

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

PRINTED: 09/09/2013
FORM APPROVED
OMB NO. 0938-039

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 08/23/2013
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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
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F 000 INITIAL COMMENTS

An Abbreviated survey investigating KY00020606 was initiated on 08/22/13 and concluded on 08/23/13. The allegation was substantiated with deficient practice identified at the scope and severity of a "D".

F 282 SS=D 483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure services were provided in accordance with each resident's written plan of care, for one (1) of three (3) sampled residents. Resident #1 sustained a fall on 05/12/13. There was not an alarm to the bed as directed by the Care Plan.

The findings include:
Review of the clinical record revealed Resident #1 was admitted by the facility on 12/14/12 with diagnoses which included Anxiety, Coronary Artery Disease, Hypertension and Back Pain.
Review of the Care Plan, dated 12/14/12 and effective until 09/27/13, revealed an intervention for a pressure alarm to the bed related to the resident's risk for falls and a history of attempts to transfer unassisted.

F 000 1) Resident #1 was checked for proper pressure alarm placement and to ensure operational on date of survey by Michelle Marshall ,RN. Care plan for resident #1 was Reviewed and interventions were in place.

F 282 2) All residents with orders for alarms would be at risk. there was a 100% audit done by the two RN unit managers, Kim Breeze and Michelle Marshall on 8/23/2013 to ensure all alarms were in place and in working order. In addition those residents with orders for the alarms care plans were also reviewed for accuracy and interventions by the MDS coordinator, Penny Scott, RN on 8/23/2013.

3) When a new order for alarm is received, the charge nurse on A or B unit will ensure alarm is put in place, and placed on safety device log,, and care plan as well as communicated to aide. 8/24/13 and ongoing

4) Charge nurse on each unit will monitor and document daily each shift starting 09/13//13 and ongoing. The nurse at the time a fall occurs is to provide immediate intervention and place on the care plan. The unit co-ordinator then is responsible to follow up on the care plan. The laptop will be

9/19/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carol L. Skahan</i>	TITLE Administrator	(X6) DATE 9/19/2013
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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 282 Continued From page 1
Review of the Nurses Notes for 05/11/13 at 2:20 AM revealed Resident #1 was found in the bathroom floor. Review of the facility's incident report and follow-up documentation for the event revealed the resident's bed alarm was not in place and was not sounding. Continued review revealed the resident fell during an attempt to self-transfer to the toilet with no injuries noted.

Interview with the Unit Coordinator, on 08/23/13 at 1:43 PM, revealed Resident #1 was to have had a pressure alarm in place to the bed at the time of the fell. She stated the bed alarm pad was observed to be in the resident's recliner chair. She further stated staff failed to replace the pad to the bed when the linens were changed.

During interview with the Director of Nursing, on 08/23/13 at 2:00 PM, she confirmed Resident #1 should have had a bed alarm in place, based on the care plan and the resident's history of attempts of unassisted transfers.

F 282

F-282 cont

brought to the weekly falls meeting and interventions will be reviewed.

In-services were completed on: 8/23/13, 8/24/13, 8/25/13, 8/26/13, 8/27/13, 8/28/13, 8/29/13, 8/30/13, and 9/10/13, By SDC, RN unit managers, and DON, to nursing staff. The In-services Included use/ placement of alarms, updating care plans..

F 323 483.25(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.

F 323

The Administrator in-serviced the non-nursing personnel for Awareness and use of gait belts, and alarms on 8/29/13,

5) DON will bring results to QA every month for three month's starting at next meeting Sept. 25, 2013 and again for the Oct and Nov QA meetings.

09/13/13

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of facility policy, it was determined the facility failed

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185314

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
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(X3) DATE SURVEY
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C
08/23/2013

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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(EACH CORRECTIVE ACTION SHOULD BE
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(X5)
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F 323

Continued From page 2
to ensure one (1) of three (3) sampled residents
received adequate supervision and assistance to
prevent accidents. Resident #1 sustained a fall
during an attempt at unassisted transfer. The
bed alarm was not in place as ordered by the
physician and directed by the plan of care. In
addition, the resident sustained two other falls, on
05/04/13 and 08/10/13, when staff failed to use a
gait belt during transfer, as directed by facility
policy.

The findings include:

Review of the policy titled "Transfer Activities",
undated, revealed a gait belt was to be used and
Certified Nursing Assistants (CNAs) were to
follow their care plan for all resident transfers.

During Interview with the Director of Nursing, on
08/23/13 at 2:00 PM, she stated it was facility
policy that a gait belt be used for all transfers.
Continued Interview revealed all staff had been
trained in the use of gait belts and were familiar
with the policy.

Review of the clinical record revealed Resident
#1 was admitted by the facility on 12/14/12 with
diagnoses which included Hypertension, Back
Pain, Coronary Artery Disease and Anxiety.

Review of the Admission Minimum Data Set
(MDS) Assessment, dated 12/27/12, revealed
Resident #1 had functional limitations in range of
motion for both lower extremities and required
staff assistance for all transfers. Therefore, the
resident was assessed to be at risk for falls and a
care plan to address the risk was initiated.

Review of the Physician's Orders for the month of

F 323

- 1) Gait belt was checked to be in use by aide assigned to resident #1 on day of survey.
- 2) All residents who need assistance for transfer are at risk. Gait belts have been numbered, when aides arrive to unit they are given gait belt which is signed out and returned at end of shift by them.
- 3) 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. Charge nurse will check each aide has signed in and out at start and end of shift. No aide is to be without a gait belt during their shift and gait belt is to be worn on aide plainly in sight.
- 4) In-services were provided with education and hands on transfer practice using gait belts for nursing staff by RN unit manager's, SDC, Therapy, and DON. In-services were completed to nursing staff on 8/23/13, 8/24/13, 8/25/13, 8/26/13, 8/27/13, 8/28/13, 8/29/13, 8/30/13 and 9/10/13 for check-off and proper transfer, using gait belts for transfer. In addition, in-services were provided to non-nursing for awareness of use of gait belts and alarms on 8/29/13.

9/13/13

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F 323 Continued From page 3
August 2013 revealed an order for a pressure alarm to the bed. The order was carried over from the previous month, but did not have an initial date associated with it. However, review of the Care Plan revealed an intervention, dated 12/23/12, for a pressure alarm to the bed.

Review of the Nurse Aide Care Guide for the month of August 2013 revealed Resident #1 was to have a pressure alarm to the bed at all times. Continued review revealed the resident required staff assistance of one (1) and the use of a gait belt for all transfers.

Review of the Nurses Notes, dated 05/04/13 at 10:00 AM, revealed Resident #1 sustained a fall in the bathroom. Review of the Incident Report and follow-up documentation for the event revealed the Certified Nursing Assistant (CNA) failed to use a gait belt during the transfer.

Interview with CNA #1, on 08/23/13 at 1:23 PM, revealed she had assisted Resident #1 to the toilet on 05/04/13. She stated she had been trained on transfers and the use of gait belts. She knew she was supposed to use a gait belt but answered the resident's call bell and did not have a belt with her. She further stated the resident lost his/her balance and the CNA "eased him/her to the floor".

Review of the Nurses Notes for 05/11/13 at 2:20 AM revealed Resident #1 was found in the bathroom floor. Review of the facility's incident report and follow-up documentation for the event revealed the resident's bed alarm was not in place and was not sounding. Continued review revealed the resident fell during an attempt to self-transfer to the toilet.

F 323
5) Don will bring results to QA every month for three Month's starting at the next meeting on Sept 25, and at the Oct. and Nov QA meetings.

10/11

09-20-13:09:57AM

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F 323	<p>Continued From page 4</p> <p>Interview with the Unit Coordinator, on 08/23/13 at 1:43 PM, revealed Resident #1 was to have had a pressure alarm in place to the bed at the time of the fall. She stated the bed alarm pad was observed to be in the resident's recliner chair. She further stated staff failed to replace the pad to the bed when the linens were changed.</p> <p>Review of the Nurses Notes, dated 08/10/13 at 8:20 AM, revealed Resident #1 was sent out to the Emergency Room for evaluation after a fall. Review of the Incident Report and follow-up documentation related to the occurrence, revealed staff failed to use a gait belt during a transfer.</p> <p>Interview with CNA #2, on 08/23/13 at 12:39 PM, revealed she assisted Resident #1 to the bathroom on 8/10/13. She stated it was facility policy for staff to use a gait belt for all transfers. She further stated she usually carried a gait belt but did not have one with her when Resident #1 fell during transfer from the toilet back to the wheelchair.</p> <p>During interview with the Director of Nursing, on 08/23/13 at 2:00 PM, she confirmed Resident #1 should have had a bed alarm in place at all times, based on the comprehensive Care Plan, the Nurse Aide Care Guide, and the resident's history of attempts of unassisted transfers. In addition, she stated it was facility policy that a gait belt be used for all transfers. Continued interview revealed all staff had been trained in the use of gait belts and were familiar with the policy. She further stated staff involved had been counseled and were re-educated on the policy.</p>	F 323		