

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 01/08/2026
NAME OF PROVIDER OR SUPPLIER Pioneer Trace Group LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**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</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 185314	Facility ID: 185314 If continuation sheet Page 1 of 3

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>not in a blister pack skid, as were most narcotics received from the pharmacy. She stated LPN7 just shut the drawer and did not count the pills. SRNA/KMA3 stated that upon her return in the morning, she failed to count the bottle of Lorazepam with the night shift nurse, LPN7, before accepting the keys for the cart. She stated she had no reason for not doing it, but just did not, although she knew it was the policy to do so. SRNA/KMA3 stated later in the shift, LPN1 asked her if she had given any lorazepam to R2, and she told LPN1 she had not because she was not allowed to give medications by g-tube. She stated LPN1 told her five lorazepam tablets were missing. She stated she and LPN1 attempted to find the Director of Nursing (DON) and were unsuccessful. She stated because of the DON's absence, they reported the missing tablets to the A Hall Unit Manager, RN2. SRNA/KMA3 stated both she and LPN1 were immediately suspended pending further investigation. The State Survey Agency (SSA) Surveyor attempted to interview LPN7 by telephone on [DATE] at 5:38 PM. However, LPN7 did not answer, and LPN7's voice mailbox was full. During an interview on [DATE] at 5:49 PM with LPN1, she stated on [DATE], she worked on the day shift and was assigned to R2. She stated he went into Hospice care that day, and the Hospice nurse obtained narcotics for him from the contracted pharmacy. She stated the Hospice nurse brought a brown pill bottle from the pharmacy for R2. She stated the Hospice nurse gave the bottle to her and SRNA/KMA3, and she counted 15 Lorazepam 0.5 mg tablets, created a narcotic count sheet, and locked them in the narcotic drawer of the medication cart. LPN1 stated she did administer a dose later that day, so there were 14 tablets left when she counted them. She stated that was the only dose she gave him. She stated, later that night, SRNA/KMA3 had the cart and would have counted with the oncoming nurse, LPN7. She stated the next morning ([DATE]), SRNA/KMA3 received the same cart from the same night nurse she had given keys to the previous evening, LPN7. She stated later in the day, she went to the cart to give R2 a dose of the lorazepam and found only nine pills, instead of 14, with five tablets missing. LPN1 stated she asked SRNA/KMA3 to do a recount with her, and the same number of pills was counted. She stated she and SRNA/KMA3 attempted to report it immediately to the DON, but the DON was not in her office. Therefore, she stated she and SRNA/KMA3 told the Unit Manager of A-Hall, RN2. She stated other medication carts and Medication Administration Records (MAR) were reviewed for accuracy, and no further discrepancies were found. She stated she and SRNA/KMA3 were sent home, pending investigation. She stated the following week, the DON called and told them they could come back to work. LPN1 stated the DON gave an in-service on counting all narcotics regardless of the type of container. During an interview on [DATE] at 5:34 PM with the Pharmacist from the contracted pharmacy, he stated there were 15 lorazepam 0.5 mg tablets picked up by the Hospice nurse, RN3, on [DATE] at 12:57 PM. He stated they were packaged in a clear brown pharmacy bottle. During an interview on [DATE] at 5:14 PM with the responding officer from the local police department, he stated he received the first call from the Administrator on [DATE] at 5:44 PM. He stated the staff member he needed to interview had left the state on a planned trip, other relevant staff had been sent home, and the timing of the holidays delayed the initiation of the investigation. He stated he planned to begin the investigation the following week, and he had been in communication with the facility Administrator. He stated there was currently no police report. During an interview on [DATE] at 6:00 PM with RN2, she stated on [DATE], the Hospice nurse had asked LPN1 to give a dose of lorazepam to Resident 2. RN2 stated when the medication was retrieved, LPN1 saw that the count was not correct. She stated both SRNA/KMA3 and LPN1 brought this information to her, the A Hall Unit Manager. She stated she took the medication bottle of lorazepam and the accompanying signature sheets. She stated the DON suspended SRNA/KMA3, LPN1, and LPN7. During an interview with the DON on [DATE] at 6:50 PM, she stated she expected the clinical staff to count all narcotics when accepting the medication</p> <p>(continued on next page)</p>		

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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.		