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

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		R-C 02/11/2016

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 An On-site Revisit Survey was initiated on 02/09/16 and concluded on 02/11/16. Based on the facility's acceptable Plan of Correction received on 11/30/15, it was determined the facility was in compliance as alleged on 11/27/15.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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

Acceptable POC 12/4/15 Requires revisit plan

PRINTED: 11/23/2015
FORM APPROVED
OMB NO. 0938-0391

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F 000	INITIAL COMMENTS	F 000		
	A Recertification Survey and on-site revisit for the 10/02/15 survey was initiated on 11/03/15 and concluded on 11/06/15. Continued non-compliance was identified with deficiencies cited with the highest Scope and Severity (S/S) of an "E".			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241	1. On 11/24/15, the Staff Development Coordinator and QAPI Nurse polled all residents, with Brief Interview for Mental Status Score (BIMS) equal to or greater than 8 and eat their meals in the dining room, regarding facility staff promoting environment of dignity and respect during their dining experience. All residents stated staff attempted to communicate to them during resident dining times.	
	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, interview, record review and review of the facility's policy, it was determined the facility failed to promote care for residents in a manner that maintained or enhanced each residents dignity and respect during meal services. Observation of the supper meal on 11/04/15 and the lunch meal on 11/06/15, revealed staff was talking with each other and not talking and interacting with the residents during meal service.		2. On 11/9/15, Administrator reviewed facility "Resident Rights Policy" and found policy to meet federal regulations. On 11/24/15, Staff Development Coordinator polled all residents in facility with BIMS of 8 or higher regarding staff promoting environment of dignity and respect during dining periods. One resident reported staff does not speak to resident during meal time, however,	
	The findings include:			
	Review of facility policy titled "Resident Rights", revised 08/13, revealed 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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR 12/3/15

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Observations on 11/04/15, from 4:45 PM until 5:15 PM, during the first (1st) supper seating revealed meal trays were served to the residents without staff attempting any verbal interactions with the residents. Staff would pick up the meal tray from the window, take the tray to the resident, remove the insulated lid and move on to serving the next tray.

Observation on 11/04/15 at 5:50 PM until 6:10 PM of the second (2nd) supper seating in the dining room for residents that needed total feeding assistance, revealed there was four (4) residents which staff was feeding; however, not interacting verbally. Further observation, revealed staff would put food in the resident's mouth, and look around or talk with another staff at the table until the resident was ready for another bite.

Observation on 11/06/15 at 11:50 AM, revealed staff were not interacting with residents during the lunch meal service, but staff was talking to other staff.

Interview with State Registered Nurse Aide (SRNA) #3 on 11/06/15 at 11:55 AM, and SRNA #5 on 11/06/15 at 11:57 AM, revealed they probably should be conversing more with the residents at mealtimes because it would seem more like home to have meal conversation.

Interview on 11/06/15 at 2:05 PM, with the Director of Nursing (DON), revealed it was important to interact with residents and she would like to see more conversation between staff and residents during meal service.

Interview on 11/06/15 at 2:20 PM, with the Administrator, revealed his expectation was for

F 241 did acknowledge that she did not require staff assistance to eat her meals. Resident did state that staff speaks to her when they deliver and remove her tray to/from room.

3. Beginning 11/9/15 through 11/20/15, Staff Development Coordinator educated all facility staff on conversing with residents in dining room to promote an environment of dignity and respect towards residents. Education included providing residents with alternative food choices when residents dislike food on tray.

4. Beginning 11/16/15, Staff Development Coordinator began auditing, twice a week, each meal and dining period for staff conversations and alternative food choices for residents to ensure environment promoting dignity and respect. Audit results will be presented before the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months then quarterly until 95% benchmark achieved. All issues found during the audit will be resolved immediately per facility

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staff to deliver trays timely, but stated it was also important to converse with residents and ensure their needs were met during meal service. The Administrator stated, staff should be making the dining experience comfortable for the residents and meal service issues would need to be addressed.

F 278 483.20(g) - (j) ASSESSMENT
SS=D ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

F 241 policy. The QAPI Committee consists of the Administrator, DON, ADON, Staff Development Coordinator, Social Services Director, MDS Coordinator, Dietary Manager, Maintenance Director, Therapy Manager, Activities Director, Housekeeping/Laundry

F 278 Supervisor, and QAPI Nurse.

11/27/15

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This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the Centers for Medicaid and Medicare (CMS) Resident Assessment Instrument (RAI), User Manual Version 3.0, it was determined the facility failed to ensure staff accurately coded the Minimum Data Set (MDS) Assessment for one (1) of sixteen (16) sampled residents (Resident #2). Review of the Annual MDS Assessment dated 02/16/15, for Resident #2, revealed the facility incorrectly coded for a Urinary Tract Infection (UTI).

The findings include:

Interview, on 11/06/15 at 2:04 PM, with the Director of Nursing (DON), revealed the facility used the CMS RAI, User Manual Version 3.0 for guidance to code the MDS.

Review of the CMS RAI, User Manual Version 3.0, section I, item 12300, UTI, revealed the UTI had a look back period of thirty (30) days for active disease. Further review revealed, code only if all the following were met; Physician, Nurse Practitioner, Physician assistant or clinical Nurse Specialist or authorized licensed staff as permitted by state law diagnosed a UTI in the last thirty (30) days, signs or symptoms attributed to UTI, significant laboratory findings, and current medication or treatment for a UTI in the last thirty (30) days.

Review of Resident #2's medical record revealed the facility admitted the resident on 05/22/14 with diagnoses which included Cerebrovascular Accident (Stroke), Hypertension (High Blood

F 278

1. On 11/9/15, MDS staff audited Resident #2 medical record and found that resident is not currently being treated for a Urinary Tract Infection.

2. On 11/9/2015, MDS staff audited all residents with a diagnosis for Urinary Tract Infections (UTI) to ensure Minimum Data Set (MDS) coding requirements had been met. Audit determined MDS staff coded these residents' MDSs according to requirements set forth in the Resident Assessment Instrument (RAI) Manual.

3. Beginning 11/9/15 through 11/20/15, the Staff Development Coordinator educated all licensed nurses were educated on RAI requirements for coding a UTI on the MDS. Education included time for question and answer period to determine staff knowledge and understanding.

4. Beginning 11/9/15, MDS staff began auditing all MDS assessments with UTI to ensure RAI requirements are met prior to completion of MDS assessment. The audit tool is a paper based audit that MDS Staff must fill

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Pressure), Hyperlipidemia (an abnormally high concentration of fats or lipids in the blood), and Benign Prostatic Hyperplasia (Enlarged Prostate).

Review of the Annual MDS Assessment dated 02/16/15, revealed in section C0500, the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of zero (0), revealing the resident had severe cognitive impairment. Further review of the MDS, revealed in section I Active Diagnoses, section 12300 was coded to reflect the resident had a UTI within the last thirty (30) days; the Assessment Reference Date (ARD) plus twenty-nine (29) days.

Review of the Nurse's Progress Notes dated 02/01/15 through 02/16/15 revealed no documented symptoms of a UTI. Review of the laboratory reports revealed no documented evidence of laboratory data reference to a UTI, 01/16/15 through 02/16/15.

Interview, on 11/05/15 at 3:40 PM, with Registered Nurse (RN) MDS Coordinator, revealed she was not in the MDS department when the Annual MDS was completed. Continued interview revealed the MDS nurse that completed section 12300 certified the MDS was accurate. Further interview, revealed the MDS was not accurate because the resident had no UTI's within the thirty (30) day look back period.

Continued interview with the DON, revealed she expected the MDS Coordinators to code based on an accurate assessment of the resident, using the four (4) criteria of the UTI and ensure the diagnoses was within the thirty (30) day look back period.

F 278 out if any resident had been treated for a UTI during assessment period. The audit tool will be turned in to DON, who will present audit finding to the QAPI Committee monthly for 3 months. QAPI Committee will determine further monitoring requirements at the time of the third month report.

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Interview, on 11/06/15 at 2:40 PM, with the Administrator, revealed it was his expectation for the MDS nurses to follow the RAI manual and be sure the information was correct before signing off on the MDS.

F 278

F 366 SS=D 483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE

Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of facility policy, it was determined the facility failed to ensure substitute meals were offered of similar nutritive value to residents who refused food served for one (1) of sixteen (16) sampled residents (Resident #10) and one (1) Unsampled Resident (Unsampled Resident A).

Observation on 11/05/15 during lunch meal service in the dining room, revealed Resident #11 had to go to the kitchen window to ask about meal substitutions due to the meal substitution not being posted. Also, interview with Resident #11 revealed staff sometimes did not want to take the meal tray back to the kitchen when he/she complained of receiving the wrong tray.

Observation on 11/04/15 of the supper meal service revealed Unsampled Resident A received a meal tray from State Registered Nursing Aide (SRNA) #1 and twice commented to SRNA #1 that he/she did not like the meal. However, SRNA #1 did not acknowledge the residents comments.

F 366 1. On 11/9/15, Dietary staff posted substitute food choices in Dining Room and outside Kitchen Door. The QAPI Nurse educated Resident #11 on where substitute food choices are posted. QAPI Nurse interviewed Unsampled Resident A regarding foods he/she did not like so those food would not be served to resident in the future.

2. Beginning 11/23/15 through 11/24/15, Staff Development Coordinator polled all residents with Brief Interview for Mental Status (BIMS) score of 8 or higher regarding whether residents are offered substitute food choices when they do not like the main choice. Some residents did state that they are not always offered substitute food choices.

3. On 11/9/15, Dietary staff posted a substitute food menu in Dining Room and outside Kitchen door. This menu

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Then, when SRNA #1 brought the last tray to Unsampled A's table for another resident, SRNA #1 was observed to tell Unsampled Resident A " you haven't even tried it, you need to eat it" and walked away without offering a substitute meal.

The findings include:

Review of facility "Alternate Foods" Policy undated, revealed staff was to offer an alternate food choice of entree and vegetable to residents that refuse menu items. The Alternate Foods were planned at the beginning of the menu cycle. Further review of the Policy, revealed alternate meals were to provide residents with choices and decrease the number of residents who refused meals.

1. Review of Resident #11's medical record revealed the facility admitted the resident on 07/03/14 with the diagnoses of Chronic Kidney Disease, Anxiety, and Urinary Tract Infection. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 08/13/15, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating the resident was cognitively intact.

Observation on 11/05/15 at 11:45 AM, revealed Resident #11 ambulated out of the dining room into the hallway and was looking at the posted menu for the lunch meal. Resident #11 then went to the kitchen window to inquire about the meal substitution for lunch.

Interview on 11/05/15 at 12:35 PM, with Resident #11 revealed the meal substitutions were not posted with the menu in the hall way next to the dining room and she/he was inquiring about the

F 366 is updated daily. Beginning 11/9/15 through 11/20/15, the Staff Development Coordinator educated all staff on substitute menu and where they are posted. Staff Development Coordinator educated, 11/9/15 through 11/20/15, all nursing staff will offer items from substitute menu when residents complain their meal. Education included time for question and answer period to determine staff knowledge and understanding.

4. Beginning 11/9/15, QAPI Nurse began auditing all Substitute food menu to ensure it is accurate and updated twice a week for 90 days. As part of this audit, the QAPI Nurse will observe the three meal times twice a week for staff offering substitute menu items appropriately. The QAPI Nurse will report audit results to QAPI Committee monthly. Any issues identified during audits will be addressed immediately and results reported to QAPI Committee.

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hot substitution meals. Resident #11 further stated, the residents had to go to the kitchen window and ask the kitchen staff about meal substitutions because the staff serving the dining room did not know the hot substitutions for each meal.

Interview on 11/06/15 at 9:20 AM, with Cook/Dietary Aide #1, revealed staff and residents were to ask about meal substitutions at the kitchen window. Continued interview revealed there was regular substitutions for the residents which were always available. "The cook decides on hot meal substitutions daily".

Interview on 11/06/15 at 9:23 AM, with Dietary Aide #2, revealed the facility offered the same sandwiches and soups daily, and the cook decided daily on the hot substitution for each meal. Further interview revealed the menus were posted in the hall but did not include the substitutions, and staff had to ask dietary staff at the kitchen window during meal service, what the substitutions were for the meal.

Interview on 11/06/15 at 9:30 AM, with the Dietary Manager (DM), revealed the hot meal substitutions were not posted because they were planned daily by the cook. The DM stated staff had to ask what the alternate and hot meal substitutions were for each meal when a resident did not like the meal offered.

Further interview on 11/06/15 at 11:00 PM, with Resident #11, revealed he/she did not like having to go to the kitchen window to ask about meal substitutions. Resident #11 revealed, staff often brought him/her the wrong tray, then did not want to take the tray back to the kitchen to get him/her

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F 366

another tray, and would tell him/her to eat the food they brought. Resident #11 stated staff should be treating residents better and this made him/her upset.

2. Observation on 11/04/15 at 4:45 PM, of the first (1st) supper seating in the dining room revealed State Registered Nurse Aide (SRNA) #1 served Unsampled Resident A's evening meal, which included a whole ham salad sandwich, with lettuce/tomato garnish, canned fruit, an unopened cookie package, and approximately 360 milliliters (ml's) of fluids. Continued observation revealed Unsampled Resident A made a face and stated he/she did not like the meal. SRNA #1 walked away without acknowledging Unsampled A's comment. SRNA #1 then served another resident at the table; and again Unsampled Resident A was heard stating he/she did not like the meal. Upon SRNA #1 bringing the last resident's tray to the table, an auditory/visual observation revealed SRNA #1 told Unsampled Resident A " you haven't even tried it, you need to eat it", and then SRNA #1 walked away without offering a substitute meal.

Phone interview with SRNA #1, on 11/06/15 at 3:30 PM, revealed he remembered telling Unsampled Resident A to "eat the sandwich, you haven't even tried it". However, further interview revealed SRNA #1 was unsure if this was an inappropriate comment to make to a resident.

Interview on 11/06/15 at 2:05 PM, with the Director of Nursing (DON), revealed her expectation was for staff to offer residents a meal substitution when residents indicated they did not like the meal which had been served, as per policy and dietary issues needed to be

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addressed. She further stated the meal substitutions needed to be posted.

Interview on 11/06/15 at 2:20 PM, with the Administrator, revealed staff should be making the dining experience comfortable for the residents and meal service had been an area of concern in the past. Further interview revealed the facility needed to address issues with meal service.

F 366

F 465 483.70(h)
SS=E SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined the facility failed to ensure the dumpster lids were covering the receptacles when not in use, the dumpster area was free of large items no longer in use, and containers near the dumpsters were kept free of standing water.

The findings include:

Review of the facility policy entitled "Waste Control, A:6.10", undated, revealed dumpster lids were to be closed at all times when not in use and the dumpster should be emptied per the facility's contract with the waste removal company.

F 465

1. On 11/6/15, Maintenance Director closed all lids to dumpster and removed all a Television, large barrel, and a cart from area near dumpsters.

2. All residents had potential of being affected.

3. On 11/9/15, Administrator reviewed facility policy "Waste Control" and determined that policy met federal regulations. Beginning 11/9/15 through 11/20/15, the Staff Development Coordinator educated all staff on keeping dumpster lids closed and area around dumpsters clear of hazards to residents. Education included time for question and answer period to determine staff knowledge and understanding.

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F 465	Continued From page 10 Observations on 11/04/15 at 3:45 PM, 11/05/15 at 11:40 AM and 11/06/15 at 1:45 PM revealed the dumpster lids were not covering the trash inside the two (2) dumpsters, there was a discarded mattress and television (TV) set near the dumpsters, and a large barrel and cart, both with standing water, beside the dumpsters. Interview with the Maintenance Supervisor, on 11/06/15 at 1:45 PM, revealed all staff was responsible for ensuring the dumpster lids were closed. He stated he would close them if he was in the area and noticed they were not closed. Continued interview revealed staff would sometimes just use one (1) side of the dumpster and the lids would not close. Further interview revealed dumpster pick up was on a Monday, Wednesday, Friday schedule. He continued by stating that unused or unwanted items, such as the mattress and TV, would be stored beside the dumpsters until there was enough items to make a load to be hauled off to the dump. Further interview revealed the containers with water in them by the dumpsters, could cause a possible insect infestation. Interview with the Director of Nursing (DON), on 11/06/15 at 2:05 PM revealed the dumpster lids should be closed at all times, the furniture items should have been put somewhere else other than in back by the dumpster and the barrel and cart should have been turned over so as not to collect water. Interview with the Administrator on 11/06/15 at 2:20 PM, revealed items by the dumpster were usually picked up on Wednesdays by the person that did lawn care for the facility, however, it obviously was not picked up this week. He stated	F 465	4. Beginning 11/9/15, Maintenance staff audited dumpsters and dumpster area to ensure lids are closed and area is free from debris. This audit is conducted weekly and will continue for 90 days. The Maintenance Director will report audit results to QAPI Committee monthly. Any issues identified during audits will be addressed immediately and results reported to QAPI Committee.	11/27/15

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		11/06/2015

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 465	Continued From page 11 The cart and barrel should not be by the dumpster as it could cause a potential problem with mosquitoes.	F 465		

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

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		R **02/11/2016**

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 000}	INITIAL COMMENTS An On-site Revisit Survey was initiated and concluded on 02/11/16. Based on the facility's acceptable Plan of Correction received on 01/28/16, it was determined the facility was in compliance as alleged on 02/04/16.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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

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		11/04/2015

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 000	INITIAL COMMENTS	K 000		

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 using a 2786S (Short Form) was conducted on 11/04/15. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid, Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The census on the day of the survey was seventy-eight (78). The facility was licensed for ninety-two (92) beds.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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