

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

PRINTED: 07/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/27/2014
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NAME OF PROVIDER OR SUPPLIER PIONEER TRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041
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F 000 INITIAL COMMENTS

An Abbreviated Survey investigating KY00021823 and KY00021865 was conducted 06/25/14 through 06/27/14. KY00021823 was unsubstantiated with no deficiencies cited. KY00021865 was unsubstantiated with an unrelated deficiency cited at a Scope and Severity of a "D".

F 225 483.13(c)(1)(ii)-(iii). (c)(2) - (4)
SS=D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

F 225 Director of Social Services counseled with resident with regard to incident on record on 7/16/2014. Resident did not register any complaints of abuse, or concerns. Resident feels secure in the facility and feels treated well by staff.

All residents with BIMS score of 10 or higher were interviewed on 6/30/14 by Becky Bryant, Director of Social Services. No additional complaints of care were registered by residents during survey.

Abuse in-services were conducted on 7/16/14 by Becky Bryant, SSD, 7/21/14 by Susan Fulton, Staff Dev., Kim Breeze, Unit Coord., and Michelle Marshall, Unit Coordinator. 7/21, 7/22, and 7/23 were conducted by Susan Fulton, on Seven Components og Abuse, including injuries of unknown origin. All employees in facility wee in-serviced with the exception of four employees, who are currently on vacation. These four employees will not be allowed to work until they have received the in-service training.

Administrator has verified all employees have had in-service training by reconciling employee roster with in-service sign in forms.

The Statt Development Coordinator, Susan Fulton will provide the QA Committee, at the monthly QA meeting, evidence (resident interviews) of polling with each abuse allegation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Michael J. Holden* TITLE: *Administrator* (X6) DATE: *7/31/14*

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

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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a thorough investigation was conducted regarding Resident #1's allegation of verbal abuse by Certified Nursing Assistant (CNA) #2 as evidenced by failure to interview other interviewable residents regarding CNA #2's care and behaviors. The findings include: Record review revealed the facility admitted Resident #1 on 03/28/14, with diagnoses which included Anxiety, Insomnia, Aftercare Healing Traumatic Fracture of Right Femur, Osteoarthritis and S/P Right Knee Surgery. Review of the Quarterly Minimum Data Set (MDS) dated 06/12/14, revealed a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating the resident was interviewable and had no cognitive impairment. Review of the facility's, "Resident Abuse Investigation Report Form", dated 05/30/14, revealed on 05/29/14 at 9:45 AM, an incident involving alleged verbal abuse of Resident #1 by CNA #2 early that morning had been reported to the Social Worker (SW). Review revealed	F 225	F 225 Cont. The Staff Development Coordinator, Susan Fulton and the Abuse Coordinator, Becky Bryant will review each allegation to ensure that all components of abuse allegation and investigation are adhered to. The QA Committee is composed of: Susan Fulton, LPN, Sandra Mitchell, RN, DON, Michelle Marshall, RN, Kim Breeze, RN, Michael Cox, AIT, Becky Bryant, LSW, Penny Scott, RN, Charles Gimm, Maint. Dir. Frances Zornes, Hsk Supr, Pamela Coleman, Diet Mgr, and Judy Bellamy, Activity Coordinator. The QA Committee will monitor compliance through the QA process for a period of 90 days.	
		F 225	Completed 7/30/14	

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F 225	<p>Continued From page 2</p> <p>Resident #1 had reported the alleged verbal abuse by CNA #2 to two (2) "shower aides" approximately "two and a half hours" earlier, at 5:00 AM to 5:30 AM. Continued review revealed Resident #1 had alleged CNA #2 had "grabbed" him/her by "the leg" and told him/her to "quit peeing" on himself/herself because he/she "was getting them in trouble". Review of the Form revealed CNA #3 had been working with CNA #2 and denied CNA #2 had told Resident #1 that. Continued review revealed Resident #1's roommate was interviewed on 05/30/14; but, had not heard "anything". Review of the Form revealed a "thorough investigation" was completed; however, further review of the Form revealed no documented evidence the facility interviewed other interviewable residents regarding CNA #2's care and behavior which she also might have provided care for.</p> <p>Interview with Resident #1 on 06/26/14 at 10:15 AM, regarding his/her allegation of verbal abuse by CNA #2 in the early morning on 05/29/14, revealed a "girl" had come into his/her room and told the resident "to stop peeing in between" his/her legs while in bed. Resident #1 stated this had "upset" him/her and he/she had not seen the "girl" since. Resident #1 indicated no one else in the facility had ever "upset" him/her like that in any way.</p> <p>Interview with the SW on 06/26/14 at 1:50 PM, revealed she indicated she had not conducted interviews with other interviewable residents who might have had care provided by CNA #2 during the investigation to ensure no further allegations of verbal abuse were reported.</p> <p>Interview with the Director of Nursing (DON) on</p>	F 225		

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F 225 Continued From page 3
06/27/14 at 10:30 AM, revealed nursing staff had not interviewed other interviewable residents who might have received care from CNA #2 during the early morning hours of 05/29/14, to ensure there were no further allegations of verbal abuse by CNA #2.

Interview, on 06/26/14 at 3:30 PM, with the Administrator revealed the facility had not interviewed other interviewable residents who had potentially been cared for by CNA #2 during their investigation. He indicated, however, the facility should have done this. The Administrator revealed the facility had not received any further allegations from residents who had been cared for by CNA #2 during the early morning hours of 05/29/14. According to the Administrator, in the future the facility would include interviewing other interviewable residents who also might have received care from an alleged perpetrator when performing the investigation.

F 225