

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

PRINTED: 07/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/30/2015
NAME OF PROVIDER OR SUPPLIER BARKLEY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4747 ALBEN BARKLEY DRIVE PADUCAH, KY 42001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance on 06/30/15, as alleged.	{F 000}			

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

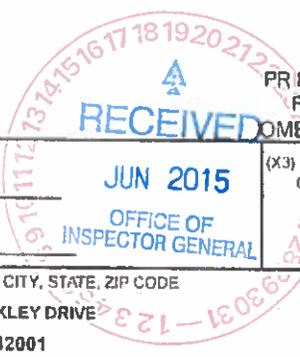
TITLE

(X8) DATE

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

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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 000	INITIAL COMMENTS An Abbreviated Survey (KY #23256) was conducted on 05/26/15 through 05/28/15. KY #23256 was substantiated with deficient practice identified at the highest scope and severity of a "D".	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Barkley Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency..	
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F 323 SS=D	483 25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident receives adequate supervision and assistive devices to prevent accidents related to falls for one (1) resident, in the selected sample of three (3) residents (Resident #1). The findings include: Review of the facility's "Falls Management" policy/procedure, revised 05/15/14, revealed those determined to be at risk for falls will receive appropriate interventions to reduce risk and minimize the actual occurrence of falls. Record review revealed the facility admitted Resident #1 on 02/27/13 with diagnoses to	F 323	F 323 On 5/28/2015, Resident #1's care plan was updated by the DNS to reflect current interventions in place to reduce risk and minimize the actual occurrence of falls, including observation to ensure that the bed was in a low position and the resident was not being positioned near the edge of the bed with no additional corrective action required. The resident did not experience any negative outcome. On 5/28/2015, other residents identified to be in a low bed position to minimize risk of falls were audited by the DNS and ADNS and determined that all other beds were in a low position and residents were positioned appropriately to reduce the risk of a fall. On 6/17/2015, LPN #1, CNA #1, CNA #2, CNA #3, and RN # 1 were re-educated on the facility "Falls Management" policy/procedure to include each resident receives adequate supervision and assistance devices to prevent accidents by the DNS with posttest completed to validate understanding.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cherubel Tysett</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6/19/15</i>
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F 323	<p>Continued From page 1</p> <p>include Congestive Heart Failure, Adult Failure to Thrive, Diabetes, Generalized Muscle Weakness, Cardiac Pacemaker, and Primary Open-Angle Glaucoma.</p> <p>Observation, on 05/26/15 at 4:15 PM and on 05/27/15 at 1:50 PM, revealed Resident #1 was lying in bed positioned on his/her right side facing the wall. His/her upper torso was positioned toward the center of the bed and his/her lower body was near the edge of the bed. Further observation revealed the bed was in the lowest position with one (1) pillow underneath the resident's head.</p> <p>Review of Resident #1's Fall Risk assessment, dated 03/23/15, revealed a score of fourteen (14), indicating he/she was at moderate risk for falls. Review of Resident #1's fall risk interventions revealed to utilize a low bed, to be properly positioned while in bed, and attempt to position the resident with pillows while in bed as he/she will allow. This will prevent him/her from getting too close to the edge of the bed.</p> <p>Review of the Order Summary Report, dated 03/30/15, revealed the bed was to be in a low position while the resident was in bed.</p> <p>Review of the facility's falls investigation revealed Resident #1 fell out of bed on 05/08/15 at 6:30 PM, and on 05/09/15 at 8:02 AM.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 05/27/15 at 3:35 PM, revealed, on 05/08/15 at 6:30 PM, Resident #1 fell out of the bed. Further interview revealed the bed was not in the lowest position at the time and pillows were not utilized for proper positioning.</p>	F 323	<p>Licensed Nurses and nurse aides will be re-educated on the facility "Falls Management" policy/procedure to include that each resident receives adequate supervision and assistance devices to prevent accidents by 6/29/2015 with posttest completed.</p> <p>Beginning 6/17/15, the Administrator, DNS, ADNS, CRC, MDS Coordinator, or RN Charge Nurse will complete visual observation audits of residents in low beds for 5 residents 3 X per week X 4 weeks, then 5 residents 1 X per week X 4 weeks</p> <p>The Director of Nursing will report findings of these audits to the Performance Improvement Committee, which consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dining Services Director, Admissions Coordinator, Payroll/Benefits Designee, Business Office Manager, Nurse Practice Educator, and Maintenance Director for further recommendations. Findings will be reviewed by the Performance Improvement Committee when they meet at least 10 times annually.</p> <p>Compliance Date: 6/30/2015</p>	

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F 323	Continued From page 2 Interview with CNA #2, on 05/28/15 at 11:10 AM, revealed Resident #1 fell out of the bed on 05/08/15 at approximately 6:30 PM. Further interview revealed the resident was positioned on his/her back and the bed was not in the lowest position.	F 323		
	<p>Interview with Licensed Practical Nurse (LPN) #1, on 05/28/15 at 2:50 PM, revealed Resident #1 fell out of the bed on 05/08/15 and was found lying face down on fall mats beside the bed, at approximately 6:30 PM. LPN #1 further revealed the resident's bed was not in the lowest position at the time of the fall.</p> <p>Interview with CNA #3, on 05/28/15 at 12:15 PM, revealed Resident #1 fell out of the bed on 05/09/15 at approximately 8:00 AM. Further interview revealed the resident tends to lie toward the edge of the bed and rolled off the bed. CNA #3 stated, "the bed was as low as it goes, but I did not attempt to reposition him/her because that's the position he/she preferred".</p> <p>Interview with Registered Nurse (RN) #1, on 05/28/15 at 11:50 AM, revealed he/she fell out of bed on 05/09/15 at 8:02 AM. Further interview revealed Resident #1 changes position in bed and preferred his/her lower body to be against the edge of the bed.</p> <p>Interview with the Director of Nursing (DON), on 05/28/15 at 4:45 PM, revealed Resident #1 fell out of bed on 05/08/15 at 6:30 PM and on 05/09/15 at 8:02 AM. Further interview revealed the root cause of the fall on 05/08/15 was identified as Resident #1 being positioned near the edge of the bed. Additional interview revealed</p>			

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F 323	Continued From page 3 the bed was not in the lowest position. The DON stated, "the resident is not fond of being positioned with pillows". Interview with the Administrator, on 05/28/15 at 5:20 PM, revealed when Resident #1 fell out of the bed, on 05/08/15 at 6:30 PM, the resident's bed was not in the lowest position. Further interview revealed use of pillows to position Resident #1 was uncomfortable for the resident and was not utilized for that reason.	F 323		