STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185314	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policies, the facility failed to ensure a resident was free from abuse due to misappropriation or exploitation for 1 of 38 sampled residents, Resident (R) 2. The findings include:Review of the facility's policy titled, Controlled Substances, revised date 12/2011, revealed nursing staff must count controlled drugs at the end of each shift. The policy stated the nurse coming on duty and the nurse going off duty must make the count together and must document and report any discrepancies to the Director of Nursing Services.Review of the facility's policy titled, Controlled Medication Storage, dated [DATE], revealed at each shift change, a physical inventory of all controlled medication(s), including the emergency supply, was conducted by two licensed nurses and was documented on the controlled medication accountability record per facility procedure.Review of the facility's policy titled Abuse Prevention, revised [DATE], revealed that misappropriation of resident property was defined as deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of the resident's belongings without the resident's consent.Review of R2's Face Sheet revealed the facility initially admitted the resident on [DATE] with diagnoses of moderate protein - calorie malnutrition, dementia, and adult failure to thrive. Further review of R2's electronic medical record (EMR) revealed he had a gastric tube (g-tube), which was used to administer his medications. Per the record, on [DATE] R2's g-tube became occluded and was replaced on [DATE] at the local hospital, and he returned to the facility on [DATE]. Further review revealed Hospice was consulted on [DATE], and orders for lorazepam (an anti-anxiety agent) and morphine (an opioid pain reliever) were given to provide comfort during end-of-life care. Per the record, R2 expired at the facility on [DATE].Review of the facility's initial Incident Report, dated [DATE], revealed documentation that R2's Brief Interview for Mental Status [BIMS] score was zero (0), indicating severe cognitive impairment. It further revealed not all of his narcotic medication was accounted for, and an internal investigation had been initiated. Review of R2's Controlled Drug Administration Record revealed the last dose of lorazepam 0.5 milligrams (mg) was administered on [DATE] at 5:02 PM.Review of the facility's Daily Staffing Sheet, dated [DATE], revealed Licensed Practical Nurse (LPN) 7, LPN1, and State Registered Nurse Aide/Kentucky Medication Aide (SRNA/KMA) 3 were on the schedule as working during the time of the incident.During an interview on [DATE] at 5:19 PM with SRNA/KMA3, she stated the Hospice nurse, Registered Nurse (RN) 3, on [DATE], went to get the medications from the contracted pharmacy for R2 and immediately returned with them in her possession. She stated she was told by LPN1 that LPN1 and the Hospice nurse had counted 15 lorazepam 0.5 mg tablets that were contained in a bottle. She stated she personally recounted with LPN1 before locking them in the narcotic drawer of the medication cart. She stated she was aware that LPN1 gave one tablet, in addition to one dose of morphine, via g-tube, later that day. She stated there had been a call-in that evening, and it was hectic. She stated at shift change at 6:00 PM, she told the oncoming nurse, LPN7, about the bottle of lorazepam, that it was (continued on next page)

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.

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cart, regardless of the type of storage container. She stated she also expected that would occur during their breaks as well.During an interview with the Administrator on [DATE] at 6:53 PM, she stated she expected the narcotics to be thoroughly counted before anyone accepted a medication cart. She also stated that education would be done. She stated she did not expect she would need to make any policy changes but would continue to reinforce the existing one.