

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

PRINTED: 11/13/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185314</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>11/08/2013</b>
--	---	--	---

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

(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 offsite revisit was conducted, and based on the acceptable Plan of Correction, the facility was deemed to be in compliance as of 10/16/13 as alleged.

{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 11/13/13  
M

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/26/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000 INITIAL COMMENTS

A Standard Recertification Survey and Abbreviated Survey was initiated on 09/24/13 and concluded on 09/26/13, with deficiencies cited. The highest scope and severity was "E". KY#00020721 was unsubstantiated with no deficiencies cited. KY#00020749 was substantiated with "D" level deficiencies cited.

F 226 483.13(c) DEVELOP/IMPLMENT SS=D ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and review of facility policy, it was determined the facility failed to have an effective system to ensure policy and procedures were implemented related to abuse for one (1) of fifteen (15) sampled residents (Resident #1). On 09/23/13 at 2:00 AM, Resident #1 alleged that SRNA #6 entered the room and was verbally abusive. The facility failed to protect the resident from the perpetrator by allowing SRNA to continue to work until 4:22 AM per time clock detail report.

The findings include:

Review of the facility policy titled, "Abuse Prevention Plan", revised June 2013, revealed that any employee who is accused of any type of abuse or neglect will not be permitted to work

F 000  
F226 Abuse was unsubstantiated through internal facility investigation. Resident apologized for inappropriate behavior and indicated he would be more cordial with aides in future. Resident was counseled by Director of Social Services and is satisfied with facility handling of matter.

F 226  
No additional residents in the facility were identified who may have been affected by this deficient practice.

A list of residents with BINS greater than 8 was developed and provided to the Activities Director and those residents were encouraged to participate in a specially called resident council meeting conducted by the Director of Social Services on 10/3/13. Each resident was given a copy of the Residents Rights which was explained in detail. A new grievance policy was established and a new grievance/complaint form has been created for residents and families to report incidents.

Grievance/complaint forms are kept outside the Social Services office. Grievances are investigated immediately.

The new Grievance policy and procedure was also presented to families at a specially called Family Council meeting on 9/26, conducted by the Director of Social Services and the State Ombudsman.

No other allegations of abuse were documented.

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael Friedman</i>	ADMINISTRATOR'S SIGNATURE <i>Administratar</i>	(X6) DATE 11/13
--	---	--------------------

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/26/2013
NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 226 Continued From page 1 during the investigation.

Record review revealed Resident #1 was admitted to the facility on 01/04/11 and readmitted on 03/16/11, with diagnosis which included Chronic Obstructive Pulmonary Disease (COPD), Functional Decline, Depression and Anxiety. Review of the Annual Minimum Data Set (MDS), dated 04/24/13 and the Quarterly MDS dated 07/12/13, revealed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident had no cognitive deficits. Review of the Comprehensive Care Plan with a review date of 08/09/13, revealed Resident #1 to have an Activities of Daily Living (ADL) Self Care Deficit Care Plan with interventions which included allowing the resident to keep his/her urinal at the bedside per Resident #1's request.

Interview, on 09/24/13, at 4:45 PM, with Resident #1 revealed the resident alleged that Stated Registered Nursing Assistant (SRNA) #6 had entered his/her room on 09/23/13 at approximately 2:00 AM, to obtain vital signs. Resident #1 stated, "I refused to let him get my vital signs at 2:00 AM". Resident #1 indicated SRNA #6 stated he would tell the nurse of the resident's refusal of vital signs. Resident #1 stated he/she informed SRNA #6, he/she would tell the nurse the same thing. According to Resident #1, he/she dosed off and dropped his/her urinal on the floor. The resident stated he rang the call light and SRNA #6 came to the room and asked what Resident #1 needed. Resident #1 indicated he/she had dropped his/her urinal and needed it picked up. He/She stated SRNA #6 informed him/her he was getting vital signs at that time. The resident stated he/she told SRNA #6 he/she just needed his/her urinal. Resident #1

F 226 The SRNA and Charge Nurse involved in the initial action were in-serviced on facility Abuse Policy on 9/26/13, by Administrator and Staff Development Coordinator Susan Fulton.

All nursing and non-nursing staff were in-serviced on facility Abuse Policy by Administrator and Staff Development Coordinator on 9/27, 10/1, and 10/7, 10/14, and 10/15/13.

Compliance will be monitored by the Administrator for all incidents of suspected abuse and in monthly QA meetings for six months.

F226 Completed 10/16/13

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

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/26/2013
NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 2 stated SRNA #6 came over by his/her bed; however, did not pick up the urinal. The resident stated SRNA #6 turned and started to walk out of the room and he/she told the SRNA, "you're about an idiot". Resident #1 stated SRNA #6 walked back over to his/her bedside and stated to the resident, "you're a mother f**ker". He/She stated he/she believed he/she stated "all I want is my urinal and I will have your job". According to Resident #1, SRNA #6 walked out of his/her room without picking up the urinal and stated he would get the nurse. Resident #1 stated he/she had a "temper" and when he/she got mad he/she would "lose" his/her "cool". Resident #1 stated he/she overheard the nurse telling the SRNA not to go back in the resident's room the rest of the night.  Interview, on 09/25/13 at 3:00 PM, with SRNA #6 revealed he had gone into Resident #1's room at approximately 2:00 AM on 09/23/13 to take his/her vital signs (v/s). He indicated he took the residents temperature; however, when he prepared take Resident #1's blood pressure (b/p) he/she said "no you're not taking it". SRNA #6 stated he told the resident, "okay I'll tell the nurse" and left the room. He stated he went into another resident's room next door to get that resident's v/s, and thought he heard Resident #1 "yelling". SRNA #6 stated he went back into Resident #1's room to make sure he/she had not fallen and the resident asked him to pick up his/her urinal off the floor. Continued interview revealed SRNA #6 informed Resident #1, he would be "right back" as he wanted to make sure the b/p cuff was not still on the other resident's arm and left. According to SRNA #6, he went back into Resident #1's room a few minutes later, donned a glove and picked the urinal up off the floor. SRNA #6 stated Resident #1 told him, "you're an	F 226			

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

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/26/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226 Continued From page 3

idiot, I've been here 3 years and if you all don't get it right I'm going somewhere else". The SRNA indicated he tried to tell the resident he was sorry, however, Resident #1 told him, he/she would have his job. SRNA #6 stated Resident #1 told him he wouldn't be working at the facility the next day after calling him/her a "mother f\*\*ker". SRNA reported he told Resident #1 he had not called him/her any names. He stated he then left the room and went to report this occurrence to the nurse. SRNA #6 stated the nurse told him not to go back into Resident #1's anymore that night. The SRNA stated he had not called Resident #1 any names; he would not talk to anyone "that way". He stated he went to "lunch" at approximately 2:30 AM and when he came back the nurse told him to write out a statement, "clock out" and go home. SRNA #6 indicated that was what he did.

Review of the Time Clock Detail Report revealed on 09/23/13 SRNA #6 clocked out at 4:22 AM approximately two (2) hours after the allegation occurred. SRNA was allowed to continue to working during this time which allowed him access to all residents in the facility.

Interview, on 09/25/13 at 5:00 PM, with Licensed Practical Nurse (LPN) #1 revealed she was the nurse in charge of Resident #1's unit on the night shift which began on the night of 09/22/13. LPN #1 stated that SRNA #6 had come to the desk and told her that Resident #1 was being hateful with him. She stated SRNA #6 reported Resident #1 was accusing him of calling the resident names and was threatening him/her with to sending him/her to another facility. LPN #1 stated she went and talked with Resident #1 who was upset because SRNA #6 didn't stop and pick

F 226

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

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/26/2013
NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 226 Continued From page 4  
up his/her urinal before going back into the other resident's room. According to LPN #1, she instructed SRNA #6 not to go back into Resident #1's room. She stated she then went to the facility's other unit to ask what she should do as she didn't know what the policy and procedure was in this case. LPN #1 stated the other nurse told her to call the Director of Nursing (DON). She stated she called the DON and was instructed to have SRNA #6 complete a statement as to what had happened. LPN #1 reported the DON also informed her to let SRNA #6 know he would be suspended pending investigation results. The LPN stated the DON told her to walk SRNA #6 to the time clock and out of the building. LPN #1 stated she was not sure what time SRNA #6 went home or where he was while she was talking to the other nurse and DON to find out what the policy and procedure was.

F 226

Interview, on 09/26/13, at 7:50 PM, with the Director of Nursing (DON) revealed staff received training on the abuse policy and procedure upon hire, annually and anytime the facility felt there was a need for it. She stated when an employee was accused of abuse, that employee should write out a statement and be suspended pending the investigation results as per the facility policy.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

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

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/26/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280 Continued From page 5  
A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review it was determined the facility failed to ensure the comprehensive care plan was revised for one (1) of fifteen (15) sampled residents (Resident #1) related to not revising the care plan to include the information the resident had all his/her teeth pulled on 08/22/13 and to reflect any additional or new interventions the resident might require as a result of having his/her teeth all pulled.

The findings include:

Record review revealed Resident #1 was admitted to the facility on 01/04/11 and readmitted on 03/16/11, with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/12/13, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15)

F 280  
F280 CNA Care Plan for resident was updated on 9/26/13, by Care Plan Team to reflect current dental status. Acute and Chronic Care Plans were updated by Care Plan Team on 10/1/13 to reflect removal of teeth.

All resident Care Plans were reviewed by Unit Coordinators Michelle Marshall and Kim Breeze on 10/1/13. No additional residents were identified that may have been affected by this deficient practice.

Nursing Staff was in-serviced on 10/4 and 10/14/13 by Unit Coordinator Michelle Marshall, Director of nursing Sandy Mitchell, and MDS Coordinator Penny Scott on completion of Acute Care Plans, updating CNA Care Plans, documentation of acute incidents, and on writing orders of consultation recommendations.

Electronic weekly summary was changed on 10/1/13 by Unit Coordinator Michelle Marshall to reflect dental status of each resident.

Check-off sheet for monitoring consults has been developed and Unit Coordinators will monitor and report any inconsistencies at morning meeting and monthly in QA for three months.

Check off sheets are compared to care plans for presence of appropriate updates by Unit Coordinators daily, Monday through Friday.

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

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/26/2013
NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	Continued From page 6 which indicated the resident was cognitively intact. Further review of this MDS Assessment revealed the facility assessed Resident #1 to have broken or loosely fitting full or partial dentures. Record review of a dental consult dated 08/22/13 revealed all of Resident #1's teeth had been pulled on that date.  Observation, on 09/24/13 at 2:15 PM, 3:30 PM and on 09/25/13 at 8:30 AM, 10:00 AM, 11:50 AM, 12:50 PM and 3:15 PM, of Resident #1 revealed he/she had no teeth or dentures in his/her mouth.  Review of Resident #1's Comprehensive Care Plan dated 08/6/13, revealed the resident was care planned for dental health problems related to loose and broken teeth. However, there was no documented evidence the care plan had been revised after Resident #1 had all his/her teeth pulled on 08/22/13.  interview, on 09/26/13 at 8:10 PM, with the Director of Nursing (DON) and Registered Nurse (RN) #5/MDS Coordinator revealed that acute issues were care planned by the nurse on the floor when an event occurred or an order was received; and, the MDS Coordinator reviewed and revised the care plan quarterly. According to the DON and MDS Coordinator, the dental health problem care plan should have been revised to include the fact that all of Resident #1's teeth had been pulled on 08/22/13, and to reflect any additional oral care needs the resident might have.				
		F 280	The MDS nurse monitors the weekly summaries with each MDS quarterly to assure accuracy in reflecting resident changes with the revision of Care Plan. electronic weekly summaries are monitored by the Charge Nurse with completion of each weekly summary to ensure chronic and CNA Care Plans are updated to reflect current resident status.  Unit Coordinators will monitor and compare to Care Plans and report any inconsistencies at morning meeting and monthly in QA for three months.  Completed 10/15/13		
F 281 SS-D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/26/2013
NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
F 281	<p>Continued From page 7</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure services provided met professional standards of quality for one (1) of fifteen (15) sampled residents (Resident #1) as evidenced by failure to ensure Physician Orders were followed.</p> <p>The findings include:</p> <p>Record review for Resident #1 revealed the resident was readmitted to the facility on 03/16/11, with diagnoses which include Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF). Review of the Quarterly Minimum Data Set (MDS) dated 07/12/13, revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating no cognitive impairment. Review of the September Monthly Physician Orders revealed Resident #1 had an order to wear oxygen (O2) at two (2) liters per minute (LPM) per nasal cannula continuously.</p> <p>Observations, on 09/24/13 at 2:15 PM, 3:30 PM and on 09/25/13 at 8:30 AM, 10:00 AM, 11:50 AM, 12:50 PM and 3:15 PM, of Resident #1 revealed an oxygen concentrator sitting behind the resident's bed; however, the concentrator was not turned on. Observations revealed no visual evidence Resident #1 was wearing a nasal cannula.</p> <p>Interview, on 09/25/13 at 3:15 PM, with Resident</p>	F 281 F 281	<p>New Physician's Order was received on 9/27/13 changing resident oxygen order from continuous to as-needed.</p> <p>All resident charts were reviewed on 10/2/13 by Unit Coordinators Michelle Marshall and Kim Breeze to identify residents refusing care without proper intervention by nursing staff. No additional residents were identified who may have been affected by this deficient practice.</p> <p>Nursing staff was in-serviced on 10/4 and 10/14/13 by Staff Development Coordinator Susan Fulton and Director of Nursing Sandy Mitchell regarding notification of Physicians and subsequent change in resident orders and care requirements. In addition, a new trigger was added on eMar on 10/2/13 by Unit Coordinator Michelle Marshall.</p> <p>A Trigger was added on eMar to prompt the Charge Nurse to complete a progress note when a medication or a treatment is refused by a resident. That Trigger sends the high risk progress note to Point Click Care Dashboard which is reviewed daily, Monday through Friday, by Unit Coordinators. Unit Coordinators ensure that the physician has been notified of any resident changes.</p>

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

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/26/2013
NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 281	Continued From page 8 #1 revealed the resident indicated he/she did not want to use oxygen except at night. Resident #1 stated if the nursing staff checked his/her oxygen saturation levels and it was low, he/she would "put it on for a while".  Interview, on 09/26/13 at 8:10 PM, with the Director of Nursing (DON) and MDS Nurse revealed the Physician's Order indicated Resident #1 was to wear the oxygen continuously. They stated if Resident #1 refused to wear the oxygen continuously the Physician should have been notified of this information and clarified if the resident needed to wear the oxygen continuously or as needed.	F 281	Compliance will be monitored through visual inspection of all Physician's orders by Unit Coordinators daily, Monday through Friday, to ensure implementation of all Physician's orders. Any inconsistencies will be reported in morning meeting and to the QA Committee in monthly meetings for three months.		
F 323 SS=E	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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policy, and review of the facility's Census and Condition Report it was determined the facility failed to ensure the environment remained as free of accidents hazard as was possible for residents. Observation during the initial tour revealed the maintenance room door to be unlocked and unoccupied with hazardous chemicals & tools	F 281  F 323	Completed 10/15/13		

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

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 09/26/2013
NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 9</p> <p>stored there. In addition, observation during the initial tour revealed the "clean up station" door was not latched and two (2) chemicals was stored in this room.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Chemical Storage" (no date) revealed, the facility recognized the need to protect residents from harm caused by environmental hazards and various materials could pose a potential hazard to residents; therefore the storage for hazardous materials should follow the manufacturer's recommendations for Material Safety Data Sheet (MSDS).</p> <p>Review of the facility's Census and Condition form revealed of the forty-three (43) residents with Dementia, six (6) of them could move independently about the facility. These residents included Residents #8, and Unsampled Residents D, E, F, G and H.</p> <p>Observation, on 09/24/13 at 2:10 PM, during initial tour revealed the "clean up station" room door on the facility's "B" Hall, adjacent to the nurse's station, was unlocked and accessible to residents. Observation revealed two (2) chemicals were stored in this room; one (1) bottle of Clorox Clean-up (a cleaning and disinfecting spray) and one (1) container of Sani-wipes (a germicidal disinfectant wipe).</p> <p>Review of the MSDS for Clorox Clean-up revealed, harmful if swallowed, may irritate eyes, nose, throat and lungs and may exacerbate conditions of the heart and lungs and seek medical attention if swallowed. Sani-wipes MSDS</p>	F 323 F323	<p>Maintenance Director and the contents of his office were moved to another building on the premises on 9/27/13.</p> <p>All residents in the facility had the potential to be affected by the deficient practice, however, no specific residents were identified who were affected, and there were no negative outcomes.</p> <p>All hazardous materials were removed from Maintenance Director's office and office was re-purposed for another use.</p> <p>The entire facility was checked for additional hazardous materials on 9/27/13 by Maintenance Director. None found.</p> <p>A new safety checklist was created to include checking of facility doors required to be locked. Beginning 10/1 Maintenance Director will check all doors required to be locked fist thing in AM and last thing in PM.</p> <p>Checking of locked areas included in QA rounds daily by Maintenance Director.</p> <p>Compliance monitored by QA committee for 90 days and quarterly thereafter.</p> <p>Completed 10/15/13</p>	

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

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/26/2013
NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE

F 323 Continued From page 10  
revealed to consult a physician if swallowed.

Additional observation, 09/24/13 at 2:40 PM, revealed the maintenance room door to be unlocked and unoccupied with hazardous chemicals accessible to the residents. These chemicals included, Delimer, five (5) bottles of Re Nu Coil Cleaner, Goof Off, two (2) cans of Smoke Check, Clear One Scale Remover, Polyurethane, Miniwax Stains, Inspectra Shield Fire Retardant, Protreat Pan Treatment, Actabs Air Conditioner Treatment, Silicone Adhesive Sealant, High Heat Silicone Sealant, Bioblast Foaming Coil Cleaner, Plastic Welder Performance Polymers, Tile Guard Grout Sealer, No Flash Electro Contact Cleaner, five (5) one (1) quart drain cleaners, Fast Band Contact Adhesive, Oatey Purple Primer, Miniwax stain, Henrys Best Floor Tile Adhesive, Desolve Drain in-line control, fifteen (15) quarts of One Shot Alikali Drain Opener, six (6) tubes of Dry Lube, four (4) loose screw looseners, eight (8) tubes of Acrylic Caulking for window and door sealer, one (1) can Kitz spray primer/sealer, two (2) gallons of Porter paint, one (1) gallon of mineral spirits, one (1) gallon of insecticide, and a variety of tools including two (2) drills, a box knife, screwdrivers, hacksaw, two (2) propane torches, a hammer and various other tools. Observation revealed five (5) residents were present in the dayroom adjacent to the maintenance room door.

Record review revealed two (2) of the five (5) residents, Resident #8 and Resident #13 could independently move about the facility. Further record review revealed Resident # 8 was admitted to the facility on 12/10/12 with diagnoses of Dementia, Impaired Thought Process, Depressive Disorder and Organic Brain Damage.

F 323

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

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/26/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323 Continued From page 11  
Record review revealed Resident #8 had a history of suicidal ideations.

Review of the manufacturer's Material Safety Data Sheet (MSDS) for Delimer, revealed it caused damage and or burns to the esophagus, mucous membranes, eyes and skin. Review of the MSDS for Re-Nu foam coil cleaner, revealed it was an acute immediate health hazard. Review of the MSDS for SmokeCheck, revealed it contained propane and butane and the liquid could cause severe burns to the skin and might lead to brain damage or death. Review of the MSDS for Scotsman Ice Machine Cleaner, revealed this product might form Hydrogen gas and might cause irreversible respiratory tract damage. Review of the MSDS for Inspecta-Shield Plus revealed, the product was harmful if swallowed. Review of the MSDS for Protreat tables revealed it was corrosive and moderately toxic if ingested. Review of the MSDS for Ketoxime Silicone Sealant revealed, the product caused eye and skin irritations. Review of the MSDS for Liquefied Petroleum Gas, revealed it caused central nervous system effects. Review of the MSDS for Devcon Plastic Welder, revealed the activator was flammable, harmful and a skin sensitizer that was an irritant to eyes, skin, inhalation and ingestion. Further review of the MSDS for the Devcon Plastic Welder revealed the adhesive from this manufacturer contained acid and was flammable, with the fine mists to be explosive below flash point. Review of the MSDS for Tile Guards Silicone Tile Grout Sealer, revealed this product caused eye, skin, and respiratory tract irritations. Review of the MSDS for Mule Kick Liquid Caustic Drain Opener, revealed contact with the eyes could cause blindness, contact with the skin

F 323

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

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185314	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/26/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323 Continued From page 12  
caused severe burns and destroyed tissue. Review of the MSDS for No Flash revealed this product could result in acute and chronic toxicity. Review of the MSDS for Oatey Purple Primer/Cleaner, revealed it was a suspected carcinogen and was harmful if swallowed, inhaled or came into contact with the skin. Review of the MSDS for 3M Fastbond Contact Adhesive revealed, it might cause blindness, decrease or completely eliminate the ability to detect odors and other neurological effects. Review of the MSDS for Henry 130 Black Thin Spread Floor Adhesive, revealed this chemical was a depressant for the central nervous system. Review of the MSDS for Desolve, revealed it was extremely corrosive and might produce burns, cause blindness and could cause death. Review of the MSDS for Henry 440 Cove Base Adhesive, revealed it was an irritant to eyes and respiratory tract. Review of the MSDS for One Shot, revealed it to be corrosive to the eyes and body tissues. Review of the MSDS for Dry Lube, revealed it might cause unconsciousness and possible death. Review of the MSDS for Loose Screw and Screwloose Industrial Penetrating Oil, revealed this product could result in irritation to the respiratory tract and affect the central nervous system. Review of the MSDS for Concrete Acrylic Caulk, revealed it was harmful if swallowed and might cause eye, skin, noes, throat and respiratory tract irritation. Review of the MSDS for PPG Paint, revealed it might be harmful if inhaled or swallowed and caused organ damage. Review of the MSDS for Mineral Spirits revealed it to be a combustibile product that was harmful or fatal if swallowed. Review of the MSDS for Spectracide Bug Stop, revealed the product to be harmful if absorbed through the skin. Review of the MSDS for Kiz Aerosol and

F 323

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

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 09/26/2013
NAME OF PROVIDER OR SUPPLIER  PIONEER TRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE FLEMINGSBURG, KY 41041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 13</p> <p>Primer revealed this product to be extremely flammable and caused toxic effects. Review of the MSDS for Total Knock Out revealed, this product could be corrosive to mucus membranes. Review of the MSDS for Minwax wood finish products, revealed the products could result in irritation of eyes, skin, respiratory tract, unconsciousness and even death.</p> <p>Interview, on 09/24/13 at 2:10 PM, with Certified Nursing Assistant (CNA)#1 revealed the door to the "clean up station room" should be locked. The CNA stated the products stored there would be harmful to a resident if they got them.</p> <p>Interview, on 09/24/13 at 2:15 PM, with Licensed Practical Nurse (LPN) #2 revealed she was unaware of how long the "clean up station room" door had not latching shut. She stated the chemicals would be harmful should a resident get to them.</p> <p>Interview, on 09/24/13 at 2:55 PM, with the Housekeeping Supervisor revealed Clorox Clean-up should not be stored in the "clean-up station room", if the door was not secured. The Housekeeping Supervisor stated the product would be harmful should a resident get to it.</p> <p>Interview, with the Maintenance Director on 09/24/13 at 2:40 PM, revealed the door was usually locked and he should have locked it upon exiting. He stated the chemicals and tools would be harmful, should a resident get to them. He stated he was not aware he had to have an MSDS sheet for all the chemicals stored in the facility.</p> <p>Interview, on 09/25/13 at 3:05 PM, with the</p>	F 323			

PRINTED: 10/10/2013  
FORM APPROVED  
OMB NO. 0938-0391

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

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 09/26/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323 Continued From page 14  
Administrator revealed the maintenance door should be locked at all times. She stated, "yes" it would be harmful to the residents, if they got in these rooms.

F 323