

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/10/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/18/2015
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NAME OF PROVIDER OR SUPPLIER  BARKLEY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001
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F 323	<p>Continued From page 124</p> <p>and wandered about the facility, and goes into other residents' rooms at times. She stated Resident #2 could be combative when redirected.</p> <p>Interview with SRNA #3, on 08/03/15 at 5:00 AM, revealed Resident #2 was up sometimes when she reported for work at 11:00 PM. She stated Resident #2 would attempt to go into other residents' rooms and would call out for his/her mother repeatedly. She further stated Resident #2 would become combative with redirection and would strike out, related to his/her confusion.</p> <p>Interview with SRNA #4, on 08/03/15 at 5:15 AM, revealed Resident #1 would sit up at night so that he/she could sleep during dialysis during the day. SRNA #4 stated Resident #1 was not a problem if his/her needs were met; and the resident was not aggressive. SRNA #4 revealed Resident #2 frequently went into Resident #1's room and ate the resident's snacks.</p> <p>Interview with SRNA #9, on 08/03/15 at 5:20 AM, revealed Resident #1 was a "loud mouth" and had a problem with others coming in his/her room, but the resident was not physically aggressive. SRNA #9 stated Resident #2 mumbles and roams entering other residents' rooms hollering "Momma". She stated the resident was totally lost but was easily redirected.</p> <p>Further review of the Comprehensive Care Plan revealed even though staff was aware Resident #2 wandered into other residents' rooms repeatedly and into Resident #1's room on 07/21/15, there was no documented evidence the care plan was ever revised to address this behavior to ensure the appropriate amount of supervision was provided to ensure the resident's</p>	F 323		
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F 323	<p>Continued From page 125 safety.</p> <p>Interview with the Social Service Director (SSD), on 08/03/15 at 6:20 AM, revealed she was notified on 07/21/15 that there would be an investigation and report to be completed on Resident #1 and Resident #2. The SSD stated she came into the facility and saw Resident #2 on arrival. She said to her knowledge, Resident #2 was not sent out for evaluation. The SSD stated there was no action taken related to Resident #2's wandering into other resident's rooms repeatedly.</p> <p>Interview with the Administrator, on 08/03/15 at 7:10 AM, revealed she did not come in on 07/21/15 when she was notified of the incident. She stated on 07/22/15 she and the Director of Nursing (DON) interviewed Resident #1. The Administrator stated she did not feel Resident #1 was at any risk due to Resident #2 as the resident could not have reached him/her and added Resident #2 could be combative. She stated Resident #2 should not have been in Resident #1's room.</p> <p>2. Record review revealed the facility admitted Resident #8 on 11/04/14 with diagnoses which included Chronic Airway Obstruction, Atrial Fibrillation, Alzheimer's Disease, Anxiety and Cerebral Infarction with Hemiplegia. Review of the quarterly Minimum Data Set (MDS) Assessment, dated 07/24/15, revealed the facility assessed Resident #8's cognition as moderately impaired with a BIMS score of eight (8). The facility assessed Resident #8 to be non-ambulatory and he/she required extensive assistance with all activities of daily living (ADL's). In addition, Resident #8 had two (2) falls with no injury and one (1) fall with minor injury, since</p>	F 323		
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F 323	<p>Continued From page 126</p> <p>01/21/15 when there was a significant change MDS completed.</p> <p>Review of Resident #8's Comprehensive Care Plan, dated 11/12/14 and in effect on 08/13/15, revealed the resident was at risk for falls with interventions for a bed and chair alarm and the resident should not be left unattended in his/her wheelchair while in room.</p> <p>Interview with Resident #8's daughter, on 09/09/15 at 1:00 PM, revealed she came into the facility on 08/13/15 around 3:00 PM and when she arrived the resident was not in his/her assigned room. The daughter stated she went to look for the resident and found the resident outside alone in the courtyard area with his/her wheelchair wheel off of the pavement and stuck in the mud. The daughter revealed she was not sure if she would be able to get the chair wheel out of the mud by herself, but was finally able to get it out of the mud. The daughter reported when the resident was taken back into the facility, she noted the resident's forehead and scalp were pink in color. The daughter stated another resident informed her when she reentered the building that the resident had taken himself/herself out into the courtyard area with no assistance. The daughter stated she took the resident back to his/her room and assisted the resident to bed; however, no staff came to assist her. The daughter stated the facility Administrator was notified of the incident by the family on 09/08/15 and the DON was notified shortly after the incident.</p> <p>Observation on 09/17/15 at 3:00 PM, revealed a SRNA was in the enclosed courtyard area sounding a clip alarm. Attempts to hear the</p>	F 323		
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F 323	<p>Continued From page 127</p> <p>alarm sounding from inside of the building by the State Agency Surveyor were unsuccessful. The clip alarm was only audible after opening the door into the courtyard and stepping into the courtyard.</p> <p>Further review of the Comprehensive Care Plan, dated 11/12/14, revealed there was no revisions to the care plan to address the resident going out into the courtyard without staff supervision even though the resident was at risk for falls and the resident's daughter was upset he/she was out there without supervision and the resident's wheel was stuck in the mud.</p> <p>Interview with Resident #8, on 09/09/15 at 1:15 PM, revealed he/she did not remember who let him/her out into the courtyard, and he/she was unsure how he/she got outside.</p> <p>Interview with SRNA #11, on 09/09/15 at 4:15 PM, revealed she was working on day shift recently and the resident's daughter was bringing the resident into the building from the courtyard area. SRNA #11 stated the daughter was yelling and asking, "who took (him/her) out there?" The SRNA revealed she attempted to help the daughter get the resident back into the room but the daughter went ahead pushing the resident up the hallway so she reported the incident to RN #1. The SRNA stated any resident may go out into the courtyard area and staff monitor the courtyard area from inside the building as they go by doors and windows. The SRNA stated, "It is everyone's responsibility to know to check on any resident's in the courtyard area." She also reported that if a resident is left outside, they could turn their wheelchair over, could get stung by a bee or have a heatstroke.</p>	F 323			

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F 323	<p>Continued From page 128</p> <p>Interview with SRNA #12, on 09/15/15 at 4:36 PM, revealed she was unsure if the facility has policies related to the courtyard area but staff are in and out of rooms and look outside if the blinds are open. SRNA #12 stated the staff also walk through the courtyard area when they go smoke and will often walk through the courtyard to get to other halls. SRNA #12 revealed she was gone on break for ten to fifteen (10-15) minutes and when she returned from break the resident's daughter was yelling, "Who took (him/her) outside?" SRNA #12 stated two (2) other residents reported they saw the resident go outside on his/her own.</p> <p>Interview with RN #1, on 09/10/15 at 10:22 AM, revealed Resident #8's daughter was noted to be bringing the resident back into the building from the courtyard area. She stated she was unsure of the date, but knew it was a weekend, as she only works weekend shifts. RN #1 revealed the daughter reported to her the resident was found outside alone in the courtyard area and the wheel of the wheelchair had gotten caught in a crack in the sidewalk. RN#1 stated she heard the resident say, "I always go out there". RN #1 reported there were no assignments made of staffing specifically to watch the courtyard area and revealed that it was everyone's responsibility to keep an eye on the courtyard. RN #1 stated the staff watch the courtyard area to make sure there wasn't a resident out there that should not be, such as a resident that is confused or a high fall risk. RN #1 said she did not make any revisions to the care plan after the incident.</p> <p>Interview with SRNA #13, on 09/14/15 at 5:52 PM, revealed some residents must have someone with them when they go outside in the courtyard. SRNA #13 stated residents at risk for</p>	F 323			

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F 323	<p>Continued From page 129</p> <p>falls have to have someone to go with them into the courtyard area.</p> <p>Interview with SRNA #20, on 09/18/15 at 9:33 AM, revealed she would not be able to hear an alarm from inside the building if the resident was in the courtyard.</p> <p>Interviews on 09/18/15 with RN #6 at 9:25 AM and SRNA #18 at 9:30 AM, revealed they did not recall ever hearing an alarm sounding from the courtyard.</p> <p>Interview with the DON, on 09/09/15 at 3:35 PM, revealed she was informed, as well as the Administrator of the incident in the courtyard with Resident #8 on 09/08/15 by the daughters. The DON stated it was reported to her the resident was found in the courtyard alone, and the wheelchair wheel was stuck in the mud. She also reported that another resident with a BIMS score of fifteen (15), told her they saw Resident #8 propel self out into the courtyard area. The DON stated the resident has a chair alarm and feels like it could be heard from inside the building if needed. She stated she did not feel like there was any reason to make a change in the resident's Care Plan related to the incident in the courtyard because it was reported to the nurse. She stated any resident in the facility has the right to go out into the courtyard as this is their home. Further interview with the DON, on 09/17/15 at 9:36 AM, revealed Resident #8 attempted to self transfer on 04/21/15 in the room and experienced a fall. The resident was attempting to transfer from the wheelchair to the bed. The DON stated intervention related to the resident not being left unattended in his/her room in wheelchair did not apply when in the courtyard because the</p>	F 323		

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F 323	Continued From page 130 resident's bed was not in the courtyard, therefore there was no risk for a fall. Furthermore, the DON revealed they had no validation that the wheelchair wheel had gone into the mud as the wheelchair was not muddy nor was there dirt evident on the chair. She stated she would not have expected the nurse to update or revise the Care Plan related to this reported incident, there was no adverse problem. She stated she feels the Courtyard is considered a common area and staff should look outside regularly to see who is in the courtyard as it is visible from all the windows and the dining rooms.  interview with the Administrator, on 09/10/15 at 8:15 AM and 1:20 PM, revealed she was unaware of the incident with Resident #8's wheelchair getting stuck in the mud. She stated no particular staff member was responsible to know the whereabouts of a resident at all times. She felt that the courtyard was a safe environment for all residents at the facility as the courtyard was monitored by staff as they look outside or walk through the courtyard to access other halls. The Administrator revealed she has checked the courtyard area and felt that there were no physical hazards. She stated the facility has a two (2) hour check for residents and it is a minimum guideline. She also revealed the facility was responsible for the resident's safety but the staff was not aware every time a resident went out into the courtyard. She stated the facility was not considered a secure unit, but they did have systems in place when they need them.	F 323			