DATE] and completed on [DATE], the facility's schedule was reviewed for the past thirty (30) days by the Payroll Benefits Coordinator to validate that at least one (1) CPR certified staff member was on duty at all times. All CPR certified staff was listed and placed in the staffing book at each nurse's station. The master nursing schedule is highlighted by the Payroll Benefits Coordinator to ensure CPR certified staff will be on duty at all times per facility policy. The Charge Nurse will review daily to validate CPR certified staff are scheduled with corrective action upon discovery. Facility staff obtained CPR certification independently of the facility through approved programs. The facility requires CPR certified staff to obtain CPR certification for healthcare providers through CPR training that includes hands-on practice and in-person skills assessments.<br>4. Two (2) of the two (2) emergency crash carts were reviewed on [DATE] by a licensed nurse on the front nurses' station; and, on [DATE] by the Clinical Reimbursement Coordinator on the back nurses's station to validate all items on the emergency cart daily check list form were available and in working order. No concerns were identified.<br>5. A Code Blue drill was conducted on [DATE] by the ADON for the 7:00 AM to 3:00 PM shift; and, on [DATE] for the 11:00 PM to 7:00 AM, and 3:00 PM to 11:00 PM shifts.<br>The facility's Executive Nurse, ADON, Nurse Practice Educator (NPE) or Regional RN support staff will continue drills weekly for four (4) weeks to include weekends using different scenarios to audit individual critical thinking skills and validate that Cardiac and/or Respiratory arrest procedures are followed. Any issues identified will be immediately addressed. Audits will continue monthly for five (5) months, then as determined by the Quality Improvement Committee.<br>6. On [DATE], all alert and oriented residents (31 of 72) with a BIMS score of eight (8) or greater were interviewed by the Director of Social Services to determine if the resident felt abused and/or neglected. The interviews included questions regarding: concerns related to care provided by any caregiver, concerns with not receiving care and services needed and who to report to if they felt abused or neglected. No concerns specifically regarding abuse or neglect were identified. Any other concerns were addressed through a formal grievance process by the Director of Social Services immediately upon discovery.<br>7. On [DATE], residents with a BIMS score lower than eight (8) or who declined to participate in the interview process (39 of 72) received a body audit performed by the licensed nurse to identify any physical signs of abuse or neglect including a change in mood or behavior. No concerns were identified.<br>On [DATE], residents who were admitted to the facility that day (2 of 72) received a baseline body audit performed by a licensed nurse. The Center Executive Director or the Center Nurse Executive met with each resident and informed him/her of who to contact if they felt abused or neglected during their stay.<br>8. The Center Nurse Executive, ADON, Nurse Practice Educator (NPE) or Licensed Nurse reviewed all current resident Progress Notes from [DATE] for timeliness and accuracy. No concerns were identified.<br>9. Education was provided for all staff on two (2) separate occasions, defined in the following timeline:<br>On [DATE], the Manager of Clinical Operations provided re-education to the Center Executive Director, Center Nurse Executive and ADON; then the Center Executive Director provided re-education to the Health Information Director, Admissions, Maintenance Director, Director of Recreation, Payroll/Benefits Coordinator, Director of Rehab and Housekeeping/Laundry Supervisor on [DATE]. A post-test with a required score of 100% was included which was graded by the Center Executive Director.<br>The Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive, or Center Executive Director provided re-education to all non-licensed staff on [DATE] through [DATE]. A post-test with a required score of 100% was included which was graded by the Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive or Center Executive Director (57 of 59). All staff not available for re-education will be provided re-education prior to initiating work assignment and new staff will be educated during his/her orientation process.<br>Education included the following topics:<br><br>* How to quickly locate a resident's code status.<br>* Procedure for identifying a resident unresponsive.<br>* Policy NSG102 Care plans including development, communication & implementation.<br>* Death pronouncement and Certification by State.<br>10. The Nurse Practice Educator (NPE), Center Nurse Executive, ADON or Registered Nurse provided re-education to the licensed staff (RNs & LPNs) from [DATE] to [DATE]. All licensed staff completed a post-test with a required score of 100% which was graded by the Nurse Practice Educator, Center Nurse Executive, ADON, Center Executive Director or Registered |

| 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 _____ | 02/13/2016 |

| 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 0155<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 2)<br>Nurse (22 of 23). All staff not available for re-education will be provided education prior to initiating work assignment and new staff will be educated during his/her orientation process. Education included the following topics:<br>* Policy NSG107 and procedure for Emergency Medical Response.<br>* Policy NSG 208 and procedure for Cardiac and/or Respiratory Arrest.<br>* Specific instruction will be provided to include evaluation of signs of irreversible death.<br>* Policy NSG 102 Care Plans including development, communication & implementation.<br>* Death pronouncement and certification by State.<br>11. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), ADON or Center Nurse Executive provided re-education to all non-licensed staff to include contract employees (31 of 59). A post-test with a required score of 100% was included which was graded by the Nurse Practice Educator (NPE). All staff not available for re-education will be provided the education prior to initiating work assignment and new staff will be educated during his/her orientation process. The education included:<br>* Policy NSG102 Care Plans including development, communication & implementation and following the care plan for Advanced Directives.<br>* Policy OPS310 Abuse and Neglect Prohibition - State of Kentucky.<br>12. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), ADON or Center Nurse Executive provided re-education to all licensed staff (18 of 23). A post-test with a required score of 100% was included which was graded by the Nurse Practice Educator (NPE). All licensed staff not available for re-education will be provided the re-education prior to initiating work assignments and new staff will be educated during his/her orientation process. The education included:<br>* Policy NSG102 Care Plans including development, communication & implementation and following the care plan for Advanced Directives.<br>* Policy OPS310 Abuse & Neglect Prohibition - State of Kentucky.<br>* Policy NSG4.20 Charting Errors and/or Omissions including late entries.<br>13. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), Center Nurse Executive, ADON, RN MDS Coordinator<br>or RN provided education to all licensed staff (6 of 23). All licensed staff not available for education will be provided education prior to initiating work assignment and new staff will be educated during his/her orientation process. The education included:<br>In the event there is not a Registered Nurse (RN) available to pronounce death, the Licensed Practical Nurse (LPN) must notify an RN or Physician to come to the facility to pronounce and sign the KY Provisional Report of Death form in the Facility Note section before the body can be released to the Funeral Home.<br>14. Beginning [DATE], the Health Information Manager, Center Nurse Executive, ADON, RN, LPN, Certified Nursing Executive, Executive, Admissions Director, Payroll Benefits Coordinator and/or Social Services Director will interview at least five (5) non-licensed staff and/or CNAs daily, across all shifts for fourteen (14) days to include weekends to validate that he/she can state the following:<br>* Where a resident's code status can be quickly located<br>* Response steps for a non-licensed staff.<br>* Articulate the purpose of a resident care plan/care card.<br>* Articulate the definition of neglect and appropriate<br>* Reporting steps.<br>Following the initial fourteen (14) days, five (5) non-licensed staff and/or CNAs will be interviewed three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the Quality Improvement (QI) Committee with corrective action upon discovery.<br>15. Beginning [DATE], the Center Executive Director, Center Nurse Executive, Nurse Practice Educator (NPE), ADON and/or Licensed Nurse will interview at least three (3) licensed staff (RN or LPN), across all shifts for fourteen (14) days to include weekends to validate that he/she can state the following:<br>* Expected medical response to an emergency.<br>* Process steps expected in response to a Cardiac and/or Respiratory Arrest.<br>* Signs of irreversible death.<br>* Where a resident's code status can be quickly located.<br>* Kentucky requirements related to death pronouncement.<br>* Articulate the definition of neglect and appropriate reporting steps.<br>* Definition of a complete medical record.<br>Beginning [DATE], the interview tool will include validation of understanding that in the event an RN is not available to pronounce death, the LPN must notify an RN or Physician to come to the facility to pronounce and sign the KY Provisional Report of Death form in the Facility Note section before the body can be released to the Funeral Home.<br>Following the initial fourteen (14) days, three (3) licensed staff will be interviewed three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the QI Committee with corrective action upon discovery.<br>16. Beginning [DATE], the Center Nurse Executive, ADON, Nurse Practice Educator (NPE), or Licensed Nurse will audit all nursing progress notes associated with unplanned transfers and associated care plans daily for fourteen (14) days to include weekends to validate:<br>* Advanced Directives are honored according to the care plan.<br>* Goods and services provided as necessary to avoid mental anguish and physical harm according to the Advanced Directive in the event that CPR is indicated.<br>Following the initial fourteen (14) days, unplanned transfers will be audited three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the QI Committee with corrective action upon discovery.<br>17. Audit results will be brought to the QI Committee by the Center Nurse Executive, Center Executive Director, or Licensed Nurse until the issue is resolved and ongoing thereafter. The QI Committee consists of at least the Medical Director, Center Nurse Executive, Center Executive Director, Social Service Director, Maintenance Director, Health Information Manager, ADON, Business Office Manager, and the Nurse Practice Educator.<br>The State Survey Agency validated the implementation of the facility's AOC as follows:<br>1. Review of an audit log, dated [DATE], revealed the Social Service Director (SSD) and an LPN reviewed all residents' records related to Advanced Directives to ensure clear documentation related to Advanced Directives.<br>2. All care plans were also audited by SSD and check off sheets were verified to ensure residents' code status were on the care plan.<br>Interviews, on [DATE] with the SSD at 11:15 AM, and LPN #1 at 2:55 PM, revealed all resident records related to Advanced Directives were reviewed on [DATE] to verify documentation and care plans were also audited to ensure code status was addressed.<br>3. Review of the log book that was implemented to verify which licensed staff was current revealed all current CPR certified staff was verified by the Payroll Benefits Coordinator on [DATE]. The log book was tabbed by month to indicate when certifications will expire. Observation on [DATE], revealed a current CPR certification list was located on each of the two (2) nursing stations.<br>Interview conducted with the Center Nurse Executive (CNE), on [DATE] at 9:00 AM revealed CPR status was verified by the Payroll Benefits Coordinator on [DATE] and a log book was implemented to maintain current CPR certification of staff and when certifications will expire. A system to address and ensure coverage of CPR certified staff on duty was implemented.<br>4. Crash carts were reviewed by LPN #1 on [DATE]. The check list was updated and will be validated daily on the 11:00 PM to 7:00 AM shift. Review of the check list on [DATE] revealed daily signatures by licensed staff on the 11:00 PM to 7:00 AM shift.<br>Interview with LPN #1, on [DATE] at 2:55 PM, verified she had inspected the crash carts on [DATE]. She revealed the carts will be inspected daily by the night shift nurse and documented on the check list.<br>5. Review of the Code Blue Drill audit revealed a drill was completed, on [DATE], by the ADON on all shifts and weekly |

| 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 _____ | 02/13/2016 |

| 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 0155<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | (continued... from page 3)<br>drills are being completed through [DATE]. Monthly drills are scheduled to start [DATE] and will be completed by [DATE].<br>Interview with the ADON, on [DATE] at 9:45 AM, revealed a Code Blue drill was conducted by her on [DATE] and drills are being done weekly on varied shifts by the ADON, the Nurse Practice Educator (NPE) and Center Nurse Executive (CNE).<br>6. Documented interviews of interviewable residents were reviewed and determined to have been completed by the Social Service Director. There were thirty-one (31) interviewable residents with two (2) refusing to participate. The interviews were directed to care by care givers, not receiving care, whom to report to if they were feeling abused/neglected. No concerns were identified. Concerns identified not related to abuse neglect were resolved through the grievance process.<br>Interview with the SSD, on [DATE] at 11:15 AM, revealed she conducted interviews with all interviewable residents on [DATE] and no concerns were identified related to abuse or neglect. She did resolve some grievance issues about other things that came from the interviews.<br>7. Review of body audits of non interviewable residents were completed by licensed nurses on [DATE]; and, there were no concerns identified. Two (2) new residents received base line audits and met with the Center Nurse Executive (CNE).<br>Interview, on [DATE] at 9:00 AM, with the Center Nurse Executive (CNE) revealed the skin assessments were divided and completed on [DATE] and two (2) new admissions were included.<br>8. Resident Progress Notes from [DATE] through [DATE], were reviewed for time and accuracy by the Center Nurse Executive (CNE). Review of the list of Progress Notes audited revealed no concerns.<br>Interview with the Center Nurse Executive (CNE), on [DATE] starting at 9:00 AM, revealed she had completed the audit of Progress Notes with no concern identified.<br>9. The Manager of Clinical Operations educated the Center Executive Director (CED), and the Center Nurse Executive (CNE), then the Center Executive Director provided education to the Admissions Director, Director of Recreation, Payroll Benefits Coordinator, Director of Rehabilitation, and the Housekeeping/Laundry Supervisor on [DATE]. Post tests were given. The education included resident code status, the unresponsive resident, care plans and death pronouncement. Review of the tests revealed 100% passed with a 100%; the test was graded by the Executive Director.<br>Interview, conducted on [DATE] at 9:00 AM, with the Center Nurse Executive (CNE), revealed she received education from the Manager of Clinical Operations on [DATE] and passed a post test with 100%.<br>Interviews, on [DATE] at 11:03 AM with the Admissions Director, 10:01 AM with the Housekeeping/Laundry Supervisor, and the Nurse Practice Educator (NPE), revealed they had received the education and it was about locating a resident's code status, identifying an unresponsive resident, care plans and death pronouncement.<br>Review of education that was provided to non-licensed staff by the Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive (CNE) and Executive Director on [DATE] through [DATE]. The post test required 100% and was graded by the Admissions Director. Two (2) staff, the Dietary Manager and Activity staff were the only remaining staff not provided the training and will receive the training prior to initiating any assignment on return to work. That education included how to locate code status, procedure for identifying a resident unresponsive, Policy NSG102 Care Plans and Death Pronouncement and Certification by State. Review of the POS [REDACTED].<br>Interviews on [DATE] with the Admissions Director at 11:03 AM, Restorative Aide #1 at 10:29 AM, CNA #5 at 10:24 AM, Dietary Aide #1 at 10:19 AM, the Housekeeping/Laundry Supervisor at 10:01 AM, and CNA #4 at 9:40 AM, revealed they had received education related to a resident's code status and where to find that information, related to unresponsive resident and what to do, care plans and death pronouncement by the RN.<br>10. Review of documented education and post tests, on [DATE], revealed 22 of 23 RNs and LPNs were educated by the Nurse Practice Educator (NPE), Center Nurse Executive (CNE), and ADON on [DATE] through [DATE]. All had post test with 100% pass rate graded by the Nurse Practice Educator (NPE), CNA, and ADON. One (1) licensed staff remains to be re-educated. The Scheduling Supervisor is to ensure that education is completed when that staff returns. Review of the education revealed it included Policy NSG 107 related to the procedure for Emergency Medical Response, Policy NSG 208 for cardiac and/or respiratory arrest, specific instructions which included evaluation of irreversible death and care plans policy NSG 102 related to care plan development, implementation and communication and death pronouncement.<br>Interviews on [DATE] with RN #2 at 10:36 AM, LPN #3 at 10:13 AM, LPN #2 at 9:48 AM, RN #3 at 9:02 AM, and the Clinical Reimbursement Coordinator (CRC) at 10:50 AM, revealed they had education related to emergency medical response, cardiac and respiratory arrest, irreversible death and care plans. They were required to pass a post test with 100%.<br>11. Review on [DATE] of education and post tests of non-licensed staff and contract employees revealed 31 of 59 had completed the education. All staff not available for re-education will be provided that education prior to initiating work assignment and new staff will be educated during orientation. Review of the education revealed Policy NSG 102 related to care plans for Advanced Directives, Policy OS310 related to abuse/neglect was provided by the Nurse Practice Educator (NPE), ADON, Center Nurse Executive (CNE). Review of the POS [REDACTED] |
| F 0224<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | **Write and use policies that forbid mistreatment, neglect and abuse of residents and theft of residents' property.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, record review, review of the facility's policies, and review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #36, it was determined the facility neglected to provide care and services that were necessary when one (1) of three (3) sampled residents (Resident #1) was found unresponsive. Resident #1 was not provided Cardio/pulmonary resuscitation (CPR) after a Code Blue was called.<br>Certified Nurse Aide (CNA) #1 and CNA #2 found Resident#1 unresponsive on [DATE] at 6:01 PM when they entered the resident's room to pick up the supper tray. The CNAs summoned Registered Nurse (RN) #1 who initiated a Code Blue by announcing it on the intercom and calling 911 (Emergency Medical System) for an ambulance. RN #2 had responded to the Code Blue and was already in Resident #1's room when RN #1 returned to the resident's room. RN #1 and RN #2 discussed that Resident #1 was a full code; however, they failed to initiate rescue ventilations or chest compressions. RN #2 returned to the ,[DATE] Hall nursing station and RN #1 returned to the ,[DATE] Hall nursing station to make notifications.<br>EMS arrived to Resident #1's room at 6:16 PM finding the resident alone, unresponsive and no staff present. Upon requesting Resident #1's code status, RN #1 informed Paramedic #1 that the resident was a full code. When Paramedic #1 asked why the Code had been stopped, RN #1 walked away without giving Paramedic #1 an answer.<br>Paramedic #1 immediately returned to Resident #1 and CPR was initiated. Resident #1 was transported to the emergency room (ER) with CPR in progress and the ER continued CPR until the resident was pronounced dead at 6:51 PM.<br>The facility's failure to ensure residents were free from mistreatment or neglect has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance (AoC) was received on [DATE], and the State Survey Agency validated the Immediate Jeopardy was removed on [DATE], 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.<br>The findings include:<br>Review of the facility's policy titled, Abuse Prohibition, last revised [DATE], revealed the purpose of the policy was to ensure that Center's staff was doing all that was within their control to prevent occurrences of abuse, mistreatment, neglect, involuntary seclusion, injuries of unknown origin and misappropriation of property for all residents. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.<br>Review of the KBN AOS #36 Resuscitation, approved ,[DATE] and revised ,[DATE], revealed a nurse would not start CPR when:<br>* There is a valid order for the patient, not to attempt resuscitation in the event of an apparent cardiac/pulmonary arrest (absence of pulse and respiration, determined by assessment using inspection, palpitation and auscultation); these are often referred to as do not attempt resuscitation; (DNAR) or do not resuscitate (DNR) orders;<br>* Obvious signs of death are present. The most reliable are: dependent livido (general bluish discoloration of the skin as in pooling of blood in dependent body parts); rigor mortis (harding of muscles or rigidity); algo mortis (cooling of the body following death); and injuries that are incompatible with life.<br>Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. Review of the Annual Minimum<br>Data Set (MDS) assessment, dated [DATE], revealed the facility assessed Resident #1's cognition as severely impaired and |

| 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 _____ | 02/13/2016 |

| 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 0224<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 4)<br>the resident was totally dependent on staff for assistance with all activities of daily living. The resident's chart was marked with a green sticker, which indicated the resident was a full code (initiate CPR). Review of the care plan, titled Resident has an established Advanced Directive as being full code and was dated and initiated on [DATE] to address the resident's desire to be a full code in the event respiratory or [MEDICAL CONDITION] occurred.<br>Review of a Late Entry Nursing Note written by RN #1, dated [DATE] at 1800 (6:00 PM), with a strike out date of [DATE] at 4:11 PM, revealed Resident was unresponsive, observed resident not breathing, no lung sounds, no pulse, pupils dilated, fixed, tongue displaced to the left, skin cool to touch, sent NA (Nurse Aide) for help, validated code status, called code blue, called 911, returned to room, two (2) licensed nurses at bedside to assist, lifted hand and observed hands to be mottled, determined time of death, notifications documented as made, and at 18:06 (6:06 PM) EMS arrived, EMS transported to hospital; however, review of this Nursing Note revealed all of the documentation had a line marked through it.<br>Further review of a Nursing Note re-written by RN #1, dated [DATE] at 4:09 PM, and documented as a Late Entry for [DATE] at 18:01 (6:01 PM), revealed the same information as the Nursing Note, dated [DATE] at 1800 (6:00 PM); however, the documentation had no lines marked through it. RN #1 gave no explanation why the [DATE] note was stricken out, and then re-written on [DATE].<br>Interview with CNA #1, on [DATE] at 3:00 PM, revealed on [DATE], he was assisting Resident #1 with the supper meal and the resident was not acting right . He stated he informed RN #1, who was in the dining room, and the RN looked at the resident and told CNA #1 to stop feeding the resident and leave his/her head in the upright position. CNA #1 stated he left to assist another resident and when he and CNA #2 returned to gather the resident's supper tray they found Resident #1 unresponsive. CNA #1 stated he immediately informed RN #1, who was still in the dining room, and she returned to the resident's room. He stated RN #1 instructed him to get RN #2 and he went to the ,[DATE] Hall nursing station to get her. CNA #1 stated when he returned to Resident #1's room, RN #1 and RN #2 were discussing the resident's code status. He stated RN #2 asked RN #1, Do you really want to crack his/her ribs? It's obvious he/she is dead. CNA #1 stated RN #1 and RN #2 did not start rescue ventilations or chest compressions. Further interview revealed the RNs left the room. When the EMS arrived, they questioned the resident's code status, started CPR, and left with Resident #1 in the ambulance.<br>Interview with CNA #2, on [DATE] at 10:50 AM, revealed she and CNA #1 were picking up supper trays on [DATE]. When they entered Resident #1's room, they found the resident unresponsive. CNA #2 stated CNA #1 went to get RN #1. She stated when she opened Resident #1's eyes, they were not moving and the resident's pupils were big. She stated Resident #1's skin was warm when she touched him/her. CNA #2 stated she told RN #1 to call a Code Blue and RN #1 went to the nursing station and announced a Code Blue over the intercom. RN #1 told CNA #1 to go get RN #2. CNA #2 stated she lifted the sheet over the resident to assist placing the CPR backboard under the resident while RN #2 was searching for the bag used for rescue breathing. She stated RN #2 wanted oxygen set at 10/L and CNA #2 set the regulator for 10/L. CNA #2 said RN #2 asked RN #1 (when RN #1 re-entered the room), which one of them was going to do compressions. CNA #2 stated they discussed CPR, and one of the RNs said, Let's agree that we did the CPR and be done with it. CNA #2 stated she had touched Resident #1's chest and it felt warm and the resident's tongue was not sticking out of his/her mouth.<br>Interview with RN #1, on [DATE] at 1:50 PM, revealed she was doing dining room duty on [DATE] and was summoned to Resident #1's room; CNA #1 reported to her that Resident #1 was acting funny. RN #1 stated she determined whatever had alarmed CNA #1 had passed and instructed CNA to stop feeding Resident #1 and to leave the resident's head in an upright position she (RN #1) returned to the dining room. She stated CNA #1 hollered again when all the trays were being picked up. RN #1 stated when she entered the resident's room, Resident #1's tongue was to the side and his/her pupils were big. RN #1 stated that she knew in her heart that Resident #1 was dead. She stated she screamed for CNA #1 to get RN #2 and she went to check the resident's chart for the code status and called 911. When she returned to Resident #1's room, RN #2 was standing by the resident's bed. RN #1 stated RN #2 asked her, Do you really want to do this to him/her? (meaning CPR). She (RN #1) picked up the resident's hand and it was dark and discolored with no capillary refill, so she and RN #2 looked at their watches and agreed on a time of death at 6:08 PM. RN #1 stated she then went to the nursing station to make notifications. She stated EMS arrived about that time and the Paramedic came to her and asked why the code had been stopped. RN #1 said she did not think she told him, Because there was no pulse, but that is how she thinks the Paramedic said she responded. She said the Paramedic asked a second time why the CPR was stopped and she . didn't have an answer for him. RN #1 additionally stated, I regret walking out of the room, I know in my mind if I brought (him/her) back, (he/she) would have nothing in (his/her) mind.<br>Interview with RN #2, on [DATE] at 10:12 AM, revealed she was summoned to Resident #1's room by CNA #1. She stated Resident #1 was blue around the mouth and felt cold when she touched his/her chest when checking for breathing. RN #2 stated she was not sure of Resident #1's code status, but she got the breathing mask out to be ready. When RN #1 came into the room, they (RN #1 and RN #2) discussed CPR and she asked RN #1, Are we doing this, because (he/she) is gone. RN #2 stated there was nothing they could do and RN #1 said No, let (him/her) be. RN #2 stated, We did not start CPR. She stated Resident #1 was not her resident and she wasn't sure how long (Resident #1) had been down. RN #2 stated, You have to make a decision about the quality of (his/her) life. She stated RN #1 had called 911 and that is what you do if a resident is a full code status. RN #2 stated Resident #1 had no respirations and no pulse and was cyanotic around the mouth and was stiff with rigor when they rolled him/her to place the back board (for CPR), and the resident rolled all together like a log.<br>Interview with Unsampled Resident A (BIMS score of 15), on [DATE] at 2:30 PM, revealed he/she was near Resident #1's room on [DATE] and a code blue was called. The resident stated somebody parked the crash cart outside the room but he/she did not see anyone take anything off the cart. He/She stated RN #1 and RN #2 . were not in the room thirty (30) seconds. The resident stated the Paramedic that came to the Code Blue was really upset and asking Who told you to stop CPR to RN #1. Unsampled Resident A stated he/she did not hear a response from RN #1.<br>Review of the Emergency Medical Service (EMS) run report, dated [DATE], revealed documentation in the narrative section which included, On arrival found . lying supine in bed unresponsive and not breathing. No staff was in the room and CPR was not being performed. Charge nurse was located and asked if patient was full code or DNR. Nurse stated patient was full code. Nurse was then asked why CPR was not being performed on the patient. Nurse stated she was unsure but they were doing CPR and decided to stop because they could not get a pulse. She was then asked who advised them to stop CPR and she never answered and walked away. Patient presents unresponsive with GCS-3. Airway patent and clear, breathing is absent, absent pulses with a long capillary refill time. Skin is warm, pale and pupils are non-reactive. No JVD noted. Breath sounds are absent. No abnormalities to abdomen. Extremities are flaccid. No injuries found.<br>Interview with Paramedic #1, on [DATE] at 11:55 AM, and review of the EMS run report, dated [DATE], revealed EMS arrived to the resident's room at 6:16 PM finding the resident alone, unresponsive, not breathing, and there was no staff present. Paramedic #1 located RN #1 at the nursing station and requested the resident's code status. RN #1 informed the EMS the resident was a full code. Paramedic #1 asked why CPR was not being performed on the resident and RN #1 replied the code was stopped due to the resident not having a pulse. RN #1 walked away from Paramedic #1 without response when he asked who authorized the code to be stopped. Paramedic #1 returned to Resident #1 where he and Emergency Medical Technicians (EMT) #1 and #2 initiated CPR. The resident's airway was patent and clear, breathing and pulses were absent and there was a long capillary refill time. The resident's skin was warm, pale and pupils were non reactive. Extremities were flaccid. Resident #1 was transported to the emergency room via ambulance.<br>Interview with the Director of Nursing (DON), on [DATE] at 12:00 PM, revealed she was not present during the event but RN #1 and RN #2 had said it was an irreversible death. The DON described neglect as Knowingly not providing a need someone has.<br>Interview with the Administrator, conducted on [DATE] at 1:25 PM, revealed RN #1 and RN #2 did not initiate chest compressions and rescue ventilations because they determined there was an indication of irreversible death and they pronounced Resident #1 dead. The Administrator stated she spoke with Paramedic #1 after the event, when she was looking into what had happened. She stated RN #1 told Paramedic #1 the resident was a full code, and when Paramedic #1 asked why no CPR was being performed, RN #1 stated because there was no pulse. RN #1 was not current in CPR certification; however, RN #2 was current in CPR certification.<br>The facility implemented the following actions to remove the Immediate Jeopardy:<br>1. All residents had the potential to be affected. All resident records were audited (76 of 76) by a licensed nurse and/or the Director of Social Services on [DATE] to determine that the resident had the right to formulate an advanced directive and the code status was clearly documented and consistently located in the resident's medical record for Cardiopulmonary Resuscitation (CPR) or Do Not Initiate Cardiopulmonary Resuscitation (CPR) as per the resident, responsible person (s) or |

| 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 _____ | 02/13/2016 |

| 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 0224<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 5)<br>Medical POA wishes. No concerns were identified.<br>2. All resident care plans (76 of 76) were audited by a licensed nurse or Social Service Director (SSD) on [DATE] and [DATE] to determine that resident code status was on the resident's plan of care. Care Plans were updated by a licensed nurse upon discovery if corrective action was required.<br>3. The facility's policy revealed that CPR certified staff would be on duty at all times. Beginning on [DATE] and ending on [DATE], all facility staff personnel files (82 of 82) were reviewed by the Payroll Benefits Coordinator to identify and track who held a current CPR certification as indicated by a current CPR card. Contract staff including housekeeping, laundry and therapy were not considered to meet this requirement. Corrective action included contacting the employee to determined if he/she had a current CPR certification with proof to be provided and placed in the certification book.<br>The Payroll Benefits Coordinator, Center Nurse Executive (CNE), Center Executive Director (CED), Assistant Director of Nursing (ADON), Nurse Practice Educator (NPE) or Receptionist will obtain a copy of the employee's CPR card to verify active dates and place in the certification book and/or personnel file.<br>Beginning on [DATE] and completed on [DATE], the facility's schedule was reviewed for the past thirty (30) days by the Payroll Benefits Coordinator to validate that at least one (1) CPR certified staff member was on duty at all times. All CPR certified staff was listed and placed in the staffing book at each nurse's station. The master nursing schedule is highlighted by the Payroll Benefits Coordinator to ensure CPR certified staff will be on duty at all times per facility policy. The Charge Nurse will review daily to validate CPR certified staff are scheduled with corrective action upon discovery. Facility staff obtained CPR certification independently of the facility through approved programs. The facility requires CPR certified staff to obtain CPR certification for healthcare providers through CPR training that includes hands-on practice and in-person skills assessments.<br>4. Two (2) of the two (2) emergency crash carts were reviewed on [DATE] by a licensed nurse on the front nurses' station; and, on [DATE] by the Clinical Reimbursement Coordinator on the back nurses's station to validate all items on the emergency cart daily check list form were available and in working order. No concerns were identified.<br>5. A Code Blue drill was conducted on [DATE] by the ADON for the 7:00 AM to 3:00 PM shift; and, on [DATE] for the 11:00 PM to 7:00 AM, and 3:00 PM to 11:00 PM shifts.<br>The facility's Executive Nurse, ADON, Nurse Practice Educator (NPE) or Regional RN support staff will continue drills weekly for four (4) weeks to include weekends using different scenarios to audit individual critical thinking skills and validate that Cardiac and/or Respiratory arrest procedures are followed. Any issues identified will be immediately addressed. Audits will continue monthly for five (5) months, then as determined by the Quality Improvement Committee.<br>6. On [DATE], all alert and oriented residents (31 of 72) with a BIMS score of eight (8) or greater were interviewed by the Director of Social Services to determine if the resident felt abused and/or neglected. The interviews included questions regarding: concerns related to care provided by any caregiver, concerns with not receiving care and services needed and who to report to if they felt abused or neglected. No concerns specifically regarding abuse or neglect were identified. Any other concerns were addressed through a formal grievance process by the Director of Social Services immediately upon discovery.<br>7. On [DATE], residents with a BIMS score lower than eight (8) or who declined to participate in the interview process (39 of 72) received a body audit performed by the licensed nurse to identify any physical signs of abuse or neglect including a change in mood or behavior. No concerns were identified.<br>On [DATE], residents who were admitted to the facility that day (2 of 72) received a baseline body audit performed by a licensed nurse. The Center Executive Director or the Center Nurse Executive met with each resident and informed him/her of who to contact if they felt abused or neglected during their stay.<br>8. The Center Nurse Executive, ADON, Nurse Practice Educator (NPE) or Licensed Nurse reviewed all current resident Progress Notes from [DATE] for timeliness and accuracy. No concerns were identified.<br>9. Education was provided for all staff on two (2) separate occasions, defined in the following timeline:<br>On [DATE], the Manager of Clinical Operations provided re-education to the Center Executive Director, Center Nurse Executive and ADON; then the Center Executive Director provided re-education to the Health Information Director, Admissions, Maintenance Director, Director of Recreation, Payroll/Benefits Coordinator, Director of Rehab and Housekeeping/Laundry Supervisor on [DATE]. A post-test with a required score of 100% was included which was graded by the Center Executive Director.<br>The Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive, or Center Executive Director provided re-education to all non-licensed staff on [DATE] through [DATE]. A post-test with a required score of 100% was included which was graded by the Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive or Center Executive Director (57 of 59). All staff not available for re-education will be provided re-education prior to initiating work assignment and new staff will be educated during his/her orientation process.<br>Education included the following topics:<br><br>* How to quickly locate a resident's code status.<br>* Procedure for identifying a resident unresponsive.<br>* Policy NSG102 Care plans including development, communication & implementation.<br>* Death pronouncement and Certification by State.<br>10. The Nurse Practice Educator (NPE), Center Nurse Executive, ADON or Registered Nurse provided re-education to the licensed staff (RNs & LPNs) from [DATE] to [DATE]. All licensed staff completed a post-test with a required score of 100% which was graded by the Nurse Practice Educator, Center Nurse Executive, ADON, Center Executive Director or Registered Nurse (22 of 23). All staff not available for re-education will be provided education prior to initiating work assignment and new staff will be educated during his/her orientation process. Education included the following topics:<br>* Policy NSG107 and procedure for Emergency Medical Response.<br>* Policy NSG 208 and procedure for Cardiac and/or Respiratory Arrest.<br>* Specific instruction will be provided to include evaluation of signs of irreversible death.<br>* Policy NSG 102 Care Plans including development, communication & implementation.<br>* Death pronouncement and certification by State.<br>11. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), ADON or Center Nurse Executive provided re-education to all non-licensed staff to include contract employees (31 of 59). A post-test with a required score of 100% was included which was graded by the Nurse Practice Educator (NPE). All staff not available for re-education will be provided the education prior to initiating work assignment and new staff will be educated during his/her orientation process. The education included:<br>* Policy NSG102 Care Plans including development, communication & implementation and following the care plan for Advanced Directives.<br>* Policy OPS310 Abuse and Neglect Prohibition - State of Kentucky.<br>12. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), ADON or Center Nurse Executive provided re-education to all licensed staff (18 of 23). A post-test with a required score of 100% was included which was graded by the Nurse Practice Educator (NPE). All licensed staff not available for re-education will be provided the re-education prior to initiating work assignments and new staff will be educated during his/her orientation process. The education included:<br>* Policy NSG102 Care Plans including development, communication & implementation and following the care plan for Advanced Directives.<br>* Policy OPS310 Abuse & Neglect Prohibition - State of Kentucky.<br>* Policy NSG4.20 Charting Errors and/or Omissions including late entries.<br>13. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), Center Nurse Executive, ADON, RN MDS Coordinator<br>or RN provided education to all licensed staff (6 of 23). All licensed staff not available for education will be provided education prior to initiating work assignment and new staff will be educated during his/her orientation process. The education included:<br>In the event there is not a Registered Nurse (RN) available to pronounce death, the Licensed Practical Nurse (LPN) must notify an RN or Physician to come to the facility to pronounce and sign the KY Provisional Report of Death form in the |

| 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 _____ | 02/13/2016 |

| 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 0224<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | (continued... from page 6)<br>Facility Note section before the body can be released to the Funeral Home.<br>14. Beginning [DATE], the Health Information Manager, Center Nurse Executive, ADON, RN, LPN, Certified Nursing Executive, Executive, Admissions Director, Payroll Benefits Coordinator and/or Social Services Director will interview at least five (5) non-licensed staff and/or CNAs daily, across all shifts for fourteen (14) days to include weekends to validate that he/she can state the following:<br>* Where a resident's code status can be quickly located<br>* Response steps for a non-licensed staff.<br>* Articulate the purpose of a resident care plan/care card.<br>* Articulate the definition of neglect and appropriate<br>* Reporting steps.<br>Following the initial fourteen (14) days, five (5) non-licensed staff and/or CNAs will be interviewed three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the Quality Improvement (QI) Committee with corrective action upon discovery.<br>15. Beginning [DATE], the Center Executive Director, Center Nurse Executive, Nurse Practice Educator (NPE), ADON and/or Licensed Nurse will interview at least three (3) licensed staff (RN or LPN), across all shifts for fourteen (14) days to include weekends to validate that he/she can state the following:<br>* Expected medical response to an emergency.<br>* Process steps expected in response to a Cardiac and/or Respiratory Arrest.<br>* Signs of irreversible death.<br>* Where a resident's code status can be quickly located.<br>* Kentucky requirements related to death pronouncement.<br>* Articulate the definition of neglect and appropriate reporting steps.<br>* Definition of a complete medical record.<br>Beginning [DATE], the interview tool will include validation of understanding that in the event an RN is not available to pronounce death, the LPN must notify an RN or Physician to come to the facility to pronounce and sign the KY Provisional Report of Death form in the Facility Note section before the body can be released to the Funeral Home.<br>Following the initial fourteen (14) days, three (3) licensed staff will be interviewed three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the QI Committee with corrective action upon discovery.<br>16. Beginning [DATE], the Center Nurse Executive, ADON, Nurse Practice Educator (NPE), or Licensed Nurse will audit all nursing progress notes associated with unplanned transfers and associated care plans daily for fourteen (14) days to include weekends to validate:<br>* Advanced Directives are honored according to the care plan.<br>* Goods and services provided as necessary to avoid mental anguish and physical harm according to the Advanced Directive in the event that CPR is indicated.<br>Following the initial fourteen (14) days, unplanned transfers will be audited three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the QI Committee with corrective action upon discovery.<br>17. Audit results will be brought to the QI Committee by the Center Nurse Executive, Center Executive Director, or Licensed Nurse until the issue is resolved and ongoing thereafter. The QI Committee consists of at least the Medical Director, Center Nurse Executive, Center Executive Director, Social Service Director, Maintenance Director, Health Information Manager, ADON, Business Office Manager, and the Nurse Practice Educator.<br>The State Survey Agency validated the implementation of the facility's AOC as follows:<br>1. Review of an audit log, dated [DATE], revealed the Social Service Director (SSD) and an LPN reviewed all residents' records related to Advanced Directives to ensure clear documentation related to Advanced Directives.<br>2. All care plans were also audited by SSD and check off sheets were verified to ensure residents' code status were on the care plan.<br>Interviews, on [DATE] with the SSD at 11:15 AM, and LPN #1 at 2:55 PM, revealed all resident records related to Advanced Directives were reviewed on [DATE] to verify documentation and care plans were also audited to ensure code status was addressed.<br>3. Review of the log book that was implemented to verify which licensed staff was current revealed all current CPR certified staff was verified by the Payroll Benefits Coordinator on [DATE]. The log book was tabbed by month to indicate when certifications will expire. Observation on [DATE], revealed a current CPR certification list was located on each of the two (2) nursing stations.<br>Interview conducted with the Center Nurse Executive (CNE), on [DATE] at 9:00 AM revealed CPR status was verified by the Payroll Benefits Coordinator on [DATE] and a log book was implemented to maintain current CPR certification of staff and when certifications will expire. A system to address and ensure coverage of CPR certified staff on duty was implemented.<br>4. Crash carts were reviewed by LPN #1 on [DATE]. The check list was updated and will be validated daily on the 11:00 PM to 7:00 AM shift. Review of the check list on [DATE] revealed daily signatures by licensed staff on the 11:00 PM to 7:00 AM shift.<br>Interview with LPN #1, on [DATE] at 2:55 PM, verified she had inspected the crash carts on [DATE]. She revealed the carts will be inspected daily by the night shift nurse and documented on the check list.<br>5. Review of the Code Blue Drill audit revealed a drill was completed, on [DATE], by the ADON on all shifts and weekly drills are being completed through [DATE]. Monthly drills are scheduled to start [DATE] and will be completed by [DATE].<br>Interview with the ADON, on [DATE] at 9:45 AM, revealed a Code Blue drill was conducted by her on [DATE] and drills are being done weekly on varied shifts by the ADON, the Nurse Practice Educator (NPE) and Center Nurse Executive (CNE).<br>6. Documented interviews of interviewable residents were reviewed and determined to have been completed by the Social Service Director. There were thirty-one (31) interviewable residents with two (2) refusing to participate. The interviews were directed to care by care givers, not receiving care, whom to report to if they were feeling abused/neglected. No concerns were identified. Concerns identified not related to abuse neglect were resolved through the grievance process.<br>Interview with the SSD, on [DATE] at 11:15 AM, revealed she conducted interviews with all interviewable residents on [DATE] and no concerns were identified related to abuse or neglect. She did resolve some grievance issues about other things that came from the interviews.<br>7. Review of body audits of non interviewable residents were completed by licensed nurses on [DATE]; and, there were no concerns identified. Two (2) new residents received base line audits and met with the Center Nurse Executive (CNE).<br>Interview, on [DATE] at 9:00 AM, with the Center Nurse Executive (CNE) revealed the skin assessments were divided and completed on [DATE] and two (2) new admissions were included.<br>8. Resident Progress Notes from [DATE] through [DATE], were reviewed for time and accuracy by the Center Nurse Executive (CNE). Review of the list of Progress Notes audited revealed no concerns.<br>Interview with the Center Nurse Executive (CNE), on [DATE] starting at 9:00 AM, revealed she had completed the audit of Progress Notes with no concern identified.<br>9. The Manager of Clinical Operations educated the Center Executive Director (CED), and the Center Nurse Executive (CNE), then the Center Executive Director provided education to the Admissions Director, Director of Recreation, Payroll Benefits Coordinator, Director of Rehabilitation, and the Housekeeping/Laundry Supervisor on [DATE]. Post tests were given. The education included resident code status, the unresponsive resident, care plans and death pronouncement. Review of the tests revealed 100% passed with a 100%; |
| F 0281<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | **Make sure services provided by the nursing facility meet professional standards of quality.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, record review, facility policy review and the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #36, it was determined the facility failed to ensure the services provided by the facility meet professional |

| 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 _____ | 02/13/2016 |

| 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 0281<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 7)<br>standards of quality for one (1) of three (3) sampled residents (Resident #1).<br>Resident #1, who was a full code status in the event of cardiac or respiratory arrest, was not provided cardiopulmonary resuscitation (CPR) when found without respirations and unresponsive. Registered Nurse (RN) #1 called a Code Blue and called 911 for the Emergency Medical System (EMS) on [DATE]; however, RN #1 and RN #2 decided the resident was already dead and did not provide CPR. EMS arrived and found the resident unresponsive and no staff was present. The Paramedic found RN #1 at the nursing station and requested the resident's code status and was informed by RN #1 that Resident #1 was a full code. RN #1 informed the Paramedic CPR they had stopped CPR because a pulse could not be obtained. CPR was initiated by the Paramedic and two (2) Emergency Medical Technicians. Resident #1 was transferred to the hospital emergency room . CPR continued at the emergency room until the resident was pronounced dead.<br>The facility's failure to provide services in accordance with acceptable standards of practice has caused or is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance (AoC) was received on [DATE], and the State Survey Agency validated the Immediate Jeopardy was removed on [DATE], 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.<br>The findings include:<br>Review of the Job Description for Registered Nurse, last revised [DATE], revealed the Registered Nurse delivers efficient and effective nursing care while achieving positive clinical outcomes and patient/family satisfaction and performs nursing functions and provides care within scope of practice.<br>Review of the KBN AOS #36 Resuscitation, approved ,[DATE] and revised ,[DATE], revealed a nurse would not start CPR when:<br>* There is a valid order for the patient not to attempt resuscitation in the event of an apparent cardiac/pulmonary arrest (absence of pulse and respiration, determined by assessment using inspection, palpitation and auscultation); these are often referred to as do not attempt resuscitation; (DNAR) or do not resuscitate (DNR) orders;<br>* Obvious signs of death are present. The most reliable are: dependent livido (general bluish discoloration of the skin as in pooling of blood in dependent body parts); rigor mortis (harding of muscles or rigidity); algo mortis (cooling of the body following death); and injuries that are incompatible with life.<br>Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. Review of the Annual Minimum<br>Data Set (MDS) assessment, dated [DATE], revealed the resident was assessed as requiring total assistance with all activities of daily living.<br>Review of Resident #1's record (chart) revealed a green sticker on it that indicated the resident was a full code. Review of the care plan titled, Resident has an established Advanced Directive, revealed the resident was a full code. The care plan was initiated on [DATE] to address the resident's desire to be a full code in the event a respiratory or [MEDICAL CONDITION] occurred. The intervention stated to Activate resident's Advanced Directive as indicated.<br>Review of Nursing Notes by RN #1, dated [DATE] at 6:00 PM, revealed the nurse determined Resident #1 was unresponsive, not breathing, there were no lung sounds, no pulse, the resident's pupils were dilated and fixed, his/her tongue was displaced to the left, and skin was cool to touch. Further review revealed she sent the NA (nurse aide) for help, validated the resident's code status, called code blue, called 911, returned to room, two (2) licensed nurses were at bedside to assist, lifted hand and observed hands to be mottled, determined time of death, notifications documented as made, EMS arrived and EMS transported to the hospital.<br>Interview with RN #1, on [DATE] at 1:50 PM, revealed, on [DATE], CNA #1 called for her when he identified the resident was unresponsive while picking up meal trays. RN #1 stated when she entered Resident #1's room, Resident #1's tongue was to the side, pupils were big and in her heart she knew Resident #1 was dead. RN #1 stated she screamed for CNA #1 to get RN #2. RN #1 stated she went to check the resident's chart for code status and called 911, then returned to Resident #1's room finding RN #2 standing by the resident's bed. RN #1 stated RN #2 asked her, Do you really want to do this to him/her? (meaning CPR). RN #1 revealed she picked up the resident's hand and it was dark and discolored with no capillary refill so she and RN #2 looked at their watches and agreed the time of death was 6:08 PM. RN #1 stated she then went to the nursing station to notify the family. EMS had arrived about this time and the Paramedic came to her and asked why the code had been stopped.<br>RN #1 was not current in CPR; however, RN #2 was current in CPR. RN #1 called the code, then decided the resident was dead. RN #1 told the Paramedic that they stopped CPR because there was no pulse. She did not tell the Paramedic that they determined the resident was dead. She did not answer the Paramedic when asked who told them to stop CPR. The RNs did not perform CPR, only called the code.<br>Interview with RN #2, on [DATE] at 10:12 AM, revealed she was summoned to Resident #1's room by CNA #1 and observed the resident was blue around the mouth and felt cold when she touched his/her chest when checking for breathing. RN #2 stated when RN #1 came into the room, she and RN #1 discussed CPR and she asked RN #1, Are we doing this because he/she is gone and RN #2 said No, let (him/her) be. RN #2 stated Resident #1 had no respirations, no pulse, was cyanotic around the mouth, and was stiff with rigor when they rolled him/her to place the back board.<br>Interview with CNA #2, on [DATE] at 10:50 AM, revealed she and CNA #1 were picking up supper trays on [DATE]. When they entered Resident #1's room, they found the resident unresponsive. CNA #2 stated RN #1 was summoned by CNA #1. CNA #2 stated she opened Resident #1's eyes and they were not moving and his/her pupils were big; and, the resident's skin was warm. CNA #2 stated she told RN #1 to call a Code Blue. CNA #2 stated RN #1 went to the nursing station and announced a code blue over the intercom and told CNA #1 to go get RN #2. CNA #2 stated she lifted the sheet over the resident to assist placing the CPR board under the resident while RN #2 was searching for the bag used for rescue breathing. RN #2 wanted the oxygen set at 10/Liters (L) and she (CNA #2) set the regulator for 10/L. CNA #2 stated RN #2 asked RN #1 who was going to do compressions and they discussed CPR and one (1) of the RNs said, Let's agree that we did the CPR and be done with it. CNA #2 stated she had touched Resident #1's chest and it felt warm and the resident's tongue was not sticking out.<br>RN #1 called a code because the resident was a full code. When returning to the resident's room, the two (2) RNs together discussed the Code Status, and whether they wanted to crack the resident's ribs (see interview) and decided to pronounce death.<br>Interview with CNA #1, on [DATE] at 3:00 PM, revealed when he and CNA #2 went into Resident #1's room to gather supper trays they found Resident #1 unresponsive. CNA #1 stated he immediately informed RN #1, and she went to the resident's room. He stated RN #1 instructed him to get RN #2 and he went to the ,[DATE] Hall nursing station to get her. CNA #1 stated RN #1 and RN #2 discussed the resident's code status and RN #2 asked RN #1, Do you really want to crack his/her ribs? It's obvious he/she is dead. and they did not start rescue ventilations or chest compressions. The RNs left the room and EMS arrived and questioned the resident's code status. EMS started CPR and transferred Resident #1 to the hospital.<br>Review of EMS run report, dated [DATE], revealed On arrival found . lying supine in bed unresponsive and not breathing. No staff was in the room and CPR was not being performed. Charge nurse was located and asked if patient was full code or DNR. Nurse stated patient was full code. Nurse was then asked why CPR was not being performed on the patient. Nurse stated she was unsure but they were doing CPR and decided to stop because they could not get a pulse. She was then asked who advised them to stop CPR and she never answered and walked away. Patient presents unresponsive with GCS-3. Airway patent and clear, breathing is absent, absent pulses with a long capillary refill time. Skin is warm, pale and pupils are non reactive. No JVD noted. Breath sounds are absent. No abnormalities to abdomen. Extremities are flaccid. No injuries found.<br>Interview with Paramedic #1, on [DATE] at 11:55 AM, revealed, on [DATE], he responded to a call for an unresponsive resident and when he arrived at Resident #1's room, there was no one in the room but the resident. He stated the resident was not breathing and he did not know the resident's code status. He located RN #1 and asked the resident's code status. The nurse responded full code. The paramedic stated he then asked why CPR was not being done and the nurse replied, We were, we stopped, we couldn't get a pulse. Paramedic #1 stated he asked RN #1 who authorized you to stop CPR and RN #1 just walked away and didn't answer. EMS initiated CPR with Emergency Medical Technician (EMT) #1 and #2. Paramedic #1 stated Resident #1 was not cold but was warm and pale and he did not see any cyanosis. He stated there was no rigor in the patient and no lividity (bluish discoloration). He stated CPR continued as the resident was transported to the emergency department and the resident received interventions in the emergency room until he/she was pronounced dead. Paramedic #1 stated If CPR is the resident's choice, then that's what you need to do.<br>Interview with the Administrator, on [DATE] at 1:25 PM, revealed RN #1 and RN #2 did not initiate chest compressions and |

| 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 _____ | 02/13/2016 |

| 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 0281<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 8)<br>rescue ventilations because they determined there was an indication of irreversible death and they pronounced Resident #1 dead. Further interview with the Administrator, on [DATE] at 11:30 AM, revealed she did not know if RN #1 should have stayed in Resident #1's room and an over head page could not be done from a resident room, but RN #1 could have called 911 from the resident's room. The Administrator stated it was a mis-communication between EMS and the nurse. RN #1 said We started then stopped, which may have meant that a code and 911 was called, then RN #1 and RN #2 decided the resident was dead. They were supposed to provide CPR unless there were irreversible signs of death.<br>Interview with the Clinical Reimbursement Coordinator (CRC), on [DATE] at 11:40 AM, revealed she expected nurses to do what is necessary in a code situation unless two (2) or more signs of death were present.<br>Interview, on [DATE] with CRC #2 at 11:50 AM, revealed she would expect CPR to be provided if that was a resident's choice and would continue until relieved by EMS. She also stated signs of irreversible death would be an indication to not initiate CPR.<br>Interview with the Director of Nursing (DON), on [DATE] at 12:00 PM, revealed when a resident is found unresponsive staff were to call for help, validate the code status, and call 911 as long as there were no signs of death.<br>The facility implemented the following actions to remove the Immediate Jeopardy:<br>1. All residents had the potential to be affected. All resident records were audited (76 of 76) by a licensed nurse and/or the Director of Social Services on [DATE] to determine that the resident had the right to formulate an advanced directive and the code status was clearly documented and consistently located in the resident's medical record for Cardiopulmonary Resuscitation (CPR) or Do Not Initiate Cardiopulmonary Resuscitation (CPR) as per the resident, responsible person (s) or Medical POA wishes. No concerns were identified.<br>2. All resident care plans (76 of 76) were audited by a licensed nurse or Social Service Director (SSD) on [DATE] and [DATE] to determine that resident code status was on the resident's plan of care. Care Plans were updated by a licensed nurse upon discovery if corrective action was required.<br>3. The facility's policy revealed that CPR certified staff would be on duty at all times. Beginning on [DATE] and ending on [DATE], all facility staff personnel files (82 of 82) were reviewed by the Payroll Benefits Coordinator to identify and track who held a current CPR certification as indicated by a current CPR card. Contract staff including housekeeping, laundry and therapy were not considered to meet this requirement. Corrective action included contacting the employee to determined if he/she had a current CPR certification with proof to be provided and placed in the certification book.<br>The Payroll Benefits Coordinator, Center Nurse Executive (CNE), Center Executive Director (CED), Assistant Director of Nursing (ADON), Nurse Practice Educator (NPE) or Receptionist will obtain a copy of the employee's CPR card to verify active dates and place in the certification book and/or personnel file.<br>Beginning on [DATE] and completed on [DATE], the facility's schedule was reviewed for the past thirty (30) days by the Payroll Benefits Coordinator to validate that at least one (1) CPR certified staff member was on duty at all times. All CPR certified staff was listed and placed in the staffing book at each nurse's station. The master nursing schedule is highlighted by the Payroll Benefits Coordinator to ensure CPR certified staff will be on duty at all times per facility policy. The Charge Nurse will review daily to validate CPR certified staff are scheduled with corrective action upon discovery. Facility staff obtained CPR certification independently of the facility through approved programs. The facility requires CPR certified staff to obtain CPR certification for healthcare providers through CPR training that includes hands-on practice and in-person skills assessments.<br>4. Two (2) of the two (2) emergency crash carts were reviewed on [DATE] by a licensed nurse on the front nurses' station; and, on [DATE] by the Clinical Reimbursement Coordinator on the back nurses's station to validate all items on the emergency cart daily check list form were available and in working order. No concerns were identified.<br>5. A Code Blue drill was conducted on [DATE] by the ADON for the 7:00 AM to 3:00 PM shift; and, on [DATE] for the 11:00 PM to 7:00 AM, and 3:00 PM to 11:00 PM shifts.<br>The facility's Executive Nurse, ADON, Nurse Practice Educator (NPE) or Regional RN support staff will continue drills weekly for four (4) weeks to include weekends using different scenarios to audit individual critical thinking skills and validate that Cardiac and/or Respiratory arrest procedures are followed. Any issues identified will be immediately addressed. Audits will continue monthly for five (5) months, then as determined by the Quality Improvement Committee.<br>6. On [DATE], all alert and oriented residents (31 of 72) with a BIMS score of eight (8) or greater were interviewed by the Director of Social Services to determine if the resident felt abused and/or neglected. The interviews included questions regarding: concerns related to care provided by any caregiver, concerns with not receiving care and services needed and who to report to if they felt abused or neglected. No concerns specifically regarding abuse or neglect were identified. Any other concerns were addressed through a formal grievance process by the Director of Social Services immediately upon discovery.<br>7. On [DATE], residents with a BIMS score lower than eight (8) or who declined to participate in the interview process (39 of 72) received a body audit performed by the licensed nurse to identify any physical signs of abuse or neglect including a change in mood or behavior. No concerns were identified.<br>On [DATE], residents who were admitted to the facility that day (2 of 72) received a baseline body audit performed by a licensed nurse. The Center Executive Director or the Center Nurse Executive met with each resident and informed him/her of who to contact if they felt abused or neglected during their stay.<br>8. The Center Nurse Executive, ADON, Nurse Practice Educator (NPE) or Licensed Nurse reviewed all current resident Progress Notes from [DATE] for timeliness and accuracy. No concerns were identified.<br>9. Education was provided for all staff on two (2) separate occasions, defined in the following timeline:<br>On [DATE], the Manager of Clinical Operations provided re-education to the Center Executive Director, Center Nurse Executive and ADON; then the Center Executive Director provided re-education to the Health Information Director, Admissions, Maintenance Director, Director of Recreation, Payroll/Benefits Coordinator, Director of Rehab and Housekeeping/Laundry Supervisor on [DATE]. A post-test with a required score of 100% was included which was graded by the Center Executive Director.<br>The Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive, or Center Executive Director provided re-education to all non-licensed staff on [DATE] through [DATE]. A post-test with a required score of 100% was included which was graded by the Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive or Center Executive Director (57 of 59). All staff not available for re-education will be provided re-education prior to initiating work assignment and new staff will be educated during his/her orientation process.<br>Education included the following topics:<br><br>* How to quickly locate a resident's code status.<br>* Procedure for identifying a resident unresponsive.<br>* Policy NSG102 Care plans including development, communication & implementation.<br>* Death pronouncement and Certification by State.<br>10. The Nurse Practice Educator (NPE), Center Nurse Executive, ADON or Registered Nurse provided re-education to the licensed staff (RNs & LPNs) from [DATE] to [DATE]. All licensed staff completed a post-test with a required score of 100% which was graded by the Nurse Practice Educator, Center Nurse Executive, ADON, Center Executive Director or Registered Nurse (22 of 23). All staff not available for re-education will be provided education prior to initiating work assignment and new staff will be educated during his/her orientation process. Education included the following topics:<br>* Policy NSG107 and procedure for Emergency Medical Response.<br>* Policy NSG 208 and procedure for Cardiac and/or Respiratory Arrest.<br>* Specific instruction will be provided to include evaluation of signs of irreversible death.<br>* Policy NSG 102 Care Plans including development, communication & implementation.<br>* Death pronouncement and certification by State.<br>11. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), ADON or Center Nurse Executive provided re-education to all non-licensed staff to include contract employees (31 of 59). A post-test with a required score of 100% was included which was graded by the Nurse Practice Educator (NPE). All staff not available for re-education will be provided the education prior to initiating work assignment and new staff will be educated during his/her orientation process. The education included: |

| 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 _____ | 02/13/2016 |

| 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 0281<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 9)<br>* Policy NSG102 Care Plans including development, communication & implementation and following the care plan for Advanced Directives.<br>* Policy OPS310 Abuse and Neglect Prohibition - State of Kentucky.<br>12. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), ADON or Center Nurse Executive provided re-education to all licensed staff (18 of 23). A post-test with a required score of 100% was included which was graded by the Nurse Practice Educator (NPE). All licensed staff not available for re-education will be provided the re-education prior to initiating work assignments and new staff will be educated during his/her orientation process. The education included:<br>* Policy NSG102 Care Plans including development, communication & implementation and following the care plan for Advanced Directives.<br>* Policy OPS310 Abuse & Neglect Prohibition - State of Kentucky.<br>* Policy NSG4.20 Charting Errors and/or Omissions including late entries.<br>13. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), Center Nurse Executive, ADON, RN MDS Coordinator<br>or RN provided education to all licensed staff (6 of 23). All licensed staff not available for education will be provided education prior to initiating work assignment and new staff will be educated during his/her orientation process. The education included:<br>In the event there is not a Registered Nurse (RN) available to pronounce death, the Licensed Practical Nurse (LPN) must notify an RN or Physician to come to the facility to pronounce and sign the KY Provisional Report of Death form in the Facility Note section before the body can be released to the Funeral Home.<br>14. Beginning [DATE], the Health Information Manager, Center Nurse Executive, ADON, RN, LPN, Certified Nursing Executive, Executive, Admissions Director, Payroll Benefits Coordinator and/or Social Services Director will interview at least five (5) non-licensed staff and/or CNAs daily, across all shifts for fourteen (14) days to include weekends to validate that he/she can state the following:<br>* Where a resident's code status can be quickly located<br>* Response steps for a non-licensed staff.<br>* Articulate the purpose of a resident care plan/care card.<br>* Articulate the definition of neglect and appropriate<br>* Reporting steps.<br>Following the initial fourteen (14) days, five (5) non-licensed staff and/or CNAs will be interviewed three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the Quality Improvement (QI) Committee with corrective action upon discovery.<br>15. Beginning [DATE], the Center Executive Director, Center Nurse Executive, Nurse Practice Educator (NPE), ADON and/or Licensed Nurse will interview at least three (3) licensed staff (RN or LPN), across all shifts for fourteen (14) days to include weekends to validate that he/she can state the following:<br>* Expected medical response to an emergency.<br>* Process steps expected in response to a Cardiac and/or Respiratory Arrest.<br>* Signs of irreversible death.<br>* Where a resident's code status can be quickly located.<br>* Kentucky requirements related to death pronouncement.<br>* Articulate the definition of neglect and appropriate reporting steps.<br>* Definition of a complete medical record.<br>Beginning [DATE], the interview tool will include validation of understanding that in the event an RN is not available to pronounce death, the LPN must notify an RN or Physician to come to the facility to pronounce and sign the KY Provisional Report of Death form in the Facility Note section before the body can be released to the Funeral Home.<br>Following the initial fourteen (14) days, three (3) licensed staff will be interviewed three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the QI Committee with corrective action upon discovery.<br>16. Beginning [DATE], the Center Nurse Executive, ADON, Nurse Practice Educator (NPE), or Licensed Nurse will audit all nursing progress notes associated with unplanned transfers and associated care plans daily for fourteen (14) days to include weekends to validate:<br>* Advanced Directives are honored according to the care plan.<br>* Goods and services provided as necessary to avoid mental anguish and physical harm according to the Advanced Directive in the event that CPR is indicated.<br>Following the initial fourteen (14) days, unplanned transfers will be audited three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the QI Committee with corrective action upon discovery.<br>17. Audit results will be brought to the QI Committee by the Center Nurse Executive, Center Executive Director, or Licensed Nurse until the issue is resolved and ongoing thereafter. The QI Committee consists of at least the Medical Director, Center Nurse Executive, Center Executive Director, Social Service Director, Maintenance Director, Health Information Manager, ADON, Business Office Manager, and the Nurse Practice Educator.<br>The State Survey Agency validated the implementation of the facility's AOC as follows:<br>1. Review of an audit log, dated [DATE], revealed the Social Service Director (SSD) and an LPN reviewed all residents' records related to Advanced Directives to ensure clear documentation related to Advanced Directives.<br>2. All care plans were also audited by SSD and check off sheets were verified to ensure residents' code status were on the care plan.<br>Interviews, on [DATE] with the SSD at 11:15 AM, and LPN #1 at 2:55 PM, revealed all resident records related to Advanced Directives were reviewed on [DATE] to verify documentation and care plans were also audited to ensure code status was addressed.<br>3. Review of the log book that was implemented to verify which licensed staff was current revealed all current CPR certified staff was verified by the Payroll Benefits Coordinator on [DATE]. The log book was tabbed by month to indicate when certifications will expire. Observation on [DATE], revealed a current CPR certification list was located on each of the two (2) nursing stations.<br>Interview conducted with the Center Nurse Executive (CNE), on [DATE] at 9:00 AM revealed CPR status was verified by the Payroll Benefits Coordinator on [DATE] and a log book was implemented to maintain current CPR certification of staff and when certifications will expire. A system to address and ensure coverage of CPR certified staff on duty was implemented.<br>4. Crash carts were reviewed by LPN #1 on [DATE]. The check list was updated and will be validated daily on the 11:00 PM to 7:00 AM shift. Review of the check list on [DATE] revealed daily signatures by licensed staff on the 11:00 PM to 7:00 AM shift.<br>Interview with LPN #1, on [DATE] at 2:55 PM, verified she had inspected the crash carts on [DATE]. She revealed the carts will be inspected daily by the night shift nurse and documented on the check list.<br>5. Review of the Code Blue Drill audit revealed a drill was completed, on [DATE], by the ADON on all shifts and weekly drills are being completed through [DATE]. Monthly drills are scheduled to start [DATE] and will be completed by [DATE].<br>Interview with the ADON, on [DATE] at 9:45 AM, revealed a Code Blue drill was conducted by her on [DATE] and drills are being done weekly on varied shifts by the ADON, the Nurse Practice Educator (NPE) and Center Nurse Executive (CNE).<br>6. Documented interviews of interviewable residents were reviewed and determined to have been completed by the Social Service Director. There were thirty-one (31) interviewable residents with two (2) refusing to participate. The interviews were directed to care by care givers, not receiving care, whom to report to if they were feeling abused/neglected. No concerns were identified. Concerns identified not related to abuse neglect were resolved through the grievance process.<br>Interview with the SSD, on [DATE] at 11:15 AM, revealed she conducted interviews with all interviewable residents on [DATE] and no concerns were identified related to abuse or neglect. She did resolve some grievance issues about other things that came from the interviews.<br>7. Review of body audits of non interviewable residents were completed by licensed nurses on [DATE]; and, there were no concerns identified. Two (2) new residents received base line audits and met with the Center Nurse Executive (CNE). |

| 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 _____ | 02/13/2016 |

| 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 0281<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 10)<br>Interview, on [DATE] at 9:00 AM, with the Center Nurse Executive (CNE) revealed the skin assessments were divided and completed on [DATE] and two (2) new admissions were included.<br>8. Resident Progress Notes from [DATE] through [DATE], were reviewed for time and accuracy by the Center Nurse Executive (CNE). Review of the list of Progress Notes audited revealed no concerns.<br>Interview with the Center Nurse Executive (CNE), on [DATE] starting at 9:00 AM, revealed she had completed the audit of Progress Notes with no concern identified.<br>9. The Manager of Clinical Operations educated the Center Executive Director (CED), and the Center Nurse Executive (CNE), then the Center Executive Director provided education to the Admissions Director, Director of Recreation, Payroll Benefits Coordinator, Director of Rehabilitation, and the Housekeeping/Laundry Supervisor on [DATE]. Post tests were given. The education included resident code status, the unresponsive resident, care plans and death pronouncement. Review of the tests revealed 100% passed with a 100%; the test was graded by the Executive Director.<br>Interview, conducted on [DATE] at 9:00 AM, with the Center Nurse Executive (CNE), revealed she received education from the Manager of Clinical Operations on [DATE] and passed a post test with 100%.<br>Interviews, on [DATE] at 11:03 AM with the Admissions Director, 10:01 AM with the Housekeeping/Laundry Supervisor, and the Nurse Practice Educator (NPE), revealed they had received the education and it was about locating a resident's code status, identifying an unresponsive resident, care plans and death pronouncement.<br>Review of education that was provided to non-licensed staff by the Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive (CNE) and Executive Director on [DATE] through [DATE]. The post test required 100% and was graded by the Admissions Director. Two (2) staff, the Dietary Manager and Activity staff were the only remaining staff not provided the training and will receive the training prior to initiating any assignment on return to work. That education included how to locate code status, procedure for identifying a resident unresponsive, Policy NSG102 Care Plans and Death Pronouncement and Certification by State. Review of the POS [REDACTED].<br>Interviews on [DATE] with the Admissions Director at 11:03 AM, Restorative Aide #1 at 10:29 AM, CNA #5 at 10:24 AM, Dietary Aide #1 at 10:19 AM, the Housekeeping/Laundry Supervisor at 10:01 AM, and CNA #4 at 9:40 AM, revealed they had received education related to a resident's code status and where to find that information, related to unresponsive resident and what to do, care plans and death pronouncement by the RN.<br>10. Review of documented education and post tests, on [DATE], revealed 22 of 23 RNs and LPNs were educated by the Nurse Practice Educator (NPE), Center Nurse Executive (CNE), and ADON on [DATE] through [DATE]. All had post test with 100% pass rate graded by the Nurse Practice Educator (NPE), CNA, and ADON. One (1) licensed staff remains to be re-educated. The Scheduling Supervisor is to ensure that education is com |
| F 0282<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Provide care by qualified persons according to each resident's written plan of care.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure care was provided in accordance with the written plan of care for one (1) of three (3) sampled residents (Resident #1).<br>The facility care planned Resident #1 as a full code in the event of cardiac or respiratory arrest. On [DATE], Resident #1 was found unresponsive and without a pulse or respirations. A Code Blue was called and Emergency Medical System (EMS) was activated. However, rescue ventilations and chest compressions were not provided to Resident #1 by Registered Nurse (RN) #1 and RN #2 because they felt the resident was already deceased . EMS responded to the 911 call and found Resident #1 alone in his/her room and Cardiopulmonary Resuscitation (CPR) had not been initiated. CPR was initiated by EMS personnel and the resident was transported to the hospital where CPR continued until the resident was pronounced dead in the Emergency department.<br>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, impairment, or death to a resident. Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance (AoC) was received on [DATE], and the State Survey Agency validated the Immediate Jeopardy was removed on [DATE], 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.<br>The findings include:<br>Review of the facility's policy titled, Care Plans, last revised [DATE], revealed a comprehensive, individualized care plan will be developed by the interdisciplinary team for each resident. The care plan will include measurable objectives to meet resident needs and goals as identified by the assessment process. The purpose of the policy was to provide necessary care and services to attain or maintain the resident's highest practicable physical, mental and psychosocial well being. The policy also revealed the care plan was communicated to appropriate staff and reviewed and revised a minimum of quarterly and as needed to reflect responses to care and changing needs and goals.<br>Review of the Job Description for a Registered Nurse, dated last revised [DATE], revealed a nurse performs nursing functions and provides care within the scope of practice.<br>Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. The Annual Minimum Data Set<br>(MDS) assessment, dated [DATE], revealed the facility assessed Resident #1's cognition as severely impaired. The facility assessed Resident #1 to require total assistance with all activities of daily living. The resident's record had a green sticker that indicated the resident was a full code, desiring to receive CPR .<br>Review of Resident #1's Comprehensive Care Plan revealed the resident had established an Advanced Directive as being full code, dated [DATE]. The resident's desire was to be a full code (administer chest compressions, breaths and activate 911) in the event respiratory or [MEDICAL CONDITION] occurred. The intervention was to Activate resident's Advanced Directive as indicated.<br>Review of Nursing Notes, dated [DATE] at 6:01 PM, and interview with Registered Nurse (RN) #1 on [DATE] at 1:50 PM, and RN #2 on [DATE] at 10:12 AM, revealed on [DATE] at 6:01 PM, Certified Nurse Aide (CNA) #1 and CNA #2 found Resident #1 unresponsive. The CNAs summoned RN #1 who initiated a Code Blue and called 911 (Emergency Medical System) at 6:06 PM, for an ambulance. The resident was unresponsive, not breathing, had no lung sounds, no pulse, pupils were dilated and fixed, tongue was displaced to the left, and skin was cool to touch, according to Nursing Notes dated [DATE] at 6:01 PM. RN #1 and RN #2 discussed Resident #1's full code status but felt the resident had expired and the RNs did not initiate rescue ventilations or chest compressions. RN #2 then returned to her workstation located by the ,[DATE] Hall and RN #1 went to the 100 Hall nursing station to make notifications. EMS arrived to the resident's room at 6:16 PM finding the resident alone, unresponsive and no staff present. Paramedic #1 requested the resident's code status and RN #1, who was at the nurse's station, informed him the resident was a full code. Paramedic #1 asked why CPR was not being performed and RN #1 walked away from Paramedic #1 without response when he asked who authorized the code to be stopped.<br>Review of the EMS run report, dated [DATE], and interview with Paramedic #1, on [DATE] at 11:55 AM, revealed he responded to a call for an unresponsive resident and when he arrived at the resident's room there was no one in the room but the resident. The resident was not breathing and he did not know the resident's code status. Paramedic #1 stated he located RN #1 at the nursing station and asked the resident's code status and the nurse responded full code. The Paramedic stated he then asked why CPR was not being performed, the nurse replied We were, we stopped, we couldn't get a pulse. He stated he returned to Resident #1 and initiated CPR with Emergency Medical Technicians (EMT) #1 and #2. Paramedic #1 stated Resident #1 was not cold but was warm and pale and he did not see any cyanosis. He stated there was no rigor in the resident and no lividity (bluish discoloration). The Paramedic and Emergency Medical Technicians (EMT) #1 and #2 initiated CPR. Resident #1 was transported to the emergency room via ambulance. The Emergency Department received Resident #1 at 6:48 PM with CPR in progress. The Emergency Department staff continued CPR interventions until 6:51 PM when Resident #1 was pronounced dead.<br>Interviews with CNA #1 on [DATE] at 3:00 PM, and CNA #2 on [DATE] at 10:50 AM, revealed on [DATE], CNA #1 was assisting Resident #1 with the supper meal when they noticed the resident was not acting right so he informed RN #1 who was in the dining room. CNA #1 stated RN #1 looked at the resident and told him (CNA #1) to stop feeding the resident and leave his/her head in the upright position. The CNAs stated when they returned to the resident's room to gather the supper trays they found Resident #1 unresponsive. CNA #1 immediately informed RN #1, who was still in the dining room; RN #1 then returned to the resident's room. CNA #1 went to the ,[DATE] Hall nursing station and got RN #2 to assist. The CNAs stated RN #1 and RN #2 discussed the resident's code status and RN #2 asked RN #1, Do you really want to crack his/her ribs? It's obvious he/she is dead. The CNAs stated then one (1) of the RNs stated, Lets agree that we did the CPR and be done with it. |

| 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 _____ | **02/13/2016** |

| 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 0282<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 11)<br>CNA #2 stated she had touched Resident #1's chest and it felt warm and the resident's tongue was not sticking out of his/her mouth. They stated RN #1 and RN #2 did not start rescue ventilations or chest compressions. The RNs left the resident's room. Further interview revealed EMS arrived and questioned the resident's code status and started CPR. EMS transferred the resident to the hospital.<br>Interview with the Administrator, on [DATE] at 1:25 PM, revealed the RNs did not initiate chest compressions and rescue ventilations per the care plan because they determined there was an indication of irreversible death and they pronounced Resident #1 dead. However, she stated that all the nurses were responsible to implement the care plans.<br>Interview with the Clinical Reimbursement Coordinator (CRC), on [DATE] at 11:40 AM, revealed she expected resident care plans to be implemented and all nurses were responsible for implementing care plans.<br>Interview with CRC #2, on [DATE] at 11:50 AM, revealed all licensed staff was responsible to provide care according to the care plan. She additionally stated she would expect CPR to be provided if that was a resident's choice unless there were signs of irreversible death.<br>Interview with the Director of Nursing (DON), on [DATE] at 12:00 PM, revealed all nurses were responsible to ensure care plan interventions were implemented.<br>Interview was Resident #1's Primary Physician, on [DATE] at 12:20 PM, revealed he could not remember if or when he was notified of Resident #1's condition prior to the transfer to the hospital. The Physician stated he expected the nurses to provide care according to the care plan.<br>The facility implemented the following actions to remove the Immediate Jeopardy:<br>1. All residents had the potential to be affected. All resident records were audited (76 of 76) by a licensed nurse and/or the Director of Social Services on [DATE] to determine that the resident had the right to formulate an advanced directive and the code status was clearly documented and consistently located in the resident's medical record for Cardiopulmonary Resuscitation (CPR) or Do Not Initiate Cardiopulmonary Resuscitation (CPR) as per the resident, responsible person (s) or Medical POA wishes. No concerns were identified.<br>2. All resident care plans (76 of 76) were audited by a licensed nurse or Social Service Director (SSD) on [DATE] and [DATE] to determine that resident code status was on the resident's plan of care. Care Plans were updated by a licensed nurse upon discovery if corrective action was required.<br>3. The facility's policy revealed that CPR certified staff would be on duty at all times. Beginning on [DATE] and ending on [DATE], all facility staff personnel files (82 of 82) were reviewed by the Payroll Benefits Coordinator to identify and track who held a current CPR certification as indicated by a current CPR card. Contract staff including housekeeping, laundry and therapy were not considered to meet this requirement. Corrective action included contacting the employee to determined if he/she had a current CPR certification with proof to be provided and placed in the certification book.<br>The Payroll Benefits Coordinator, Center Nurse Executive (CNE), Center Executive Director (CED), Assistant Director of Nursing (ADON), Nurse Practice Educator (NPE) or Receptionist will obtain a copy of the employee's CPR card to verify active dates and place in the certification book and/or personnel file.<br>Beginning on [DATE] and completed on [DATE], the facility's schedule was reviewed for the past thirty (30) days by the Payroll Benefits Coordinator to validate that at least one (1) CPR certified staff member was on duty at all times. All CPR certified staff was listed and placed in the staffing book at each nurse's station. The master nursing schedule is highlighted by the Payroll Benefits Coordinator to ensure CPR certified staff will be on duty at all times per facility policy. The Charge Nurse will review daily to validate CPR certified staff are scheduled with corrective action upon discovery. Facility staff obtained CPR certification independently of the facility through approved programs. The facility requires CPR certified staff to obtain CPR certification for healthcare providers through CPR training that includes hands-on practice and in-person skills assessments.<br>4. Two (2) of the two (2) emergency crash carts were reviewed on [DATE] by a licensed nurse on the front nurses' station; and, on [DATE] by the Clinical Reimbursement Coordinator on the back nurses's station to validate all items on the emergency cart daily check list form were available and in working order. No concerns were identified.<br>5. A Code Blue drill was conducted on [DATE] by the ADON for the 7:00 AM to 3:00 PM shift; and, on [DATE] for the 11:00 PM to 7:00 AM, and 3:00 PM to 11:00 PM shifts.<br>The facility's Executive Nurse, ADON, Nurse Practice Educator (NPE) or Regional RN support staff will continue drills weekly for four (4) weeks to include weekends using different scenarios to audit individual critical thinking skills and validate that Cardiac and/or Respiratory arrest procedures are followed. Any issues identified will be immediately addressed. Audits will continue monthly for five (5) months, then as determined by the Quality Improvement Committee.<br>6. On [DATE], all alert and oriented residents (31 of 72) with a BIMS score of eight (8) or greater were interviewed by the Director of Social Services to determine if the resident felt abused and/or neglected. The interviews included questions regarding: concerns related to care provided by any caregiver, concerns with not receiving care and services needed and who to report to if they felt abused or neglected. No concerns specifically regarding abuse or neglect were identified. Any other concerns were addressed through a formal grievance process by the Director of Social Services immediately upon discovery.<br>7. On [DATE], residents with a BIMS score lower than eight (8) or who declined to participate in the interview process (39 of 72) received a body audit performed by the licensed nurse to identify any physical signs of abuse or neglect including a change in mood or behavior. No concerns were identified.<br>On [DATE], residents who were admitted to the facility that day (2 of 72) received a baseline body audit performed by a licensed nurse. The Center Executive Director or the Center Nurse Executive met with each resident and informed him/her of who to contact if they felt abused or neglected during their stay.<br>8. The Center Nurse Executive, ADON, Nurse Practice Educator (NPE) or Licensed Nurse reviewed all current resident Progress Notes from [DATE] for timeliness and accuracy. No concerns were identified.<br>9. Education was provided for all staff on two (2) separate occasions, defined in the following timeline:<br>On [DATE], the Manager of Clinical Operations provided re-education to the Center Executive Director, Center Nurse Executive and ADON; then the Center Executive Director provided re-education to the Health Information Director, Admissions, Maintenance Director, Director of Recreation, Payroll/Benefits Coordinator, Director of Rehab and Housekeeping/Laundry Supervisor on [DATE]. A post-test with a required score of 100% was included which was graded by the Center Executive Director.<br>The Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive, or Center Executive Director provided re-education to all non-licensed staff on [DATE] through [DATE]. A post-test with a required score of 100% was included which was graded by the Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive or Center Executive Director (57 of 59). All staff not available for re-education will be provided re-education prior to initiating work assignment and new staff will be educated during his/her orientation process.<br>Education included the following topics:<br><br>* How to quickly locate a resident's code status.<br>* Procedure for identifying a resident unresponsive.<br>* Policy NSG102 Care plans including development, communication & implementation.<br>* Death pronouncement and Certification by State.<br>10. The Nurse Practice Educator (NPE), Center Nurse Executive, ADON or Registered Nurse provided re-education to the licensed staff (RNs & LPNs) from [DATE] to [DATE]. All licensed staff completed a post-test with a required score of 100% which was graded by the Nurse Practice Educator, Center Nurse Executive, ADON, Center Executive Director or Registered Nurse (22 of 23). All staff not available for re-education will be provided education prior to initiating work assignment and new staff will be educated during his/her orientation process. Education included the following topics:<br>* Policy NSG107 and procedure for Emergency Medical Response.<br>* Policy NSG 208 and procedure for Cardiac and/or Respiratory Arrest.<br>* Specific instruction will be provided to include evaluation of signs of irreversible death.<br>* Policy NSG 102 Care Plans including development, communication & implementation.<br>* Death pronouncement and certification by State.<br>11. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), ADON or Center Nurse Executive provided |

| 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 _____ | 02/13/2016 |

| 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 0282<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 12)<br>re-education to all non-licensed staff to include contract employees (31 of 59). A post-test with a required score of 100% was included which was graded by the Nurse Practice Educator (NPE). All staff not available for re-education will be provided the education prior to initiating work assignment and new staff will be educated during his/her orientation process. The education included:<br>* Policy NSG102 Care Plans including development, communication & implementation and following the care plan for Advanced Directives.<br>* Policy OPS310 Abuse and Neglect Prohibition - State of Kentucky.<br>12. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), ADON or Center Nurse Executive provided re-education to all licensed staff (18 of 23). A post-test with a required score of 100% was included which was graded by the Nurse Practice Educator (NPE). All licensed staff not available for re-education will be provided the re-education prior to initiating work assignments and new staff will be educated during his/her orientation process. The education included:<br>* Policy NSG102 Care Plans including development, communication & implementation and following the care plan for Advanced Directives.<br>* Policy OPS310 Abuse & Neglect Prohibition - State of Kentucky.<br>* Policy NSG4.20 Charting Errors and/or Omissions including late entries.<br>13. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), Center Nurse Executive, ADON, RN MDS Coordinator<br>or RN provided education to all licensed staff (6 of 23). All licensed staff not available for education will be provided education prior to initiating work assignment and new staff will be educated during his/her orientation process. The education included:<br>In the event there is not a Registered Nurse (RN) available to pronounce death, the Licensed Practical Nurse (LPN) must notify an RN or Physician to come to the facility to pronounce and sign the KY Provisional Report of Death form in the Facility Note section before the body can be released to the Funeral Home.<br>14. Beginning [DATE], the Health Information Manager, Center Nurse Executive, ADON, RN, LPN, Certified Nursing Executive, Executive, Admissions Director, Payroll Benefits Coordinator and/or Social Services Director will interview at least five (5) non-licensed staff and/or CNAs daily, across all shifts for fourteen (14) days to include weekends to validate that he/she can state the following:<br>* Where a resident's code status can be quickly located<br>* Response steps for a non-licensed staff.<br>* Articulate the purpose of a resident care plan/care card.<br>* Articulate the definition of neglect and appropriate<br>* Reporting steps.<br>Following the initial fourteen (14) days, five (5) non-licensed staff and/or CNAs will be interviewed three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the Quality Improvement (QI) Committee with corrective action upon discovery.<br>15. Beginning [DATE], the Center Executive Director, Center Nurse Executive, Nurse Practice Educator (NPE), ADON and/or Licensed Nurse will interview at least three (3) licensed staff (RN or LPN), across all shifts for fourteen (14) days to include weekends to validate that he/she can state the following:<br>* Expected medical response to an emergency.<br>* Process steps expected in response to a Cardiac and/or Respiratory Arrest.<br>* Signs of irreversible death.<br>* Where a resident's code status can be quickly located.<br>* Kentucky requirements related to death pronouncement.<br>* Articulate the definition of neglect and appropriate reporting steps.<br>* Definition of a complete medical record.<br>Beginning [DATE], the interview tool will include validation of understanding that in the event an RN is not available to pronounce death, the LPN must notify an RN or Physician to come to the facility to pronounce and sign the KY Provisional Report of Death form in the Facility Note section before the body can be released to the Funeral Home.<br>Following the initial fourteen (14) days, three (3) licensed staff will be interviewed three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the QI Committee with corrective action upon discovery.<br>16. Beginning [DATE], the Center Nurse Executive, ADON, Nurse Practice Educator (NPE), or Licensed Nurse will audit all nursing progress notes associated with unplanned transfers and associated care plans daily for fourteen (14) days to include weekends to validate:<br>* Advanced Directives are honored according to the care plan.<br>* Goods and services provided as necessary to avoid mental anguish and physical harm according to the Advanced Directive in the event that CPR is indicated.<br>Following the initial fourteen (14) days, unplanned transfers will be audited three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the QI Committee with corrective action upon discovery.<br>17. Audit results will be brought to the QI Committee by the Center Nurse Executive, Center Executive Director, or Licensed Nurse until the issue is resolved and ongoing thereafter. The QI Committee consists of at least the Medical Director, Center Nurse Executive, Center Executive Director, Social Service Director, Maintenance Director, Health Information Manager, ADON, Business Office Manager, and the Nurse Practice Educator.<br>The State Survey Agency validated the implementation of the facility's AOC as follows:<br>1. Review of an audit log, dated [DATE], revealed the Social Service Director (SSD) and an LPN reviewed all residents' records related to Advanced Directives to ensure clear documentation related to Advanced Directives.<br>2. All care plans were also audited by SSD and check off sheets were verified to ensure residents' code status were on the care plan.<br>Interviews, on [DATE] with the SSD at 11:15 AM, and LPN #1 at 2:55 PM, revealed all resident records related to Advanced Directives were reviewed on [DATE] to verify documentation and care plans were also audited to ensure code status was addressed.<br>3. Review of the log book that was implemented to verify which licensed staff was current revealed all current CPR certified staff was verified by the Payroll Benefits Coordinator on [DATE]. The log book was tabbed by month to indicate when certifications will expire. Observation on [DATE], revealed a current CPR certification list was located on each of the two (2) nursing stations.<br>Interview conducted with the Center Nurse Executive (CNE), on [DATE] at 9:00 AM revealed CPR status was verified by the Payroll Benefits Coordinator on [DATE] and a log book was implemented to maintain current CPR certification of staff and when certifications will expire. A system to address and ensure coverage of CPR certified staff on duty was implemented.<br>4. Crash carts were reviewed by LPN #1 on [DATE]. The check list was updated and will be validated daily on the 11:00 PM to 7:00 AM shift. Review of the check list on [DATE] revealed daily signatures by licensed staff on the 11:00 PM to 7:00 AM shift.<br>Interview with LPN #1, on [DATE] at 2:55 PM, verified she had inspected the crash carts on [DATE]. She revealed the carts will be inspected daily by the night shift nurse and documented on the check list.<br>5. Review of the Code Blue Drill audit revealed a drill was completed, on [DATE], by the ADON on all shifts and weekly drills are being completed through [DATE]. Monthly drills are scheduled to start [DATE] and will be completed by [DATE].<br>Interview with the ADON, on [DATE] at 9:45 AM, revealed a Code Blue drill was conducted by her on [DATE] and drills are being done weekly on varied shifts by the ADON, the Nurse Practice Educator (NPE) and Center Nurse Executive (CNE).<br>6. Documented interviews of interviewable residents were reviewed and determined to have been completed by the Social Service Director. There were thirty-one (31) interviewable residents with two (2) refusing to participate. The interviews were directed to care by care givers, not receiving care, whom to report to if they were feeling abused/neglected. No concerns were identified. Concerns identified not related to abuse neglect were resolved through the grievance process.<br>Interview with the SSD, on [DATE] at 11:15 AM, revealed she conducted interviews with all interviewable residents on [DATE] |

| 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 _____ | **02/13/2016** |

| 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 0282<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 13)<br>and no concerns were identified related to abuse or neglect. She did resolve some grievance issues about other things that came from the interviews.<br>7. Review of body audits of non interviewable residents were completed by licensed nurses on [DATE]; and, there were no concerns identified. Two (2) new residents received base line audits and met with the Center Nurse Executive (CNE).<br>Interview, on [DATE] at 9:00 AM, with the Center Nurse Executive (CNE) revealed the skin assessments were divided and completed on [DATE] and two (2) new admissions were included.<br>8. Resident Progress Notes from [DATE] through [DATE], were reviewed for time and accuracy by the Center Nurse Executive (CNE). Review of the list of Progress Notes audited revealed no concerns.<br>Interview with the Center Nurse Executive (CNE), on [DATE] starting at 9:00 AM, revealed she had completed the audit of Progress Notes with no concern identified.<br>9. The Manager of Clinical Operations educated the Center Executive Director (CED), and the Center Nurse Executive (CNE), then the Center Executive Director provided education to the Admissions Director, Director of Recreation, Payroll Benefits Coordinator, Director of Rehabilitation, and the Housekeeping/Laundry Supervisor on [DATE]. Post tests were given. The education included resident code status, the unresponsive resident, care plans and death pronouncement. Review of the tests revealed 100% passed with a 100%; the test was graded by the Executive Director.<br>Interview, conducted on [DATE] at 9:00 AM, with the Center Nurse Executive (CNE), revealed she received education from the Manager of Clinical Operations on [DATE] and passed a post test with 100%.<br>Interviews, on [DATE] at 11:03 AM with the Admissions Director, 10:01 AM with the Housekeeping/Laundry Supervisor, and the Nurse Practice Educator (NPE), revealed they had received the education and it was about locating a resident's code status, identifying an unresponsive resident, care plans and death pronouncement.<br>Review of education that was provided to non-licensed staff by the Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive (CNE) and Executive Director on [DATE] through [DATE]. The post test required 100% and was graded by the Admissions Director. Two (2) staff, the Dietary Manager and Activity staff were the only remaining staff not provided the training and will receive the training prior to initiating any assignment on return to work. That education included how to locate code status, procedure for identifying a resident unresponsive, Policy NSG102 Care Plans and Death Pronouncement and Certification by State. Review of the POS [REDACTED].<br>Interviews on [DATE] with the Admissions Director at 11:03 AM, Restorative Aide #1 at 10:29 AM, CNA #5 at 10:24 AM, Dietary Aide #1 at 10:19 AM, the Housekeeping/Laundry Supervisor at 10:01 AM, and CNA #4 at 9:40 AM, revealed they had received education related to a resident's code status and where to find that information, related to unresponsive resident and what to do, care plans and death pronouncement by the RN.<br>10. Review of documented education and post tests, on [DATE], revealed 22 of 23 RNs and LPNs were educated by the Nurse Practice Educator (NPE), Center Nurse Executive (CNE), and ADON on [DATE] through [DATE]. All had post test with 100% pass rate graded by the Nurse Practice Educator (NPE), CNA, and ADON. One (1) licensed staff remains to be re-educated. The Scheduling Supervisor is to ensure that education is completed when that staff returns. Review of the education revealed it included Policy NSG 107 related to the procedure for Emergency Medical Response, Policy NSG 208 for cardiac and/or respiratory arrest, specific instructions which included evaluation of irreversible death and care plans policy NSG 102 related to care plan development, implementation and communication and death pronouncement.<br>Interviews on [DATE] with RN #2 at 10:36 AM, LPN #3 at 10:13 AM, LPN #2 at 9:48 AM, RN #3 at 9:02 AM, and the Clinical Reimbursement Coordinator (CRC) at 10:50 AM, revealed they had education related to emergency medical response, cardiac and respiratory arrest, irreversible death and care plans. They were required to pass a post test with 100%.<br>11. Review on [DATE] of education and post tests of non-licensed staff and contract employees revealed 31 of 59 had completed the education. All staff not available for re-education will be provided that education prior to initiating work assignment and new staff will be educated during orientation. Review of the education revealed Policy NSG 102 related to care plans for Advanced Directives, Policy OS310 related to abuse/neglect was provided by the Nurse Practice Educator (NPE), ADON, Center Nurse Executive (CNE). Review of the POS [REDACTED].<br>Interviews, on [DATE] with CNA #4 at 9:40 AM, the Housekeeping/Laundry Supervisor at 10:01 AM, Dietary Aide #1 at 10:19 AM, CNA #5 at 10:24 AM, and Restorative Aide #1 at 10:29 AM, revealed they received education related to Advanced Directives and the facility's policy for Abuse and Neglect. They were all required to pass a post test with 100%.<br>12. Review of the education post tests completed [DATE] through [DATE] revealed a 100% pass rate of licensed staff (18 of 23). The education was given by the Nurse Practice Educator (NPE), ADON, and Center Nurse Executive (CNE). The education included Policy NSG102 related to care plan development, communication and implementation for following the care plan for Advanced Directives. The education also included Policy OPS310 related to Abuse and Neglect Prohibition and Policy NSG 4.20 related to charting errors and/or omissions.<br>Interviews, on [DATE] with RN #2 at 10:36 AM, LPN #3 at 10:13 AM, LPN #2 at 9:48 AM, RN #3 at 9:02 AM, and the Clinical Reimbursement Coordinator (CRC) at 10:50 AM, revealed they had education related to implementing the care plan for Advanced Directives and the facility's Abuse and Neglect Policy, as well as charting errors and/or omissions. They were required to pass a post test with 100%.<br>13. The Nurse Practice Educator (NPE), Center Nurse Executive (CNE), ADON, and Clinical Reimbursement Coordinator (CRC) provided education to all licensed staff (6 of 23). This education was to ensure staff could state where code status could be quickly located, response steps for non licensed staff, articulate the purpose of resident care plan/care card, and articulate the definition of neglect and appropriate reporting steps. Staff not available for education will be provided education prior to initiating work assignment and new staff will be educated during orientation.<br>Review of sign off |
| F 0514<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Keep accurate, complete and organized clinical records on each resident that meet professional standards**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview, record review, and facility policy review, it was determined the facility failed to ensure the clinical record for one (1) of three (3) sampled residents (Resident #1) was maintained in accordance with accepted professional standards and practices that were complete and accurately documented.<br>Resident #1 was found unresponsive, not breathing and had no pulse on [DATE]. Record review revealed documentation in the Nursing Notes, dated [DATE], that was titled late entry that a Code Blue was called when Resident #1 was found unresponsive. The Note indicated when returning to the room the resident's hand was observed to be mottled and a time of death was determined. Notifications were documented. The same Nursing Note revealed Emergency Medical System (EMS) was notified and EMS arrived, and transported the resident to the hospital. The same Nursing Note entry was stricken out on [DATE] and then re-documented on [DATE] as another late entry for [DATE].<br>The facility's failure to ensure the clinical record was maintained in accordance with accepted professional standards and practices that were complete and accurately documented has caused or is likely to cause serious injury, harm, or impairment or death to a resident. Immediate Jeopardy was identified on [DATE] and determined to exist on [DATE]. The facility was notified of the Immediate Jeopardy on [DATE]. An acceptable Allegation of Compliance (AoC) was received on [DATE], and the State Survey Agency validated the Immediate Jeopardy was removed on [DATE], 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.<br>The findings include:<br>Review of the facility's policy titled, Charting Errors and/or Omissions, dated as last revised [DATE], revealed documentation to include: Facilities will follow professional standards of practice when changes or clarifications to medical records are necessary. Changes or clarifications may be made to paper and/or electronic medical records. The Purpose: to accurately correct errors or omissions to medical records; Correcting an error in an electronic health information system. If it is necessary to change or add information in a patient's medical record, the person making the entry will: Use one of the following words to identify change/addition: Addendum to add information; Late Entry when pertinent information was missed or not written in a timely manner; Clarification to avoid incorrect interpretation of information that was been previously documented. |

| 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 _____ | 02/13/2016 |

| 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 0514<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 14)<br>Record review revealed the facility admitted Resident #1 on [DATE] with [DIAGNOSES REDACTED]. The Annual Minimum Data Set<br>(MDS) assessment, dated [DATE], revealed the facility assessed Resident #1 with severe cognitive impairment and required total assistance with all activities of daily living.<br>On [DATE] at 6:01 PM, Resident #1 was found unresponsive by Certified Nurse Aide (CNA ) #1 and CNA #2 who summoned Registered Nurse (RN) #1, and RN #1 initiated a Code Blue and called 911 Emergency Medical System (EMS) at 6:06 PM. RN #1 and RN #2 discussed Resident #1's full code status but felt the resident had expired; the RNs did not initiate cardiopulmonary resuscitation (CPR), which included no rescue ventilations or chest compressions. EMS arrived to Resident #1's room at 6:16 PM finding the resident alone, unresponsive and no staff present. Paramedic #1 requested the resident's code status; RN #1 revealed the resident was a full code. EMS initiated CPR and transferred the resident to the Emergency Department (ED). Resident #1 arrived to the ED with CPR in progress and the ED continued CPR interventions until 6:51 PM when Resident #1 was pronounced dead.<br>Review of computer documented Nursing Notes by RN #1, dated [DATE] at 6:00 PM (actual entry time), that had been stricken out on [DATE] at 4:11 PM by RN #1, revealed a Late Entry 6:01 PM (after actual entry time) resident unresponsive, observed resident not breathing, no lung sounds, no pulse, pupils dilated, fixed, tongue displaced to the left, skin cool to touch, sent NA #1 (nurse aide) for help, validated code status, called code blue, called 911, returned to room, two (2) licensed nurses at bedside to assist, lifted hand and observed hands to be mottled, determined time of death, notifications documented as made and, 18:06 (6:06 PM) EMS arrived, EMS transported to hospital.<br>Review of a late entry Nursing Note by RN #1, dated [DATE] at 6:34 PM, revealed documentation to include resident had an unplanned transfer. Contact person was notified of the transfer with name listed.<br>Review of a Nursing Note, dated [DATE] at 4:09 PM (actual entry time), revealed documentation by RN #1 including Late Entry for [DATE] at 6:01 PM, resident non responsive, observed resident not breathing, no lung sounds, no pulse, pupils dilated, fixed, tongue displaced to left, skin cool to touch, sent NA #1 (nurse aide) for help, validated code status, called code blue, called 911, returned to room, two (2) licensed nurses at bedside to assist, lifted hand and observed hands to be mottled, determined time of death, notifications listed and, at 6:06 PM, EMS arrived, EMS transported to hospital.<br>Interview with RN #1, on [DATE] at 3:00 PM, revealed no explanation why her documentation on [DATE] reflected Resident #1 was non-responsive with a Code Blue called, but no information related to CPR was documented. She gave no explanation about why she had documented a Code Blue for the resident and determined death of the resident without a time. Additionally, RN #1 did not provide an explanation why she had struck through the Nursing Note entry made on [DATE] at 6:00 PM, and on [DATE] at 4:11 PM, and had re-documented the same information on [DATE] at 4:09 PM.<br>Interview with the Director of Nursing (DON), conducted on [DATE] at 12:00 PM, revealed she expected the resident's clinical records to be clear (not confusing), concise, and accurately documented.<br>The facility implemented the following actions to remove the Immediate Jeopardy:<br>1. All residents had the potential to be affected. All resident records were audited (76 of 76) by a licensed nurse and/or the Director of Social Services on [DATE] to determine that the resident had the right to formulate an advanced directive and the code status was clearly documented and consistently located in the resident's medical record for Cardiopulmonary Resuscitation (CPR) or Do Not Initiate Cardiopulmonary Resuscitation (CPR) as per the resident, responsible person (s) or Medical POA wishes. No concerns were identified.<br>2. All resident care plans (76 of 76) were audited by a licensed nurse or Social Service Director (SSD) on [DATE] and [DATE] to determine that resident code status was on the resident's plan of care. Care Plans were updated by a licensed nurse upon discovery if corrective action was required.<br>3. The facility's policy revealed that CPR certified staff would be on duty at all times. Beginning on [DATE] and ending on [DATE], all facility staff personnel files (82 of 82) were reviewed by the Payroll Benefits Coordinator to identify and track who held a current CPR certification as indicated by a current CPR card. Contract staff including housekeeping, laundry and therapy were not considered to meet this requirement. Corrective action included contacting the employee to determined if he/she had a current CPR certification with proof to be provided and placed in the certification book.<br>The Payroll Benefits Coordinator, Center Nurse Executive (CNE), Center Executive Director (CED), Assistant Director of Nursing (ADON), Nurse Practice Educator (NPE) or Receptionist will obtain a copy of the employee's CPR card to verify active dates and place in the certification book and/or personnel file.<br>Beginning on [DATE] and completed on [DATE], the facility's schedule was reviewed for the past thirty (30) days by the Payroll Benefits Coordinator to validate that at least one (1) CPR certified staff member was on duty at all times. All CPR certified staff was listed and placed in the staffing book at each nurse's station. The master nursing schedule is highlighted by the Payroll Benefits Coordinator to ensure CPR certified staff will be on duty at all times per facility policy. The Charge Nurse will review daily to validate CPR certified staff are scheduled with corrective action upon discovery. Facility staff obtained CPR certification independently of the facility through approved programs. The facility requires CPR certified staff to obtain CPR certification for healthcare providers through CPR training that includes hands-on practice and in-person skills assessments.<br>4. Two (2) of the two (2) emergency crash carts were reviewed on [DATE] by a licensed nurse on the front nurses' station; and, on [DATE] by the Clinical Reimbursement Coordinator on the back nurses's station to validate all items on the emergency cart daily check list form were available and in working order. No concerns were identified.<br>5. A Code Blue drill was conducted on [DATE] by the ADON for the 7:00 AM to 3:00 PM shift; and, on [DATE] for the 11:00 PM to 7:00 AM, and 3:00 PM to 11:00 PM shifts.<br>The facility's Executive Nurse, ADON, Nurse Practice Educator (NPE) or Regional RN support staff will continue drills weekly for four (4) weeks to include weekends using different scenarios to audit individual critical thinking skills and validate that Cardiac and/or Respiratory arrest procedures are followed. Any issues identified will be immediately addressed. Audits will continue monthly for five (5) months, then as determined by the Quality Improvement Committee.<br>6. On [DATE], all alert and oriented residents (31 of 72) with a BIMS score of eight (8) or greater were interviewed by the Director of Social Services to determine if the resident felt abused and/or neglected. The interviews included questions regarding: concerns related to care provided by any caregiver, concerns with not receiving care and services needed and who to report to if they felt abused or neglected. No concerns specifically regarding abuse or neglect were identified. Any other concerns were addressed through a formal grievance process by the Director of Social Services immediately upon discovery.<br>7. On [DATE], residents with a BIMS score lower than eight (8) or who declined to participate in the interview process (39 of 72) received a body audit performed by the licensed nurse to identify any physical signs of abuse or neglect including a change in mood or behavior. No concerns were identified.<br>On [DATE], residents who were admitted to the facility that day (2 of 72) received a baseline body audit performed by a licensed nurse. The Center Executive Director or the Center Nurse Executive met with each resident and informed him/her of who to contact if they felt abused or neglected during their stay.<br>8. The Center Nurse Executive, ADON, Nurse Practice Educator (NPE) or Licensed Nurse reviewed all current resident Progress Notes from [DATE] for timeliness and accuracy. No concerns were identified.<br>9. Education was provided for all staff on two (2) separate occasions, defined in the following timeline:<br>On [DATE], the Manager of Clinical Operations provided re-education to the Center Executive Director, Center Nurse Executive and ADON; then the Center Executive Director provided re-education to the Health Information Director, Admissions, Maintenance Director, Director of Recreation, Payroll/Benefits Coordinator, Director of Rehab and Housekeeping/Laundry Supervisor on [DATE]. A post-test with a required score of 100% was included which was graded by the Center Executive Director.<br>The Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive, or Center Executive Director provided re-education to all non-licensed staff on [DATE] through [DATE]. A post-test with a required score of 100% was included which was graded by the Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive or Center Executive Director (57 of 59). All staff not available for re-education will be provided re-education prior to initiating work assignment and new staff will be educated during his/her orientation process.<br>Education included the following topics:<br><br>* How to quickly locate a resident's code status. |

| 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 _____ | 02/13/2016 |

| 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 0514<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 15)<br>* Procedure for identifying a resident unresponsive.<br>* Policy NSG102 Care plans including development, communication & implementation.<br>* Death pronouncement and Certification by State.<br>10. The Nurse Practice Educator (NPE), Center Nurse Executive, ADON or Registered Nurse provided re-education to the licensed staff (RNs & LPNs) from [DATE] to [DATE]. All licensed staff completed a post-test with a required score of 100% which was graded by the Nurse Practice Educator, Center Nurse Executive, ADON, Center Executive Director or Registered Nurse (22 of 23). All staff not available for re-education will be provided education prior to initiating work assignment and new staff will be educated during his/her orientation process. Education included the following topics:<br>* Policy NSG107 and procedure for Emergency Medical Response.<br>* Policy NSG 208 and procedure for Cardiac and/or Respiratory Arrest.<br>* Specific instruction will be provided to include evaluation of signs of irreversible death.<br>* Policy NSG 102 Care Plans including development, communication & implementation.<br>* Death pronouncement and certification by State.<br>11. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), ADON or Center Nurse Executive provided re-education to all non-licensed staff to include contract employees (31 of 59). A post-test with a required score of 100% was included which was graded by the Nurse Practice Educator (NPE). All staff not available for re-education will be provided the education prior to initiating work assignment and new staff will be educated during his/her orientation process. The education included:<br>* Policy NSG102 Care Plans including development, communication & implementation and following the care plan for Advanced Directives.<br>* Policy OPS310 Abuse and Neglect Prohibition - State of Kentucky.<br>12. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), ADON or Center Nurse Executive provided re-education to all licensed staff (18 of 23). A post-test with a required score of 100% was included which was graded by the Nurse Practice Educator (NPE). All licensed staff not available for re-education will be provided the re-education prior to initiating work assignments and new staff will be educated during his/her orientation process. The education included:<br>* Policy NSG102 Care Plans including development, communication & implementation and following the care plan for Advanced Directives.<br>* Policy OPS310 Abuse & Neglect Prohibition - State of Kentucky.<br>* Policy NSG4.20 Charting Errors and/or Omissions including late entries.<br>13. Beginning on [DATE] through [DATE], the Nurse Practice Educator (NPE), Center Nurse Executive, ADON, RN MDS Coordinator<br>or RN provided education to all licensed staff (6 of 23). All licensed staff not available for education will be provided education prior to initiating work assignment and new staff will be educated during his/her orientation process. The education included:<br>In the event there is not a Registered Nurse (RN) available to pronounce death, the Licensed Practical Nurse (LPN) must notify an RN or Physician to come to the facility to pronounce and sign the KY Provisional Report of Death form in the Facility Note section before the body can be released to the Funeral Home.<br>14. Beginning [DATE], the Health Information Manager, Center Nurse Executive, ADON, RN, LPN, Certified Nursing Executive, Executive, Admissions Director, Payroll Benefits Coordinator and/or Social Services Director will interview at least five (5) non-licensed staff and/or CNAs daily, across all shifts for fourteen (14) days to include weekends to validate that he/she can state the following:<br>* Where a resident's code status can be quickly located<br>* Response steps for a non-licensed staff.<br>* Articulate the purpose of a resident care plan/care card.<br>* Articulate the definition of neglect and appropriate<br>* Reporting steps.<br>Following the initial fourteen (14) days, five (5) non-licensed staff and/or CNAs will be interviewed three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the Quality Improvement (QI) Committee with corrective action upon discovery.<br>15. Beginning [DATE], the Center Executive Director, Center Nurse Executive, Nurse Practice Educator (NPE), ADON and/or Licensed Nurse will interview at least three (3) licensed staff (RN or LPN), across all shifts for fourteen (14) days to include weekends to validate that he/she can state the following:<br>* Expected medical response to an emergency.<br>* Process steps expected in response to a Cardiac and/or Respiratory Arrest.<br>* Signs of irreversible death.<br>* Where a resident's code status can be quickly located.<br>* Kentucky requirements related to death pronouncement.<br>* Articulate the definition of neglect and appropriate reporting steps.<br>* Definition of a complete medical record.<br>Beginning [DATE], the interview tool will include validation of understanding that in the event an RN is not available to pronounce death, the LPN must notify an RN or Physician to come to the facility to pronounce and sign the KY Provisional Report of Death form in the Facility Note section before the body can be released to the Funeral Home.<br>Following the initial fourteen (14) days, three (3) licensed staff will be interviewed three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the QI Committee with corrective action upon discovery.<br>16. Beginning [DATE], the Center Nurse Executive, ADON, Nurse Practice Educator (NPE), or Licensed Nurse will audit all nursing progress notes associated with unplanned transfers and associated care plans daily for fourteen (14) days to include weekends to validate:<br>* Advanced Directives are honored according to the care plan.<br>* Goods and services provided as necessary to avoid mental anguish and physical harm according to the Advanced Directive in the event that CPR is indicated.<br>Following the initial fourteen (14) days, unplanned transfers will be audited three (3) times per week for four (4) weeks, then weekly for four (4) weeks, then monthly for four (4) months then as determined by the QI Committee with corrective action upon discovery.<br>17. Audit results will be brought to the QI Committee by the Center Nurse Executive, Center Executive Director, or Licensed Nurse until the issue is resolved and ongoing thereafter. The QI Committee consists of at least the Medical Director, Center Nurse Executive, Center Executive Director, Social Service Director, Maintenance Director, Health Information Manager, ADON, Business Office Manager, and the Nurse Practice Educator.<br>The State Survey Agency validated the implementation of the facility's AOC as follows:<br>1. Review of an audit log, dated [DATE], revealed the Social Service Director (SSD) and an LPN reviewed all residents' records related to Advanced Directives to ensure clear documentation related to Advanced Directives.<br>2. All care plans were also audited by SSD and check off sheets were verified to ensure residents' code status were on the care plan.<br>Interviews, on [DATE] with the SSD at 11:15 AM, and LPN #1 at 2:55 PM, revealed all resident records related to Advanced Directives were reviewed on [DATE] to verify documentation and care plans were also audited to ensure code status was addressed.<br>3. Review of the log book that was implemented to verify which licensed staff was current revealed all current CPR certified staff was verified by the Payroll Benefits Coordinator on [DATE]. The log book was tabbed by month to indicate when certifications will expire. Observation on [DATE], revealed a current CPR certification list was located on each of the two (2) nursing stations.<br>Interview conducted with the Center Nurse Executive (CNE), on [DATE] at 9:00 AM revealed CPR status was verified by the Payroll Benefits Coordinator on [DATE] and a log book was implemented to maintain current CPR certification of staff and when certifications will expire. A system to address and ensure coverage of CPR certified staff on duty was implemented. |

| 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 _____ | 02/13/2016 |

| 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 0514<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 16)<br>4. Crash carts were reviewed by LPN #1 on [DATE]. The check list was updated and will be validated daily on the 11:00 PM to 7:00 AM shift. Review of the check list on [DATE] revealed daily signatures by licensed staff on the 11:00 PM to 7:00 AM shift.<br>Interview with LPN #1, on [DATE] at 2:55 PM, verified she had inspected the crash carts on [DATE]. She revealed the carts will be inspected daily by the night shift nurse and documented on the check list.<br>5. Review of the Code Blue Drill audit revealed a drill was completed, on [DATE], by the ADON on all shifts and weekly drills are being completed through [DATE]. Monthly drills are scheduled to start [DATE] and will be completed by [DATE].<br>Interview with the ADON, on [DATE] at 9:45 AM, revealed a Code Blue drill was conducted by her on [DATE] and drills are being done weekly on varied shifts by the ADON, the Nurse Practice Educator (NPE) and Center Nurse Executive (CNE).<br>6. Documented interviews of interviewable residents were reviewed and determined to have been completed by the Social Service Director. There were thirty-one (31) interviewable residents with two (2) refusing to participate. The interviews were directed to care by care givers, not receiving care, whom to report to if they were feeling abused/neglected. No concerns were identified. Concerns identified not related to abuse neglect were resolved through the grievance process.<br>Interview with the SSD, on [DATE] at 11:15 AM, revealed she conducted interviews with all interviewable residents on [DATE] and no concerns were identified related to abuse or neglect. She did resolve some grievance issues about other things that came from the interviews.<br>7. Review of body audits of non interviewable residents were completed by licensed nurses on [DATE]; and, there were no concerns identified. Two (2) new residents received base line audits and met with the Center Nurse Executive (CNE).<br>Interview, on [DATE] at 9:00 AM, with the Center Nurse Executive (CNE) revealed the skin assessments were divided and completed on [DATE] and two (2) new admissions were included.<br>8. Resident Progress Notes from [DATE] through [DATE], were reviewed for time and accuracy by the Center Nurse Executive (CNE). Review of the list of Progress Notes audited revealed no concerns.<br>Interview with the Center Nurse Executive (CNE), on [DATE] starting at 9:00 AM, revealed she had completed the audit of Progress Notes with no concern identified.<br>9. The Manager of Clinical Operations educated the Center Executive Director (CED), and the Center Nurse Executive (CNE), then the Center Executive Director provided education to the Admissions Director, Director of Recreation, Payroll Benefits Coordinator, Director of Rehabilitation, and the Housekeeping/Laundry Supervisor on [DATE]. Post tests were given. The education included resident code status, the unresponsive resident, care plans and death pronouncement. Review of the tests revealed 100% passed with a 100%; the test was graded by the Executive Director.<br>Interview, conducted on [DATE] at 9:00 AM, with the Center Nurse Executive (CNE), revealed she received education from the Manager of Clinical Operations on [DATE] and passed a post test with 100%.<br>Interviews, on [DATE] at 11:03 AM with the Admissions Director, 10:01 AM with the Housekeeping/Laundry Supervisor, and the Nurse Practice Educator (NPE), revealed they had received the education and it was about locating a resident's code status, identifying an unresponsive resident, care plans and death pronouncement.<br>Review of education that was provided to non-licensed staff by the Admissions Director, Recreation Director, Housekeeping/Laundry Supervisor, Center Nurse Executive (CNE) and Executive Director on [DATE] through [DATE]. The post test required 100% and was graded by the Admissions Director. Two (2) staff, the Dietary Manager and Activity staff were the only remaining staff not provided the training and will receive the training prior to initiating any assignment on return to work. That education included how to locate code status, procedure for identifying a resident unresponsive, Policy NSG102 Care Plans and Death Pronouncement and Certification by State. Review of the POS [REDACTED].<br>Interviews on [DATE] with the Admissions Director at 11:03 AM, Restorative Aide #1 at 10:29 AM, CNA #5 at 10:24 AM, Dietary Aide #1 at 10:19 AM, the Housekeeping/Laundry Supervisor at 10:01 AM, and CNA #4 at 9:40 AM, revealed they had received education related to a resident's code status and where to find that information, related to unresponsive resident and what to do, care plans and death pronouncement by the RN.<br>10. Review of documented education and post tests, on [DATE], revealed 22 of 23 RNs and LPNs were educated by the Nurse Practice Educator (NPE), Center Nurse Executive (CNE), and ADON on [DATE] through [DATE]. All had post test with 100% pass rate graded by the Nurse Practice Educator (NPE), CNA, and ADON. One (1) licensed staff remains to be re-educated. The Scheduling Supervisor is to ensure that education is completed when that staff returns. Review of the education revealed it included Policy NSG 107 related to the procedure for Emergency Medical Response, Policy NSG 208 for cardiac and/or respiratory arrest, specific instructions which included evaluation of irreversible death and care plans policy NSG 102 related to care plan development, implementation and communication and death pronouncement.<br>Interviews on [DATE] with RN #2 at 10:36 AM, LPN #3 at 10:13 AM, LPN #2 at 9:48 AM, RN #3 at 9:02 AM, and the Clinical Reimbursement Coordinator (CRC) at 10:50 AM, revealed they had education related to emergency medical response, cardiac and respiratory arrest, irreversible death and care plans. They were required to pass a post test with 100%.<br>11. Review on [DATE] of education and post tests of non-licensed staff and contract employees revealed 31 of 59 had completed the education. All staff not available for re-education will be provided that education prior to initiating work assignment and new staff will be educated during orientation. Review of the education revealed Policy NSG 102 related to care plans for Advanced Directives, Policy OS310 related to abuse/neglect was provided by the Nurse Practice Educator (NPE), ADON, Center Nurse Executive (CNE). Review of the POS [REDACTED].<br>Interviews, on [DATE] with CNA #4 at 9:40 AM, the Housekeeping/Laundry Supervisor at 10:01 AM, Dietary Aide #1 at 10:19 AM, CNA #5 at 10:24 AM, and Restorative Aide #1 at 10:29 AM, revealed they received education related to Advanced Directives and the facility's policy for Abuse and Neglect. They were all required to pass a post test with 100%.<br>12. Review of the education post tests completed [DATE] through [DATE] revealed a 100% pass rate of licensed staff (18 of 23). The education was given by the Nurse Practice Educator (NPE), ADON, and Center Nurse Executive (CNE). The education included Policy NSG102 related to care plan development, communication and implementation for following the care plan for Advanced Directives. The education also included Policy OPS310 related to Abuse and Neglect Prohibition and Policy NSG 4.20 related to charting errors and/or omissions.<br>Interviews, on [DATE] with RN #2 at 10:36 AM, LPN #3 at 10:13 AM, LPN #2 at 9:48 AM, RN #3 at 9:02 AM, and the Clinical Reimbursement Coordinator (CRC) at 10:50 AM, revealed they had education related to implementing the care plan for Advanced Directives and the facility's Abuse and Neglect Policy, as well as charting errors and/or omissions. They were required to pass a post test with 100%.<br>13. The Nurse Practice Educator (NPE), Center Nurse Executive (CNE), ADON, and Clinical Reimbursement Coordinator (CRC) provided education to all licensed staff (6 of 23). This education was to ensure staff could state where code status could be quickly located, response steps for non licensed staff, articulate the purpose of resident care plan/care card, and articulate the definition of neglect and appropriate reporting steps. Staff not available for education will be provided education prior to initiating work assignment and new staff will be educated during orientation.<br>Review of sign off sheets, dated [DATE], of additional education that was conducted for six (6) of 23 licensed staff related to an RN available to pronounce death, the LPN must notify an RN or Physician to come to the facility to pronounce and sign the KY Provisional Report of Death form in the Facility Note section before the body can be released to the funeral home. This education was given by the Nurse Practice Educator (NPE), Center Nurse Executive (CNE), ADON, and Clinical Reimbursement Coordinator (CRC). Staff not available for education will be provided prior to initiating work assignment and new staff will receive the education in orientation.<br>Interviews, conducted on [DATE] with LPN #1 at 2:55 PM, RN #3 at 9:02 AM, LPN #2 at 9:48 AM, LPN #3 at 10:13 AM and RN #2 at<br>10:36 AM, revealed they had received education related to death pronouncement by the RN or Physician and the KY Provisional Report of Death form in the Facility Note section.<br>14. Review of interviews of five (5) non-licensed staff and/or CNAs revealed interviews were conducted daily from [DATE] through [DATE] related to understanding of where a resident's code status can be located, response steps for non-licensed staff, the purpose of care plan/care card, the definition of neglect and reporting steps.<br>Interview with the Center Nurse Executive (CNE), on [DATE] at 9:00 AM, revealed daily interviews will be completed [DATE], and then interviews will be conducted three (3) times a week for four (4) weeks, then one (1) time monthly for four (4) months projected to be complete [DATE].<br>Interviews, conducted on [DATE] with CNA #4 at 9:40 AM, Dietary Aide #1 at 10:19 AM, CNA #5 at 10:24 AM, and Restorative Aide #1 at 10:29 AM, revealed they received education related to where a resident's code status was located and the |

| 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 _____ | **02/13/2016** |

| 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 0514<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 17)<br>response steps for non-licensed staff to follow, as well as the purpose of the care plan and care card. Additionally, the definition of neglect and the reporting steps.<br>15. Beginning [DATE], licensed staff interviews were conducted by the Center Nurse Executive (CNE), Nurse Practice Educator (NPE), and ADON. Review revealed the interviews addressed expected medical response to an emergency, process steps expected in response to a Cardiac and/or Respiratory Arrest, signs of irreversible death, where a resident's code status could be located, Kentucky requirements related to death pronouncement, the definition of neglect and appropriate rep |