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

PRINTED: 07/02/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
-		185314	B. WING			06/12/2020	
NAME OF PROVIDER OR SUPPLIER PIONEER TRACE GROUP, LLC				STREET ADDRESS, CITY, STATE, 2 115 PIONEER TRACE FLEMINGSBURG, KY 4104			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AF DEFICIENCY)		TION SHOULD THE APPROPE	JLD BE COMPLÉTION	
F 000	KY#00031827 and a COVID-19 Focus was initiated on 06/06/12/2020. Comp Complaint KY#000 with no deficiencies facility had implemed Disease Control and	rvey investigating Complaint Complaint KY#00031829 and ed Infection Control Survey /11/2020 and concluded on plaint KY#00031827 and // 31829 were unsubstantiated is cited. It was determined the rented the CMS and Centers for d Prevention (CDC) etices to prepare for	FO	000			
LABORATORY	DIRECTOR'S OR PROVIDE	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	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

PRINTED: 07/02/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185314	B. WING			06/12/2020	
NAME OF PROVIDER OR SUPPLIER PIONEER TRACE GROUP, LLC				11	TREET ADDRESS, CITY, STATE, ZIP CODE 15 PIONEER TRACE LEMINGSBURG, KY 41041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	LD BE COMPLETION	
E 000	Initial Comments		€ 000				
	Survey was initiated concluded on 06/12	sed Emergency Preparedness d on 06/11/2020 and 2/2020. It was determined terns with 42 CFR §483.73 b)(6).					
			٠				
		· · · · · · · · · · · · · · · · · · ·					
	2						
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		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.

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 100484 06/12/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 115 PIONEER TRACE PIONEER TRACE GROUP, LLC FLEMINGSBURG, KY 41041 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 000 Initial Comments N 000 A Complaint Survey investigating Complaint KY#00031827 and Complaint KY#00031897 and a COVID-19 Focused Infection Control Survey was initiated on 06/11/2020 and concluded on 06/12/2020. Complaint KY#00031827 and Complaint KY#00031829 were unsubstantiated with no deficiencies cited. It was determined the facility had implemented the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 69.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE