STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185314	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER TRACE GROUP, LLC	**115 PIONEER TRACE FLEMINGSBURG, KY 41041**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, it was determined the facility failed to protect residents from physical abuse for one (1) of five (5) sampled residents (Resident #2). On 06/11/2020 at 9:30 PM, Resident #1 struck Resident #2 during an altercation, resulting in a skin tear. The findings include: Review of the facility Abuse Prevention Policy, revised 01/12/17, revealed physical abuse was defined as hitting, slapping, punching, kicking, and controlling behavior through corporal punishment. Continued review revealed the facility would provide each resident an environment free from any type of abuse, and any violations would be reported to the Office of the Inspector General within twenty-four (24) hours of the initial report, or two (2) hours if significant injury or death had occurred. Review of the facility Investigation, dated 06/16/2020, revealed an allegation of physical abuse occurred on 06/11/2020 at 9:30 PM. Per the Investigation, State Registered Nurse Aide (SRNA) #8 heard Resident #1 yelling, went to his/her room, and observed Resident #1 and Resident #2 hitting each other. Continued review revealed Resident #2 had followed Resident #1 into his/her room to get food, resulting in an altercation in which Resident #2 sustained a skin tear to his/her right arm. Both residents were placed on one-on-one (1:1) supervision until they went to bed, then placed on fifteen (15) minute checks throughout the night. Review of the Skin Assessment for Resident #1 and Resident #2, dated 06/11/2020, revealed no injury to Resident #1, and a skin tear to Resident #2's right forearm. Review of Resident #1's medical record revealed the facility admitted the resident on 08/22/19 with [DIAGNOSES REDACTED]. The facility assessed Resident #1 in a Significant Change Minimum Data Set (MDS) Assessment, dated 04/20/2020, as having a Brief Interview for Mental Status (BIMS) score of (3) out of fifteen (15), indicating severe cognitive impairment. Further, the facility assessed the resident as having behaviors of rejecting care. Review of Resident #1's Comprehensive Care Plan, initiated 09/11/19, revealed the resident was at risk for behavior/actions that place resident at risk for altercation with other residents related to impaired cognition, with a goal that the resident would interact safety within environment and respond to staff intervention as evidenced by no negative interactions with fell ow residents. Interventions included one on one (1:1) when agitated, or anxious, provide diversional activity, provide meaningful activity, redirect to safe area when wandering and remove from stimulating environment and allow time for rest and reflection. All interventions were initiated 09/11/19. The Care Plan was revised on 06/11/2020 related to the altercation with Resident #2, with new interventions to prevent further occurrence. Review of Resident #2's medical record revealed the facility admitted the resident on 05/04/17 with [DIAGNOSES REDACTED]. The facility assessed Resident #2, in Quarterly Minimum Data Set (MDS) Assessment, dated 06/02/2020, as having a Brief Interview for Mental Status (BIMS) of nine (9) out of fifteen (15), indicating moderate cognitive impairment. Further, the facility assessed the resident as having no behaviors. Review of Resident #2's Comprehensive Care Plan initiated 09/09/14, revised 12/28/17, revealed the resident had Behavioral Symptoms and would exhibit behavior related to verbal taunts to instigate altercations with other residents; makes noises while in hallway; repeats other resident's words, and also [MEDICATION NAME] and sings to disrupt environment. The goal stated the resident would have a decrease in behavioral episodes and be free from injury related to non-compliant behaviors through next review. The interventions included consult with Psyche Services as needed; document episodes of non-compliant behavior; educate resident on outcome of non-compliant behaviors; if taunting other residents, ask him/her to please not do so, and medications as ordered. Review of Resident #2's Progress Note, dated 06/11/2020, signed by Licensed Practical Nurse (LPN) #3, revealed staff heard yelling, and found Resident #2 in another resident's room, in an altercation over food. Further, Resident #2 had a skin tear to his/her right forearm 3 centimeters (cm) x 2 cm, and the Director of Nursing (DON) and Nurse Practitioner were notified. Continued review revealed attempts were made to notify Resident #2's family. Per the Note, a new order for treatment to Resident #2's skin tear was obtained. Resident #2's Comprehensive Care Plan was revised on 06/11/2020 related to the altercation with Resident #1, with new interventions to prevent further occurrence. Interview with Resident #2, on 06/22/2020 at 10:40 AM, revealed he/she and another resident got into it , and he/she had a healing skin tear to his/her right forearm. Resident #2 could not recall what the argument was about. Further interview revealed Resident #2 could not recall any previous incidents in which he/she was abused or harmed by residents or staff. When questioned if he/she felt safe at the facility, Resident #2 stated he/she would leave if he/she didn't feel safe. Interview with SRNA #8, on 06/23/2020 at 1:11 PM, revealed he was on his way to the shower room where the linen carts were kept to get some sheets for another resident, when he heard smacking. SRNA #8 stated he followed the sounds to Resident #1's room, and saw Resident #1 and Resident #2 sitting in their wheelchairs, smacking at each other. SRNA #8 stated he pulled Resident #2 out of Resident #1's room, and alerted Licensed Practical Nurse (LPN) #3. SRNA #8 stated he sat with Resident #2 until he/she went to bed. Per interview, Resident #2 told SRNA #8 he/she wanted some of Resident #1's snack crackers and had stuck his/her hand in the box even though Resident #1 didn't want to share. SRNA #8 stated he had never known either resident to act that way, and described the conflict as out of the ordinary for them. Interview with SRNA #4, on 06/22/2020 at 2:12 PM, revealed Resident #1 informed her about the incident that occurrence on 06/11/2020 between Resident #1 and Resident #2. She stated per her conversation with Resident #1, Resident #1 shared some of his/her snack crackers with Resident #2, and they got into an argument when Resident #2 went to get more without asking. She stated she wasn't able to make out anything else Resident #1 was trying to say, but since the incident she had not noticed any changes in either Resident #1's or Resident #2's behaviors. She stated Resident #1 had some trouble communicating, and would sometimes get agitated when he/she could not be understood. Interview with LPN #3, on 06/23/20 at 3:08 PM, revealed he had spoken with Resident #2 and attempted to speak with Resident #1 after the incident. Per interview, he determined Resident #2 had observed Resident #1 eating some snack crackers and followed him/her into his/her room to talk and eat some snack crackers. When Resident #2 reached to get some crackers without asking, Resident #1 struck him/her in the arm. LPN #3 stated he had assessed both residents, with no injury to Resident #1 and a skin tear to Resident #2's right forearm. LPN #3 described Resident #2 as good-hearted; however, stated other residents didn't always understand his/her social behaviors, and therefore he tried to keep Resident #2 where he could see him/her. LPN #3 stated there had not been any problems between the two (2) residents since the incident. The DON was on leave and unavailable for interview during the Survey. Interview with the Assistant Director of Nursing (ADON), on 06/23/2020 at 2:25 PM, revealed it was her expectation staff would protect residents from abuse to the best of their ability. She stated both Resident #1 and Resident #2 ambulated with wheelchairs, and staff had been alerted to monitor them for any further aggressive behaviors. The ADON stated after the incident, Resident #1 and Resident #2 were observed sharing a shack and talking in front of the nurse's station. Interview with the Administrator, on 06/23/20 at 3:18 PM, revealed protecting residents from abuse was a priority. He stated it was his expectation residents not to be abused or neglected. Per interview, following the altercation between Residents #1 and #2, both residents were immediately separated

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.

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and assessed, and were placed on increased supervision, as per facility protocol. The Administrator stated both residents had a history of [REDACTED]. Further, both residents appeared to have forgotten about the incident, and were interacting positively a few days later. The Administrator concluded by stating there was usually consistent staff on the hall shared by Resident #1 and Resident #2, who were knowledgeable about both residents and what their reactions might be, and he would expect them to be alert to any signs of tension or aggression in the future to prevent reoccurrence.