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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185314		C 10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER TRACE NURSING HOME	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 000	INITIAL COMMENTS A Standard Recertification Survey and an Abbreviated Survey investigating ARO#KY00016828 and ARO#KY00016921 was initiated on 10/18/11 and concluded on 10/20/11. ARO#KY00016828 was substantiated with no deficiencies cited. ARO#KY00016921 was unsubstantiated with no deficiencies cited. Deficiencies were cited on the Standard Survey with the highest Scope and Severity (S/S) of an "E". A Life Safety Code Survey was conducted on 10/19/11 with deficiencies cited with the highest S/S of an "F".	F 000	F 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	
F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 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. 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	F 156		

RECEIVED NOV - 7 2011 BY:

RECEIVED NOV - 9 2011 BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Johnson | TITLE: Administrator | (X6) DATE: 11/07/201

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	Continued From page 1 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. 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 facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. 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; 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. 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	F 156	F 156 Signs were posted in the front lobby of the facility on 10/20/2011 on how to apply for and use Medicare and Medicaid benefits. The Admissions Coordinator conducted an audit on 11/03/2011 of the facility admission packet to ensure that all information was included as required by tag F 156. No areas were identified to be deficient. The Admissions Coordinator will conduct a weekly audit to ensure all required postings are in place. Any identified areas of concern will be reported immediately to the Administrator. The Admissions Coordinator will report monthly to the Quality Assurance Committee and the committee will track and trend all findings to determine if any further changes are necessary.	11/04/2011

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F 156	Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. 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 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. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to prominently display information regarding how to apply for and use Medicare and Medicaid benefits. The findings include:	F 156		

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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 156	Continued From page 3 Observation, on 10/20/11 at 2:35 PM, revealed there was no sign posted for Medicare and Medicaid and how to apply for these services and benefits. Interview, on 10/20/11 at 2:45 PM, with the Business Office Manager (BOM), in the Front Office, revealed the Resident Rights signs were posted in the front foyer, but there was no sign of how to apply for and use Medicare and Medicaid benefits. Interview, on 10/20/11 at 2:50 PM, with the Administrator, in the Front Office, revealed she would research and locate the sign and indicate to the surveyor where the signage was located. Further interview validated, she was not able to locate a sign related to how to apply for and use Medicare and Medicaid benefits.	F 156		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain and promote the dignity of residents in a manner and in an environment that maintained or enhanced their dignity. The facility failed to ensure meal trays were served in a manner to promote dignity	F 241		

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F 241	Continued From page 4 and enhance the residents' individuality for unsampled residents in the Unit One (1) dining room. The findings include: Observation, on 10/18/11 at 11:55 AM, of the lunch meal, in Unit One's (1) dining room, revealed trays were being served and one (1) resident at table one (1) and one (1) resident at table two (2) did not receive their trays before staff served other tables. Continued observation, on 10/18/11, of the lunch meal in Unit One's (1) dining room, revealed the unsampled resident at table one (1) continued to be without a tray while the other residents were eating and table five (5) was being served. Further observation, revealed staff was serving table three (3) while one (1) resident at table one (1) and one (1) resident at table two (2) still had no tray. Continued observation revealed staff was serving table six (6) while residents at tables one (1), two (2), and three (3) were still not completely served. Observation further revealed staff was serving table seven (7) while residents at table one (1), two (2), and six (6) still were not yet served their meal. Observation at 12:05 PM revealed there was a ten (10) minute wait for the unsampled resident at table two (2) to receive his/her tray while the other residents at the table were consuming their meal. Observation, on 10/18/11 at 12:10 PM, in Unit One's (1) dining room, revealed an unsampled resident at table one (1) asked Registered Nurse (RN) #13 why he/she had not received his/her tray. Observation revealed fifteen (15) minutes	F 241	F 241 Meal trays were prepared and served immediately upon recognition of un-served residents presence in the dining room on 10/18/2011. The Unit Coordinators completed an audit on 10/18/2011 of the dietary intake record of all residents who were served in the dining room to identify any residents with decreased meal intakes related to this deficient practice. No residents were found to be affected. The deficient practice had the potential too affect all residents with PO diets, but only identified residents in F tag 241 were affected with untimely service. Immediate interview by the Unit Coordinators of the nursing and dietary staff on 10/18/2011 serving the dining room revealed no other residents were found to be affected by this deficient practice. The Social Services Director interviewed all interview able residents on 11/04/2011 concerning any dignity issues; no areas of concern were identified. All staff was in-serviced on 10/21/2011 by the Ombudsman on resident rights. All staff was in-serviced by the Social Services Director and Staff Education Nurse on 11/11/2011 on promoting and enhancing residents dignity. On 10/19/2011 the Dietary Manager designated a dietary staff	

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F 241	Continued From page 5 had lapsed since the other residents at table one (1) were served. Interview, on 10/18/11 at 12:10 PM, with RN #13, in Unit One's (1) dining room, validated the unsampled resident had asked RN #13 if he/she had been forgotten because he/she didn't have a tray yet. Interview, on 10/18/11 at 12:15 PM, with License Practical Nurse (LPN) #3, in Unit One's (1) dining room, revealed the facility did not have assigned seating for the residents in the dining room. Further interview revealed trays normally came out table by table and all residents at each table should have been served before serving other tables. Observation of the evening meal, on 10/18/11 at 4:35 PM, in Unit One's (1) dining room, revealed staff served meal trays to the restorative table first then staff began to serve table one (1). Then staff began to serve table seven (7), however before all residents were served at table seven (7), staff began serving table six (6). Then, staff began serving table three (3), but all the residents at table six (6) were not completely served. Staff began serving table two (2) leaving residents at tables six (6) and three (3) with no meal while other residents at those tables were eating. One (1) unsampled resident at table two (2) waited ten (10) minutes for his/her tray while other residents at the table were eating their meals. Interview, on 10/18/11 at 5:00 PM, with State Registered Nursing Assistant (SRNA) #4, in Unit One's (1) dining room, revealed each table should be served before another table is started.	F 241	member for all meals to observe for arrival of resident to the dining room and notification of dietary staff for preparation of meal tray. All Dietary staff was in-serviced on 10/19/2011 on the new designation of staff and responsibilities of designation by the Dietary Manager. All Dietary and Nursing staff were in-serviced on 11/11/2011 on proper policy and procedure on dining room meal service with emphasis on serving all residents at one table before serving residents seated at another table and the proper procedure for identifying any residents that arrive in the dining room after meal service has started. The Dietary Manager and/or Restorative Nurse and/or Charge nurse will monitor this procedure Sunday – Saturday to ensure all residents are being served timely upon arrival to the dining room. The Dietary Manager and/or Restorative nurse and/or Charge nurse will notify the Director of Nursing with any areas of concern immediately. The Director of Nursing will report all findings to the Quality Assurance committee monthly and the committee will track and trend all findings to determine if any further changes are necessary. 11/12/2011	

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F 241	Continued From page 6 Further interview, validated SRNA #4 served a tray to a resident at the next table when all the residents at table six (6) had not yet been served.	F 241	F 281	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure services provided met professional standards of care. The facility failed to ensure Physician's Orders were followed for one (1) of fifteen (15) sampled residents (Resident #10). Resident #10's Physician's Orders were not followed related to checking the resident's dialysis arteriovenous (AV) fistula for a "buzz" (placing a finger over the AV fistula for at distinct buzzing feeling) three times a day. The findings include: Review of Resident #10's medical record revealed diagnoses which included Chronic Kidney Disease, and Renal Failure. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 07/19/11, revealed the facility assessed the resident as having moderate impairment in cognitive skills for decision making and as receiving dialysis. Observation of the resident on 10/20/11 at 11:30 AM revealed a dialysis AV fistula in the resident's left arm.	F 281	On 10/20/2011 the Unit Coordinator in-serviced the Charge nurse on following physician orders and verifying the frequency of an order. On 10/20/2011 the Charge Nurse immediately corrected Residents #10's Treatment Administration Record to reflect the physicians order of checking the buzz 3 times a day. On 10/27/2011 and 10/28/2011 the A and B unit charge nurses audited all physicians orders to ensure physicians orders were accurately transcribed to the appropriate location. No other physician orders were found to be affected by this deficient practice. On 10/21/2011 and 11/11/2011 the Unit Coordinators in-serviced all nurses on transcription and implementation of physicians orders. The Unit Coordinators will audit 25% of all transcription and implementation of physicians orders weekly and will report all findings to the Director of Nursing weekly. The Director of Nursing will report to the Quality Assurance Committee monthly and the committee will track and trend the findings of the audits to determine if further changes or education are necessary. 11/12/2011	

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F 281	Continued From page 7 Review of the Physician's Orders dated 10/11 revealed orders for dialysis on Monday, Wednesday, and Friday and to check the dialysis AV fistula for a buzz three (3) times a day and call the Physician if unable to feel the buzz. Review of the Treatment Administration Record (TAR) for 10/11 revealed instructions to feel for buzz three (3) times a day, and call the Physician if unable to feel the buzz. Further review revealed the TAR was marked for this to be completed on the day shift and night shift (two (2) times a day). The TAR was initialed as the intervention being completed on the day shift and night shift for 10/01/11 through 10/20/11. Interview, on 10/20/11 at 3:00 PM, with Licensed Practical Nurse (LPN) #1 who was assigned to Resident #10, revealed the nurses worked twelve (12) hour shifts and she worked the 6:00 AM to 6:00 PM shift three (3) days a week. She stated she checked the buzz one time on her shift. Further interview verified the TAR had instructions to check the buzz three (3) times a day; however, was only signed off as being checked two (2) times a day. Interview, on 10/20/11 at 3:00 PM, with the Unit Manager assigned to Resident #10, revealed the nurses on day shift were to check the buzz two (2) times during the shift, although the TAR was just marked to check the buzz on days and evenings and the documentation did not indicate the buzz was being checked three (3) times a day. Further interview revealed she was unaware LPN #1 was just checking the buzz one (1) time during the day shift.	F 281		

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined the facility failed to meet the requirement to store, distribute, and serve food under sanitary conditions. Observation on 10/18/11 revealed the facility failed to identify the storage of fifteen (15) eight (8) ounce cartons of chocolate milk with an expiration date of 10/04/11. Observation further revealed the Holbart Blender and the bowl of the small blender were stored dirty. The findings include: Observation, on 10/19/11 08:50 AM, revealed that the Holbart Blender had thin, yellow colored oil on top of the mixing head, support stand, spindle and inside the mixing bowl. Further observation revealed the blender was covered in an opaque, white plastic bag. Observation, when the bag was removed, revealed a thick, dark, congealed material was on the Holbart Blender guides. Further observation revealed when the blender bowl was removed a half empty bag of 'Snyder's'	F 371	F 371 The dietary staff immediately cleaned the Holbart blender and small electric mixer on 10/19/2011 and the Snyders pretzels and cartons of chocolate milk were immediately discarded of on 10/19/2011. The Dietary Manager conducted a cleaning audit of the entire kitchen on 10/19/2011 and no other areas were found to be affected by this deficient practice. The Dietary Manager conducted an audit of all perishable items on 10/19/2011 and no other items were found to be affected by this deficient practice. All Dietary Staff were in-serviced by the Dietician and Dietary Manager on 11/04/2011 on proper cleaning and storage procedures for all equipment in the kitchen, proper guidelines for discarding of perishable items, the cleaning check-off list and monitoring of perishable items daily. The Dietary Staff will be responsible for a cleaning check-off list of all equipment Sunday- Saturday and the Dietary Manager will audit the cleanliness of the equipment Monday-Friday and the Cook will audit the cleanliness of the equipment on Saturday and Sunday and will immediately inform the Dietary Manager of any concerns.	

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F 371	Continued From page 9 brand 'Sourdough Nibbles' was stored beneath. Interview with Dietary Staff #1 and Dietary Staff #2, on 10/19/11 at 09:00 AM, revealed that all dietary equipment should be cleaned and covered when not in use. Continues interview confirmed the blender was stored dirty, covered in an oily substance and could not be used for food preparation. Interview with the Kitchen Manager, on 10/19/11 at 9:15 AM, revealed all kitchen equipment was to be cleaned daily, and covered to prevent dust accumulation. She confirmed the Hobart Blender was dirty with oil and could not be used to prepare food. She further stated that she usually inspected the equipment but had not noticed the oil. Observation, on 10/19/11 09:10 AM, revealed of small electric mixer with hard, white encrusted material in the bottom of the mixing bowl. Interview with Cook #1, on 10/19/11 9:10 AM, revealed she noticed the bottom of the mixing bowl was dirty (hard, white, encrusted material) prior to using it. Cook #1 stated the bowl should have been properly cleaned after the last use. Interview with the Kitchen Manager, on 10/19/11 at 9:15 AM, revealed the mixing bowl was dirty, and that it should have been properly cleaned after the last use prior to placing it in storage. Observation, on 10/18/11 at 10:15 AM, revealed fifteen (15), eight (8) ounce cartons of chocolate milk were stored in the refrigerator with an expiration date of 10/04/11.	F 371	The Dietary Manager will inform the Administrator of any areas of concerns immediately. The Dietary Manager will report to the Quality Assurance Committee monthly and the committee will track and trend all findings to determine if any further changes are necessary. All Dietary staff will be responsible for monitoring expiration dates of all perishable items on a daily basis. The Dietary Manager will audit all perishable items on Tuesday and Thursday and will report any identified areas of concern to the Administrator immediately. The Dietary Manager will report to the Quality Assurance Committee monthly and the committee will track and trend all findings to determine if any further changes are necessary.	11/05/2011

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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 371	Continued From page 10 Interview with the Kitchen Manager, on 10/18/11 10:15 AM, revealed out of date (expired) dairy products should not be stored in the walk-in refrigerator. The Kitchen Manager stated that expired items should be discarded immediately upon expiration.	F 371		
F 441 SS=D	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. (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	F 441	F 441 On 10/19/2011, 10/20/2011, and 10/21/2011 the Unit Coordinators in-serviced all nurses and medication aides on proper policy and procedure regarding contamination of pills during administration of medications. On 10/21/2011 all nurses and medication aides were in-serviced by the Unit Coordinators on proper hand hygiene during administration of medications. All nurses and medication aides were audited on medication pass administration by our consulting pharmacy between 10/24/2011 through 11/11/2011. No other residents were found to be affected by this deficient practice. On 11/04/2011 and 11/11/2011 all nurses and medication aides were in-serviced by our consulting pharmacy and the staff education nurse	

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	185314		C 10/20/2011

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 441	Continued From page 11 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 record review, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection. Observation during medication pass revealed staff failed to use proper hand hygiene prior to and after medication administration. In addition, staff was observed to drop pills on the medication cart, pick up the pills with their bare hands, and administer the medication. The findings include: 1. Observation of medication pass, on 10/18/11 at 5:00 PM, revealed Certified Medication Aide (CMA) #2 administered medications to Unsampled Resident C after adjusting the resident's bedside table. There was no evidence the CMA washed or sanitized her hands before or after administration of the medication to Unsampled Resident C. Further observation, on 10/18/11 at 5:07 PM, revealed CMA #2, then set up and administered	F 441	on proper policy and procedure for administration of medications. On 11/11/2011 all staff was in-serviced by the staff education nurse on proper hand washing techniques. On 11/03/2011 the infection control nurse audited the facilities infection control program in relation to the requirements of tag F 441. No areas of concern were identified. On 11/11/2011 all staff was in-serviced by the Infection Control Nurse on the facility infection control program. The Staff Education Nurse and/or Unit Coordinator will audit 3 nurses and/or medication aides during administration of medications weekly. The Staff Education Nurse and/or Unit Coordinator will report all findings to the Director of Nursing weekly. The Director of Nursing will report all findings to the Quality Assurance Committee and Infection Control Committee monthly. The Quality Assurance Committee and the Infection Control Committee will track and trend the findings of the audits to determine if further changes or education are necessary.	11/12/2011

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F 441	Continued From page 12 medications to Unsampled Resident B which included assisting the resident with administration of an inhaler with her bare hands. The CMA then walked out of the resident's room without washing or sanitizing her hands. Interview, on 10/18/11 at 5:15 PM with CMA #2, revealed she had never been observed to administer medications by the facility staff or the pharmacist; however, thought she only needed to wash or sanitize her hands after administration of medication to every three (3) residents during medication pass. Interview, on 10/20/11 at 3:30 PM, with the Infection Control Nurse and the Director of Nursing revealed they were unaware of any concerns with staff not using proper hand hygiene during medication administration, and staff was to wash or sanitize their hands prior to and after medication administration. 2. Observation of medication pass, on 10/19/11 at 8:15 AM, revealed Licensed Practical Nurse (LPN) #2 dropped a pill, picked it up with her bare hands and placed it in the medication cup with the other pills. The LPN then administered the cup of medications to Unsampled Resident A. Interview, on 10/18/11 at 8:25 AM, with LPN #2 revealed she should not have touched the pill with her bare hands and should have discarded the medication after she dropped it on the medication cart. 3. Observation of medication pass, on 10/19/11 at 9:15 AM revealed Registered Nurse (RN) #3 dropped two (2) pills on the medication cart and	F 441		

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F 441	Continued From page 13 picked them up with her bare hands. She then placed the pills in the medication cup and administered them to Resident #5. Interview, on 10/19/11 at 9:25 AM, with RN #3 revealed she was unaware she was not to touch pills with her bare hands and unaware she couldn't pick pills up off the medication cart when she dropped them. She stated she had been observed on medication pass by the administrative nurses and the pharmacist. Continued interview, on 10/20/11 at 3:30 PM, with the Infection Control Nurse and the Director of Nursing revealed the pharmacist randomly watched staff on medication pass, and each staff member was to be observed yearly. Further interview revealed staff was not to touch medication with their bare hands and was not to administer medication that had been dropped on the medication carts.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F 514 On 10/19/2011 resident # 6's chart was audited by The Unit Coordinator for code status documentation and the physician order sheet was updated to reflect code status. On 10/19/2011 the Unit Coordinators and Medical Records Director conducted a 100% audit of all current resident charts to ensure accuracy of code status orders. During the audit conducted by the Unit Coordinators and Medical Records Director on 10/19/2011, 19 additional residents charts were found to have	

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F 514	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy it was determined the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete, accurately documented and systemically organized for one (1) of fifteen (15) sampled residents (Resident #6). The facility failed to ensure the "do not resuscitate" (DNR) status was documented correctly for Resident #6 and failed to ensure forms were up to date. The findings include: Review of the facility's policy, "Code Status Policy," dated July 2011, revealed an order must be obtained from the resident's attending physician (or a physician that may be on call for the resident's attending physician) and signed by the physician. Review of Resident #6's medical record revealed the facility admitted Resident #6 with diagnoses which included Corinary Artery Disease, Depression, Functional Decline, Hypothyroidism, Pacemaker, Anxiety, and Insomnia. Further review revealed the resident's Power of Attorney (POA) signed a DNR consent form on 09/11/09, validating resident's wishes of being a DNR. Futcher review revealed on 11/04/09 the resident's physician signed the DNR order. Continued validation of Resident #6's current DNR status, revealed monthly Physician's orders dated October 2011, September 2011, August	F 514	conflicting documentation regarding code status but 100% of the spines of the residents medical record displayed accurate code status. All 19 identified residents with conflicting documentation regarding code status information were verified with the resident and/or responsible party for accuracy. A chart audit of all current residents was completed by the Unit Coordinators and Director of Nursing on 11/08/2011, 11/09/2011 and 11/11/2011 to ensure all requirements of F tag 514 was present in the medical record. No medical records were found to be deficient. On 10/21/2011 all nurses were in-serviced on verifying code status during change over each month, with new admissions and re-admissions to the facility by the Unit Coordinators. The pharmacy was contacted on 10/19/2011 to document code status of each resident on the preprinted medication administration records each month. On 10/27/2011 and 10/28/2011 the charge nurses completing change over audited 100% of all current residents code status to ensure accuracy. On 11/01/2011 the Unit Coordinators audited 100% of all current residents code status documentation to ensure accuracy and required documentation was present. No residents were found to be affected by	

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F 514	Continued From page 15 2011, and July 2011, all indicated resident was a full code status with a date of 09/10/09. Interview, on 10/19/11 at 9:30 AM, with Registered Nurse (RN) #13, revealed the first place she looks to determine the DNR status of a resident was the spine of the resident's medical record. Further interview, revealed when the chart was not available the Medication Administration Record (MAR) was the next place she would look. During the interview with RN #13, a record review was completed to determine if the DNR status was documented on the MAR. Record review, validated the DNR status was not on the Resident #6's MAR. Continued interview, confirmed if the chart was not available the nurse would not have knowledge of the DNR status of a resident. Interview, on 10/19/11 at 10:00 AM, with License Practical Nurse (LPN) #3, revealed the DNR status must match the physician order and the advance directive paperwork. Interview, on 10/19/11 at 10:15 AM, with LPN #2 revealed if the resident's medical record was not on the unit, she would not be able to determine the current DNR status of residents. Interview on 10/19/11 at 10:30 AM, with RN #4, revealed the Emergency Medical Services (EMS) DNR paperwork was handled by Social Services (SS) and then given to the units for placement in the medical record. Further interview revealed the nurses were to look at the spine of a medical record to determine the DNR status of residents and then the nurses were to look for the appropriate paperwork.	F 514	this deficient practice. On 11/11/2011 the Unit Coordinators in-serviced all nurses to transcribe all code status orders onto physicians telephone orders to be faxed to the pharmacy and audited by the Unit Coordinators Monday – Friday. All orders received on the weekend will be audited by the Unit Coordinators on the following Monday. The Unit Coordinators will audit the resident chart when code status orders are received to ensure all documentation is present and accurate in the medical record Monday – Friday and weekend orders will be reviewed on the following Monday. The Unit Coordinators will report all findings to the Director of Nursing as audits are completed. The Director of Nursing will report all the findings to the Quality Assurance Committee monthly and the committee will track and trend the findings of the audits to determine if further changes or education are necessary.	11/12/2011

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F 514	Continued From page 16 Interview, on 10/19/11 at 11:00 AM, with the Administrator, revealed she was not aware of this situation of the medical records being inaccurate and didn't know how it got that way. Further interview revealed nurses should be checking that information during the monthly change over with order verification. Interview, on 10/19/11 at 3:00 PM, with Resident #6, confirmed Resident #6's wishes was that of the DNR status.	F 514		

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	185314	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/19/2011

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 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 (5) 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 10/19/2011. Pioneer Trace Nursing Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was seventy three (73). The facility is licensed for ninety two (92). 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) of an "F".	K 000	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 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3	K 018		

RECEIVED NOV - 7 2011 BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Watson — TITLE: Administrator — (X6) DATE: 11/07/2011

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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	185314	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER TRACE NURSING HOME	116 PIONEER TRACE FLEMINGSBURG, KY 41041

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K 018	Continued From page 1 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors opening into the corridor would resist the passage of smoke, according to National Fire Protection Association (NFPA) standards. Doors opening into the corridor must resist the passage of smoke and fire. The deficiency had the potential to affect two (2) smoke compartments, twenty eight (28) residents, staff and visitors. The findings include: Observation on 10/19/2011 at 10:52 AM, revealed resident room doors three (3) and eight (8) would not resist the passage of smoke. Resident room door three (3) had a gap of approximately 1/4 inch at the top of the door. Resident room door eight (8) had a gap of approximately ½ inch at the door facing. The observations were confirmed with the Maintenance Director. Interview on 10/19/2011 at 10:52 AM, with the Maintenance Director, revealed he was unaware of the doors not resisting the passage of smoke.	K 018	K 018 The Maintenance Director ordered replacement doors for rooms (3) and (8) on 11/02/2011. The doors were a special order item and the delivery date is 11/15/2011. The doors will be installed by 11/21/2011 by the Maintenance Director. The Maintenance Director conducted a walk-thru audit of all doors in the facility on 11/03/11 and no other doors were found to be deficient. The Maintenance Director will conduct a monthly audit of all doors to ensure they met requirements. The Maintenance Director will inform the Administrator of any concerns immediately. The Maintenance Director will report all findings monthly to the Quality Assurance Committee and the committee will track and trend all findings to determine if any further changes are necessary.	11/22/2011

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K 018	Continued From page 2 Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials: Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.	K 018		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or	K 021		

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K 021	Continued From page 3 hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in exit corridors were held open only by approved devices, according to National Fire Protection Association (NFPA) standards. Doors located in an exit corridor are permitted only to be held open with devices that release upon activation of the fire alarm, sprinkler system or a combination of both. The deficiency had the potential to affect two (2) smoke compartments, fourteen (14) residents, staff and visitors. The findings include: Observation on 10/19/2011 at 11:09 AM, revealed the Maintenance Office, Environmental Office, and Dining Room doors were equipped with manual hold open devices. The observation was	K 021	K 021 The Maintenance Director immediately removed the manual hold open devices from the Maintenance Office, Environmental Office and Dining doors on October 19, 2011. The Maintenance Director conducted a walk-thru audit of all doors in the facility on 10/20/2011 and no other doors were found to be deficient. The Maintenance Director will conduct a monthly audit of all doors to ensure there are no manual hold open devices in place. The Maintenance Director will inform the Administrator of any concerns immediately. The Maintenance Director will report all findings monthly to the Quality Assurance Committee and the committee will track and trend all findings to determine if any further changes are necessary.	10/20/2011

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER TRACE NURSING HOME	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 021	Continued From page 4 confirmed with the Maintenance Director. Interview on 10/19/2011 at 11:09 AM, with the Maintenance Director, revealed he was unaware these manual hold open devices were not approved for that use. Reference: NFPA 101 (2000 edition) 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.	K 021		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185314		10/19/2011

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K 029	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection (NFPA) standards. Rooms that are used for storage of combustible materials must be equipped with a self closer. The deficiency had the potential to affect all staff in the kitchen area and laundry area. The findings include: Observation on 10/19/2011 at 10:49 AM, revealed a door for the pantry storage room did not have a self closer. The observation was confirmed with the Maintenance Director. Interview on 10/19/2011 at 10:49 AM, with the Maintenance Director, revealed the door's self closer had quit working about one (1) week ago and he had not replaced the malfunctioning self closer with a new self closer. Observation on 10/19/2011 at 10:41 AM, revealed a door in the laundry room did not a have a self closer. The observation was confirmed with the Maintenance Director. Interview on 10/19/2011 at 10:41 AM, with the Maintenance Director, revealed the door had never had a self closer. Reference: NFPA 101 (2000 edition) 19.3.2.1 Hazardous Areas. Any hazardous areas	K 029	K 029 The Maintenance Director placed self closers on the laundry and pantry room doors on 11/04/2011. The Maintenance Director conducted a walk-thru audit of all doors in the facility on 11/02/2011 and no doors were found to be deficient. The Maintenance Director will conduct a monthly audit of all doors to ensure that self closing devices are properly placed. The Maintenance Director will inform the Administrator of any concerns immediately. The Maintenance Director will report all findings monthly to the Quality Assurance Committee and the committee will track and trend all findings to determine if any further changes are necessary.	11/05/2011

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	185314		10/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER TRACE NURSING HOME	115 PIONEER TRACE FLEMINGSBURG, KY 41041

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K 029	Continued From page 6 shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated,	K 029		

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	185314	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/19/2011

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FLEMINGSBURG, KY 41041

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K 029	Continued From page 7 factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were illuminated according to National Fire Protection Association (NFPA) standards. Exit lighting must be arranged so the failure of one bulb would not leave the exit in darkness. The deficiency had the potential to affect all exits, ninety two (92) residents, staff and visitors. The findings include: Observation on 10/19/2011 at 10:46 AM, revealed exits from the facility were provided with a fixture containing a single bulb. The observation was confirmed with the Maintenance Director. Interview on 10/19/2011 at 10:46 AM, with the Maintenance Director, revealed all exits from the facility were provided with a fixture containing a single bulb. Reference: NFPA 101 (2000 edition)	K 045	K 045 The Maintenance Director replaced all exit lighting with dual bulb security lights by 11/17/2011. The Maintenance Director conducted a walk- thru audit of the facility on 11/02/2011 and no other exits were found to be deficient. The Maintenance Director will conduct a monthly audit to ensure all exit lighting meets requirements. The Maintenance Director will inform the Administrator of any concerns immediately. The Maintenance Director will report all findings monthly to the Quality Assurance Committee and the committee will track and trend all findings to determine if any further changes are necessary.	11/18 /2011

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	185314	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/19/2011

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K 045	Continued From page 8 7.8.1.4" Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination. level of less than 0.2 ft-candle (2 lux) in any designated area. A.7.8.1.4 An example of the failure of any single lighting unit is the burning out of an electric bulb.	K 045		