

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

PRINTED: 11/28/2012  
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  11/09/2012
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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  F 156 SS=C	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey was conducted on 11/07-09/12. Deficient practice was identified with the highest scope and severity at "F" level. No substandard quality of care was identified.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the</p>	F 000  F 156	<p>This plan of correction is not meant to establish any standard of care, contract obligation or position and Pioneer Trace Nursing Home reserves the right to raise all possible contentions and defenses in any type of civil or criminal claims, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver to any potentially applicable peer review, quality assurance or self critical examination privileges which Pioneer Trace Nursing Home does not waive and reserves the right to assert any administrative, civil, or criminal action or proceeding. Pioneer Trace Nursing Home offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE  Administrator	(X6) DATE  12/05/12
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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 156	<p>Continued From page 1</p> <p>facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These</p>	F 156	<p>Resident A, B and #16 who were affected by the deficient practice no longer reside in the facility. All residents who would have received the Medicare Non-Coverage notice would have been affected because the form did not include the appeal process. The facility began using the form entitled Notice of Medicare Non-Coverage (Attachment A) on 11/12/12 for all residents who would require the notice, which now includes the information necessary to request an appeal. The Social Services Director will maintain a copy of each notice that is issued in the residents' financial file, as well as maintain a log of all notices issued. The Admissions Director will audit the log and residents' financial file on a weekly basis to ensure the correct form is in use. The Admissions Director will immediately notify the Administrator of any discrepancies and will report monthly to the Quality Assurance Committee. The Quality Assurance Committee will track and trend all findings to determine if any further changes are necessary.</p>	11/13/12	

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F 156	<p>Continued From page 2</p> <p>requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure information provided in a Medicare Non-Coverage notice sent to one of seventeen sampled residents (Resident #16) and two unsampled residents (Residents A and B) included the appeal process. The notice sent to residents and/or the resident's responsible party failed to include the information for the beneficiary to request an appeal when Medicare services were exhausted.</p> <p>The findings include:</p>	F 156		
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F 156	<p>Continued From page 3</p> <p>Review of the facility's notice titled "Medicare Coverage for Incoming Medicare Residents" provided for residents upon admission to the facility revealed the resident would be notified by the facility when Medicare services were exhausted. However, the form did not include information regarding the resident or responsible party's right to appeal.</p> <p>1. A review of Resident #16's closed record revealed the facility issued an "Advance Beneficiary Notice of Non-coverage" to Resident #16's responsible party on 09/05/12. The notice stated the resident was no longer qualified for Medicare coverage effective 09/08/12 and an appeal could be filed if the resident or responsible party disagreed with the decision. However, the notice failed to include information regarding the appeal information/rights.</p> <p>2. Record review of Resident A revealed the facility issued an Advance Beneficiary Notice to the resident's responsible party on 11/01/12. The notice stated the resident was no longer qualified for Medicare coverage effective 11/04/12 and an appeal could be filed if the resident or responsible party disagreed with the decision. However, the notice failed to include information regarding the appeal information/rights.</p> <p>3. Record review of Resident B revealed the facility issued an Advance Beneficiary Notice to the resident's responsible party on 10/05/12. The notice stated the resident was no longer qualified for Medicare coverage effective 10/10/12 and an appeal could be filed if the resident or responsible party disagreed with the decision. However, the notice failed to include information regarding the</p>	F 156			

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F 156	Continued From page 4 appeal information/rights.  Interview conducted with the Social Services Coordinator (SSC) on 11/09/12 at 3:10 PM, revealed she was responsible to send the Medicare Non-Coverage notice to residents or their responsible parties. The SSC stated she was not familiar with the appeal information required to be provided to the resident/responsible party when issuing an Advance Beneficiary Notice and had not provided the residents or responsible parties with the appeal information.	F 156		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the facility's policies, it was determined the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Eleven resident room doors had chipped wood with sharp edges in resident rooms 9, 12, 17, 19, 21, 27, 29, 30, 33, 43, and 45; four resident room walls had scuffed and/or cracked drywall in resident rooms 10, 35, 29, and 45; a fan was observed to have dust all over it; and one fall mat was observed in resident room 30 beside the bed to have worn edges.  The findings include:	F 253	Resident room doors 9, 12, 17, 19, 21, 27, 29, 30; 33, 43, and 45 were repaired by 11/30/2012. An audit of all doors was completed on 11/13/2012 and no other doors were found to be affected. The drywall in resident rooms 10, 35, 29, and 45 were all repaired by 11/27/2012. An audit of all rooms was completed on 11/13/2012 and no other rooms were found to be affected. The fan was removed and is no longer in use in the facility. The fall mat was removed immediately and replaced with a new fall mat. An environmental audit was conducted on 11/13/2012 and no other resident equipment or fans were found to be affected and no other environmental concerns were identified.	

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F 253	Continued From page 5  A review of the facility's policy titled, "Maintenance Service," with a date of January 2005, revealed maintenance service would be provided to all areas of the building, grounds, and equipment. In addition, the policy revealed the Maintenance Department was responsible for maintaining the building in good repair and free from hazards.  An interview conducted with the Administrator on 11/09/12 at 2:40 PM, revealed staff was to use a Communication Form to notify the Housekeeping and Maintenance Departments of issues which needed to be addressed; however, the facility did not have a policy related to the Communication Form.  Observations during the environmental tour of the facility on 11/09/12 at 1:30 PM, revealed the following areas to be in need of repairs and/or cleaning:  -Bedroom doors in resident rooms 9, 12, 17, 19, 21, 27, 29, 30, 33, 43, and 45 were observed to have chipped wood with sharp edges. -The sheetrock on the wall between the beds in resident rooms 10, 35, and 45 was observed to have scraped areas. In addition, the wall above the heating/air unit in resident room 29 was observed to have cracks in the sheetrock. -A fall mat beside the bed next to the door of resident room 30 was observed to have worn edges. -A portable fan sitting on the B Hall nurses' station desk was observed to be dusty and in need of cleaning.  An interview conducted with the Maintenance	F 253	The Quality Assurance nurse will identify a member of the Quality Assurance Committee to complete an environmental audit weekly. The Quality Assurance team member will be responsible for completing the communication form when a problem is identified as well as reporting to the Quality Assurance Nurse and Administrator on a weekly basis. The Quality Assurance Committee was in-serviced on 11/13/2012 on properly conducting an environmental audit and completion of the communication form by the Administrator and Maintenance Director. The Quality Assurance Nurse in-serviced all staff on 12/07/2012 on identifying environmental concerns and completion of the communication form. The Quality Assurance Nurse will report to the Quality Assurance Committee monthly all concerns that were identified and what measures were taken to correct the identified concern. The Quality Assurance Committee will track and trend the findings to determine if any further changes are necessary.	12/08/2012	

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F 253	Continued From page 6 Supervisor and the Housekeeping Supervisor on 11/09/12 at 2:20 PM, revealed they both made frequent rounds throughout the facility to check for cleaning and maintenance issues and had not identified the areas in need of repair or cleaning. Both staff members stated the facility utilized a Communication Form which could be completed by any staff person that identified an area in need of repair or cleaning and then given to the supervisors or placed under the door of the supervisors' offices. Both supervisors also stated they had not received Communication Forms for the identified areas of concern.  An interview conducted with the Administrator on 11/09/12 at 2:23 PM, revealed the facility conducted monthly Quality Assurance (QA) rounds of the environment and stated the most recent QA round had been conducted a week prior to the interview. However, according to the Administrator, the reported findings had not been identified or reported by staff.	F 253			
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329			

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F 329	<p>Continued From page 7</p> <p>given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and a review of facility policies, the facility failed to ensure the drug regimen for three of seventeen sampled residents (Residents #6, #7, and #9) was free of unnecessary drugs. Residents #7 and #9 received an antipsychotic medication without adequate indication for the use of the medication.</p> <p>The findings include:</p> <p>Review of the Medication Regimen Review policy (dated June 2011) revealed the consultant pharmacist would review each resident's medication regimen monthly to identify any medication irregularities. The policy further noted the pharmacist would report these irregularities to the nursing coordinator and to the physician.</p> <p>1. Review of the medical record revealed the facility admitted Resident #6 on 06/25/10 with diagnoses including Hypertension, Diabetes Mellitus, Parkinson's Disease, Congestive Heart Failure, Gastroesophageal Reflux, and</p>	F 329	<p>On 11/09/2012 Resident #6's physician added the diagnosis of Diabetic Neuropathy for the use of Neurontin. On 11/09/2012 Resident #7's physician added the diagnoses of Organic Brain Syndrome for the use of Depakote. On 11/12/2012 Resident #9's physician discontinued use of the Seroquel. The Consultant Pharmacist completed a review of all current residents' medical records from 11/09/2012 to 11/19/2012 to ensure supporting diagnosis for all medications prescribed and use of unnecessary drugs. Fourteen residents were found to be affected by this deficient practice. All issues identified during the medical record review were communicated and addressed with the resident's physician and orders were received by 12/06/2012. Nursing Administration developed a policy to maintain current medical diagnoses for each resident's medical record (Attachment B). All nurses were in-serviced on 12/07/2012 on implementation of the Medical Diagnosis Policy by the Unit</p>	

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F 329	<p>Continued From page 8</p> <p>Hyperlipidemia. Review of the physician's orders revealed the resident had an order for 300 milligrams (mg) of Neurontin to be administered one time every day. Further review of the medical record revealed there was no evidence the resident had a diagnosis for the use of the Neurontin.</p> <p>The Director of Nursing (DON) confirmed in interview at 3:00 PM on 11/09/12 that Resident #6's medical record did not contain a diagnosis for the use of the Neurontin.</p> <p>2. Review of the medical record revealed the facility admitted Resident #7 on 02/10/10 with diagnoses to include Coronary Artery Disease, Status Post Laminectomy, Spinal Stenosis, Hypertension, Hyperlipidemia, Status Post Right Femoral Neck Fracture, and Dementia.</p> <p>Review of the November 2012 physician's orders revealed 125 mg of Depakote (treatment of seizures and specific psychiatric disorders) was prescribed for Resident #7 to be administered twice a day. According to the physician's orders, the medication was initiated on 03/29/12. However, there was no evidence a supporting diagnosis had been determined for the use of this medication.</p> <p>Interview conducted with Registered Nurse (RN) #1 on 11/09/12 at 9:30 AM, revealed she believed the Depakote had been prescribed for Resident #7 in March 2012 due to episodes of agitation and anxiety.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #1 on 11/09/12 at 10:10 AM,</p>	F 329	<p>Coordinator. The facility has contracted with a new consultant pharmacist as of 12/01/2012 to carry thru the new facility policy for Psychopharmacological Medication Use (Attachment C). The Unit Coordinators will audit the Medical Diagnosis Sheet upon residents admission, readmission, and with any additional medications or diagnoses. The Unit Coordinators will immediately report any concerns to the Director of Nursing. The MDS Coordinator will review all medical diagnoses during the RAI process and report any concerns to the Director of Nursing. The Director of Nursing will report monthly to the Quality Assurance Committee. The Quality Assurance Committee will track and trend all findings to determine if any further changes are required.</p>	12/08/2012	

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F 329	<p>Continued From page 9</p> <p>revealed the nurses were responsible to review the residents' medication and diagnoses upon admission to ensure each medication had a supporting diagnosis. The LPN stated she had not been trained/directed to review any newly ordered medications for diagnosis. LPN #1 also stated she believed the medication had been prescribed for agitation.</p> <p>Interview with the Consultant Pharmacist on 11/09/12 at 10:35 AM, revealed he was responsible to conduct a monthly review of the each resident's medication and diagnoses. The Consultant Pharmacist stated he was aware Resident #7 received Depakote and believed the medication had been prescribed due to possible seizure activity, and did not question the lack of a seizure diagnosis since Resident #7 had improved after the medication had been initiated.</p> <p>3. A review of the medical record for Resident #9 revealed the facility admitted the resident on 12/11/09 with diagnoses that included Iron Deficiency Anemia, Senile Dementia, Depression, Hypertension, Cardiac Arrhythmia, Osteoarthritis, Osteoporosis, Vertebral Column Fracture, and Fractured Femur. A review of the physician's orders revealed the resident had an order for Seroquel (an antipsychotic) to be administered three times a day. Further review of the medical record revealed no evidence the resident had a diagnosis for the use of the Seroquel.</p> <p>An interview with the DON on 11/09/12 at 3:00 PM, revealed she was aware Seroquel was an antipsychotic and that Resident #9 did not have a diagnosis of psychosis.</p>	F 329			

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F 329	Continued From page 10 An interview with the facility's Consultant Pharmacist on 11/09/12 at 10:30 AM, revealed he thought the diagnosis of dementia was adequate for the use of Seroquel and did not question its use for Resident #9.	F 329		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED  Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy, the facility failed to ensure menus were followed for two of seventeen sampled residents (Residents #9 and #2). A review of the menu for 11/07/12 revealed residents that were on pureed diets were to receive spaghetti as the entree, however, observations of the evening meal on 11/07/12 revealed facility staff served Residents #2 and #9, who had physician's orders for pureed diets, an entree of pureed spaghetti covered with brown gravy. In addition, the menu also revealed residents were to receive peach cobbler for dessert and facility staff failed to ensure Resident #2 received a dessert with the evening meal on 11/07/12.  The findings include:  A review of the facility's policy titled "Philosophy and Policy on Nutrition," undated, revealed the	F 363	A replacement tray was offered to Resident #2's family and was declined, but when offered a dessert, resident ate the dessert. Resident #9 ate 80% of the evening meal on 11/07/2012. Nine other residents would have been affected by this deficient practice. The Dietary Manager in-serviced dietary staff on 11/07/2012 regarding following the recipe and menu as well as proper meal preparation. The Dietician in-serviced dietary staff on 12/12/2012 regarding following the recipe and menu as well as proper meal preparation. The Dietary Manager will audit the dietary staff regarding following the recipe and menu and proper meal preparation to ensure accuracy of tray preparation three times per week randomly for all meals. The Dietary Manager will report all findings	

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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 363	<p>Continued From page 11</p> <p>facility utilized cycle menus that meet the nutritional and therapeutic needs of the residents. The policy revealed the resident would receive the correct diet. The policy also revealed residents would be served attractive and tasty food.</p> <p>A review of the menu for 11/07/12 revealed residents that were on pureed diets were to receive pureed spaghetti at the evening meal on 11/07/12. A review of the recipe for pureed spaghetti revealed the spaghetti noodles were to be pureed in the food processor with water or butter and thickener until smooth. The spaghetti sauce was to be processed with thickener added until smooth. According to the recipe, the pureed spaghetti sauce was to be ladled over the pureed spaghetti noodles when served.</p> <p>1. A review of the medical record for Resident #9 revealed the resident was to receive a pureed diet due to chewing/swallowing problems. Further review of the resident's medical record revealed the resident was severely cognitively impaired and unable to be interviewed.</p> <p>Observations at the evening meal on 11/08/12 revealed Resident #9 was in the dining room being fed pureed spaghetti with brown gravy over it, pureed green beans, and pureed bread. Staff was attempting to feed the resident with little success. The resident ate approximately 25 percent of the meal with much encouragement from the staff.</p> <p>2. A review of the medical record for Resident #2 revealed the facility admitted the resident on 10/02/12, with diagnoses including Cerebral</p>	F 363	<p>weekly to the Dietician and Administrator. The Dietician will audit the dietary staff regarding following the recipe and menu as well as proper meal preparation three times per month. The Dietician will report all findings to the Dietary Manager and the Administrator weekly. The Dietary Manager will report monthly to the Quality Assurance Committee. The Quality Assurance Committee will track and trend all data to determine if any further changes are necessary.</p>	12/13/2012	

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F 363	<p>Continued From page 12</p> <p>Vascular Accident, Depression, Heart Failure, and Closed Fracture of the Vertebral Column. The medical record also revealed a physician's order dated 11/01/12, for the resident to receive a mechanical soft diet, pureed meat, and nectar-thickened liquids. A further review of the medical record revealed the resident was assessed by the facility to not be interviewable.</p> <p>Observation of the evening meal on 11/07/12 at 5:40 PM, revealed the resident was served a food tray by the facility staff which contained pureed spaghetti with brown gravy over it, green beans, garlic bread, thickened water, and thickened tea. However, the food tray did not contain a dessert. The resident was observed to be fed the meal by his/her family member, and was observed to eat five percent of his/her meal.</p> <p>An interview conducted with Resident #2's family member on 11/07/12 at 5:45 PM, revealed the resident liked spaghetti. However, the family member stated the resident did not like gravy on his/her spaghetti. The family member also stated the resident usually received a dessert and was unsure why staff had failed to serve the resident a dessert.</p> <p>An interview conducted with the Cook on 11/07/12 at 5:53 PM, revealed he was responsible for preparing the evening meal. The Cook stated it was his understanding that gravy was supposed to be poured over the pureed spaghetti.</p> <p>An interview conducted with the Dietary Aide on 11/07/12 at 5:55 PM, revealed she was responsible for placing the dessert on Resident</p>	F 363		

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F 363	Continued From page 13 #2's evening meal tray. The Dietary Aide stated she was also responsible for checking to ensure the meal tray was accurate. The Dietary Aide stated she had just missed the dessert and thought the gravy was supposed to be on the spaghetti.  An interview conducted with the Dietary Manager on 11/07/12 at 6:00 PM, revealed the pureed spaghetti was supposed to have plain spaghetti sauce on top and not brown gravy. The Dietary Manager acknowledged staff should have served Resident #2 a dessert and stated the Cook was "just nervous." The Dietary Manager stated she usually monitored meal service for accuracy. However, the Dietary Manager stated she had been at the dishwasher and had failed to ensure the Cook followed the menu and the recipe.	F 363			
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure foods were palatable and at the proper temperature for residents on the B Hall of the facility for the lunch meal on 11/08/12.  The findings include:	F 364			

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F 364	<p>Continued From page 14</p> <p>A review of the facility's policy titled "Minimum Temperature at Point of Service to Resident," undated, revealed the minimum temperature at the point of delivery to the resident should be appropriate. The policy revealed the minimum temperature at delivery for pureed meat and vegetables was to be at a temperature greater than 115 degrees.</p> <p>A review of the facility's policy titled "Philosophy and Policy on Nutrition," undated, revealed residents would be served attractive and tasty food.</p> <p>Observation of the lunch meal on the B Hall of the facility on 11/08/12 at 11:50 AM, revealed a closed insulated cart of meal trays was transferred from the kitchen and delivered to the B Hall. The last tray was removed from the cart at 12:25 PM (35 minutes after it arrived to the unit) and was intercepted by the surveyor to conduct a tray test.</p> <p>Observations of the test tray with Licensed Practical Nurse (LPN) #3 on 11/08/12 at 12:30 PM, revealed the pureed chicken with gravy was 96 degrees Fahrenheit and tasted warm; and the carrots were 84 degrees Fahrenheit and tasted cold. LPN #3 confirmed the food items were not served in accordance with the facility's policy related to the temperature of food items at the point of service and were not palatable.</p> <p>An interview with State Registered Nursing Assistant (SRNA) #4 on 11/08/12 at 12:35 PM, revealed it usually took 15 to 20 minutes to pass the lunch trays. The SRNA stated the temperatures obtained from the pureed chicken</p>	F 364	<p><b>F 364</b> There were no other residents found to be affected by the deficient practice.</p> <p>The facility dietician conducts monthly test tray audits for point of service temperatures and palatability and there have been no concerns with meal tray delivery identified.</p> <p>All nursing staff was in-serviced on 12/7/12 on timely point of service to ensure palatability and temperatures as well as determining if meal trays should be replaced if a delay were to occur during the meal tray delivery process by the Unit Coordinator.</p> <p>The Dietary Manager will audit the meal tray delivery process twice a week for random meal times and report any identified concerns immediately to the Director of Nursing.</p> <p>The Dietary Manager and the Director of Nursing will report monthly to the Quality Assurance Committee.</p> <p><b>Completed 12/8/2012</b></p>		

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F 364	<p>Continued From page 15</p> <p>and carrots from the test tray, in her opinion, were too cold and the tray should have been replaced. The SRNA stated she was unaware of why it had taken so long for staff to obtain the last tray from the meal cart and stated the timeframe to pass the trays could have been the reason the food was not within the acceptable temperature range.</p> <p>An interview with SRNA #5 on 11/08/12 at 12:40 PM, revealed it usually took 30 to 35 minutes to pass the lunch trays and stated if a tray sat for any longer than 35 minutes it should be replaced. SRNA #5 also stated the temperatures of the pureed chicken and carrots from the test tray, in her opinion, were too cold, and the tray should have been replaced.</p> <p>An interview conducted with the Director of Nursing (DON) on 11/09/12 at 2:25 PM, revealed the facility monitored meal service to ensure residents received the appropriate assistance with eating, received food in a timely manner, and that the food was at an appropriate temperature when served to the residents. The DON acknowledged the pureed chicken, gravy, and carrots were not at an appropriate temperature, were not palatable, and should have been sent back to the kitchen to replace the tray. The DON stated that prior to the observation on 11/08/12, the facility had not identified an issue with food not being at the proper temperature or not palatable.</p>	F 364		
F 387 SS=D	<p>483.40(c)(1)-(2) FREQUENCY &amp; TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days</p>	F 387		

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F 387

Continued From page 16 thereafter.

A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

This REQUIREMENT is not met as evidenced by:  
Based on record review, interview, and a review of facility policy, the facility failed to ensure one of seventeen sampled residents (Resident #9) was seen by a physician at least once every thirty days for the first ninety days after admission and at least once every sixty days thereafter. In addition, the facility's policy revealed the physician would complete a progress note at the time of each visit. However, a review of Resident #9's medical record revealed no evidence the resident's physician had visited the resident or completed a progress note within the required time frames.

The findings include:  
A review of the facility's Medical Records Policy, no date given, revealed physician's progress notes were to be completed at the time of each visit by the physician. There was no indication in the policy addressing the frequency of physician visits.  
A review of the medical record for Resident #9 revealed the facility admitted the resident on 12/11/09. Continued review of the medical record revealed no evidence the resident's physician had written any progress notes or had seen the resident at least every 60 days. Physician

F 387

The Medical Records Director reviewed Resident #9's chart on 11/08/2012 and did not find additional progress notes from the physician for the timeframe indicated, but did note numerous contacts with the physician by the facility nursing staff. On 11/08/2012 the residents' physician was made aware that he had not followed the regulations for physician visits. All residents in the facility had the potential to be affected by the deficient practice. The Medical Records Director completed a chart audit on all current residents on 11/09/2012 to review timeliness of physician progress notes. All current residents' physician visits were found to be timely. The facility implemented a new Medical Records Policy regarding Physician Visits (Attachment D) on 11/09/2012. The Medical Records Director will audit all current residents' charts at the beginning of each month and prepare a list of all residents who are due to be seen by the physician. The Medical Records Director will maintain a copy of all residents due to be seen and will provide each physician in writing a list of their residents by the 10<sup>th</sup> of each month that are due to be seen.

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F 387	<p>Continued From page 17</p> <p>Progress notes in the resident's medical record for 2012 of dates the resident was seen by the physician were noted to be 02/02/12, 06/14/12 (a timeframe of 131 days from the previous visit), and 09/07/12 (a timeframe of 83 days from the previous visit).</p> <p>An interview with the Unit Manager on 11/09/12 at 11:05 AM, revealed Medical Records staff was responsible to review the medical records to ensure the physician visits were timely.</p> <p>An interview with the Medical Records (MR) staff person at 1:55 PM on 11/09/12 revealed the MR staff person had only been employed by the facility for one month. The MR staff person stated she was aware she was responsible to review the records to ensure physician visits/progress notes were timely.</p> <p>An interview with the Director of Nursing (DON) on 11/09/12 at 2:05 PM, revealed she was not aware physician progress notes had not been completed and in the resident's medical record or whether the physician had seen the resident within the required timeframes. The DON further stated she had not audited charts to monitor the medical records for completeness or to determine if the physician visits had been completed timely.</p> <p>An interview with the facility's Administrator on 11/09/12 at 2:00 PM, revealed the Administrator was not aware physicians had not documented progress notes at the time of each visit. According to the Administrator, the DON was the direct supervisor of the medical records staff.</p>	F 387	<p>If the physician has not visited their residents due to be seen by the 25<sup>th</sup> of each month, the Medical Records Director will notify them again in writing of their residents due to be seen. If the physician does not visit the resident by the last day of the month, the Medical Records Director will notify the Director of Nursing immediately and the Director of Nursing will contact the physician directly to ensure the physician visits their residents timely. The Director of Nursing will report any concerns immediately to the Administrator and to the Quality Assurance Committee each month. The Quality Assurance Committee will track and trend all findings to determine if further intervention is necessary.</p>	11/10/2012
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

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F 428	<p>Continued From page 18</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure drug irregularities were identified in the monthly drug regimen review conducted for one of seventeen sampled residents (Resident #7). Resident #7 had a physician's order to receive Depakote twice a day. Interview with the Consultant Pharmacist revealed a Depakote level should be obtained every six months to monitor the therapeutic level of the medication. However, there was no evidence the laboratory tests had been conducted.</p> <p>The findings include: Review of the Medication Regimen Review policy (dated June 2011) revealed the Consultant Pharmacist would review each resident's medication regimen monthly to identify any medication irregularities. The policy further noted the Pharmacist would report these irregularities to the nursing coordinator and to the physician.</p>	F 428	<p>Depakote level for Resident #7 was drawn and results were within normal limits and physician gave no further orders. The Consultant Pharmacist completed a drug regimen review of all current residents' medical records from 11/09/2012-11/19/2012 for any irregularities. Nine residents were found to be affected by this deficient practice. The physicians of the nine residents identified in the review were contacted and orders received and carried out. Nursing Administration developed a policy regarding Medication and Lab Monitoring (Attachment E). All Nurses were in-serviced on implementation of the new policy on 12/07/2012 by the Unit Coordinator. The new Consultant Pharmacist will perform a monthly drug regimen review and will notify the Director of Nursing and nursing of any recommendations to be communicated to the physician. The Unit Coordinators will audit all new physicians' orders to ensure appropriate labs are ordered for medications that require laboratory monitoring.</p>	

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F 428	Continued From page 19 Interview with the Consultant Pharmacist on 11/09/12 at 10:35 AM, revealed a Depakote level should be conducted every six months to monitor the therapeutic levels of Depakote.  Review of Resident #7's medical record revealed on 03/29/12 the resident's physician prescribed 125 milligram (mg) of Depakote (treatment of seizures and specific psychiatric disorders) to be administered twice a day.  A review of the laboratory test results for Resident #7 revealed no evidence a blood test to determine the resident's Depakote level had been performed since the medication had been initiated on 03/29/12 in order to determine if the dosage of Depakote the resident received was therapeutic.  Interview with the Consultant Pharmacist on 11/09/12 at 10:35 AM, revealed he was aware Resident #7 was receiving Depakote routinely. The Consultant Pharmacist stated he conducted monthly drug regimen reviews, which included ensuring laboratory tests were performed according to the recommended guidelines. However, the Consultant Pharmacist stated he had not identified Depakote blood levels had not been conducted for Resident #7 since the medication was initiated in March 2012.	F 428	The Unit Coordinators will report any concerns immediately to the Director of Nursing. The Director of Nursing will report all concerns to the Quality Assurance Committee each month. The Quality Assurance Committee will track and trend all data to determine if further changes are required.	12/08/2012	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441			

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F 441 Continued From page 20

(a) Infection Control Program  
The facility must establish an Infection Control Program under which it -  
(1) Investigates, controls, and prevents infections in the facility;  
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and  
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection  
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.  
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.  
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens  
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, and policy review, it was determined the facility failed to ensure personnel handled, stored, processed, and transported linen so as to prevent the spread

F 441 The facility immediately rerouted where the soiled linen entered the laundry room so it no longer passes thru the clean laundry storage area. All residents had the potential to be affected by this deficient practice but no infections have ever been identified from clean linens. Administration implemented a policy for Transportation of Soiled Linen (Attachment F), that all soiled linen will now enter the soiled laundry area at the rear entry of the laundry room therefore not passing thru the clean laundry storage area. All Housekeeping and Laundry staff was in-serviced on the new policy by the Administrator on 11/30/2012 and all nursing staff on 12/07/2012 by the Unit Coordinator. The Quality Assurance nurse will identify a member of the Quality Assurance Committee to complete random audits of the transportation of soiled linen into the laundry room three times a week. The Quality Assurance Committee team member will report all findings to the Quality Assurance Nurse. The Quality Assurance Nurse will report monthly to the Quality Assurance Committee any concerns identified. The Quality Assurance Committee will track and trend all findings to determine if any further changes are necessary.

12/08/2012

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

PRINTED: 11/28/2012  
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  11/09/2012
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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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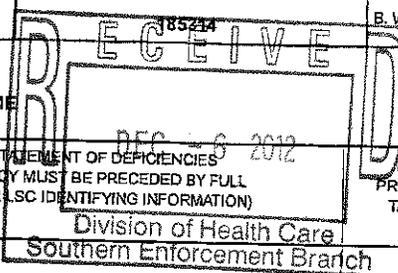
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 21 of infection. Observation of the facility's laundry room on 11/09/12 revealed staff transported soiled linen into the soiled laundry area through the clean laundry storage area.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Laundry Services," with a revision date of October 2010, revealed it was the facility's policy that clean linen was not to come in contact with dirty linen.</p> <p>Observation on 11/09/12 at 11:00 AM, revealed laundry staff folding towels on a table located in front of the washers and dryers. The interior access to the soiled linen area was a walkway located between the washers/dryers and the table. Staff transported soiled linen to the soiled linen area by means of the walkway and, as a result, there was a potential the soiled linen could come into contact with the clean linens.</p> <p>An interview conducted with the Housekeeping Supervisor on 11/09/12 at 11:05 AM, revealed laundry staff brings laundry into the laundry room in covered containers past the clean laundry storage area to the end of the hall to the soiled laundry storage room. The Housekeeping Supervisor stated she had not identified this as being a problem because the facility had always transported dirty laundry that way.</p> <p>An interview conducted with the Infection Control Nurse on 11/09/12 at 1:00 PM, revealed soiled laundry transported past the clean linen area in the laundry room was a concern. The Infection Control Nurse also stated she had not previously identified the issue.</p>	F 441		

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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		
(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 441	Continued From page 22  An interview conducted with the Administrator on 11/09/12 at 1:55 PM, revealed she had not identified soiled laundry transported beside the clean laundry area as a concern. The Administrator acknowledged the facility's method of transporting laundry could be an infection control issue and the need to change how the facility transported the soiled laundry into the laundry room.	F 441			

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 85234		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2012	
NAME OF PROVIDER OR SUPPLIER <b>PIONEER TRACE NURSING HOME</b>				STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041			
(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
K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a) Building: 01  Plan Approval: 1977  Survey under: NFPA 101 (2000 edition)  Facility type: SNF/NF  Type of structure: Type V  Smoke Compartment: Five  Fire Alarm: Complete fire alarm  Sprinkler System: Complete sprinkler system  Generator: Natural gas generator installed in 2009  A standard Life Safety Code survey was conducted on 11/08/12. Pioneer Trace Nursing Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 81. The facility is licensed for 92 beds.  The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) with the highest scope and severity (S/S) at "D" level.			K 000	This plan of correction is not meant to establish any standard of care, contract obligation or position and Pioneer Trace Nursing Home reserves the right to raise all possible contentions and defenses in any type of civil or criminal claims, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver to any potentially applicable peer review, quality assurance or self critical examination privileges which Pioneer Trace Nursing Home does not waive and reserves the right to assert any administrative, civil, or criminal action or proceeding. Pioneer Trace Nursing Home offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1			K 012			



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 12/05/2012

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.

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:  185314		(A4) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  11/08/2012	
NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041			
(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			
K 012	Continued From page 1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide complete sprinkler coverage according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one smoke compartment, four residents, staff, and visitors.  The findings include:  Observation on 11/08/12 at 11:30 AM, revealed the Main Entrance had one canopy larger than four feet wide and was constructed of combustible material (wood trusses). The canopy was not provided with sprinkler protection. The observation was confirmed with the Maintenance Director.  Interview on 11/08/12 at 11:30 AM, with the Maintenance Director, revealed he was not aware the canopy needed to have sprinkler protection installed under the canopy.  Reference: NFPA 13 (1999 Edition).  5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width.  Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.  NFPA 101 (2000 Edition).	K 012	Simplex will be completing an installation of a sprinkler system for the canopy on the Main Entrance of the facility. Simplex will be installing the system no later than December 18, 2012. The sprinkler system will be inspected by Simplex quarterly and any concerns identified will be reported to the Maintenance Director and Administrator. The Maintenance Director will report the results of the inspection reports quarterly to the Quality Assurance Committee. The Quality Assurance Committee will track all data and determine if further changes are necessary.	12/19/2012			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/08/2012
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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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K 012

Continued From page 2

19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.)  
Exception:\* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met:

(a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings.

(b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill.

(c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.

K 012

Table 19.1.6.2 Construction Type Limitations

Construction Type	Stories			
	1	2	3	4
I(443)	X	X	X	X
I(332)	X	X	X	X
II(222)	X	X	X	X
II(111)	X	X*	X*	NP
II(000)	X*	X*	NP	NP
III(211)	X*	X*	NP	NP
III(200)	X*	NP	NP	NP
IV(2HH)	X*	X*	NP	NP
V(111)	X*	X*	NP	NP
V(000)	X*	NP	NP	NP

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/08/2012
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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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K 012	Continued From page 3  X: Permitted type of construction. NP: Not permitted. *Building requires automatic sprinkler protection. (See 19.3.5.1.)	K 012		
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