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	05/27/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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 the facility's document and polices, the facility failed to protect the residents' right to be free from mental and verbal abuse for 3 of 7 sampled residents, Resident (R) 1, R7, and R11. Resident (R) 2 had a history of verbal and physical outburst behaviors. Residents observed R2 throwing objects, physically hitting staff, and attempts were made to hit other residents and staff. This caused the residents psychosocial harm in which they made statements of being afraid, scared, walking on eggshells, and fear for their safety when R2 was around.Immediate Jeopardy (IJ) was identified on 05/21/2026 in the area of 42 CFR 483.12 Freedom from Abuse, Neglect, and Exploitation and was determined to exist on 05/13/2026. Substandard Quality of Care (SQC) was also determined to exist. The facility submitted an acceptable IJ Removal Plan on 05/27/2026. The immediacy was determined to be removed on 05/27/2026, prior to exit.The findings include:Review of the facility's policy titled, Reporting Abuse to Facility Management, dated 12/2023, revealed abuse was defined as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.Review of the facility's policy titled, Abuse Prohibition, dated 01/12/2017, revealed the facility would provide each resident with an environment free from any type of abuse. It further revealed the facility would not condone any form of resident abuse and would continually monitor response to the facility's policies, procedures, training programs, and system to prevent resident abuse from occurring. 1. Review of R2's admission Record revealed the facility admitted the resident on 12/03/2024 with diagnoses of mood (affective) disorder, persistent mood disorder, genetically related intellectual disability, anxiety disorder, moderate intellectual disabilities, developmental disorder of scholastic skills, conduct disorders, and mild dementia.Review of R2's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 03/10/2026 revealed the facility assessed R2 to have a Brief Interview for Mental Status [BIMS] score of nine of 15, indicating moderate cognitive impairment. Review of the facility's document Long Term Care Facility - Self-Reported Incident Form, dated 01/08/2026, revealed R1 and R2 were involved in a resident-to-resident altercation. According to witness interviews conducted by the facility, R2 told R1, I hate you, and I'm not going to talk to you, and I'm going to kill you. The report revealed staff separated the residents, initiated 1:1 supervision, and R2 was sent to the emergency room for evaluation, returning to the facility the same day. Further review of the facility's investigation revealed R1 stated he did not feel safe at the facility due to R2.Review of R2's undated Care Plan revealed the facility identified verbally abusive behaviors related to moderate intellectual disability, mood disorder, aggressive behavior, and developmental delay. The care plan focus was initiated on 12/10/2024 and documented incidents, including becoming verbally abusive toward a roommate, striking a visitor, yelling and cursing at staff, yelling profanities at residents, behavioral outbursts in the dining room related to seating arrangements on 01/19/2026, yelling and cursing while hitting a handrail on 01/30/2026, yelling and cursing on 02/01/2026, and becoming upset with another resident in the dining room on 02/05/2026. Interventions initiated on 12/10/2024 included analyzing triggers and circumstances associated with behaviors, assessing coping skills, evaluating medication (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

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	05/27/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	side effects, providing positive feedback for appropriate behaviors, obtaining psychiatric consultation as indicated, redirecting the resident, and removing the resident from situations when behaviors escalated. Additional interventions included offering diversion activities, initiated on 04/06/2026, and utilizing noise-reduction earphones, initiated on 05/14/2026, after the 05/13/2026 incident with R1.Further review of R2's undated Care Plan further revealed the facility identified physical aggressive behaviors related to moderate intellectual disability, mood disorder, aggressive behavior, and developmental delay. The care plan focus was initiated on 12/10/2024 and documented incidents in which R2 struck a visitor on 12/06/2024, struck an employee on 04/16/2025, struck a staff member on 05/09/2025, and struck a staff member on 10/31/2025. Interventions included 15-minute monitoring initiated on 01/09/2026, monitoring and reporting danger to self and others, identifying triggers, providing redirection, and removing the resident from situations when behaviors escalated. Continued review revealed an additional behavior focus was initiated on 02/03/2026 after R2 slammed a bedroom door, kicked a footboard, thrashed in bed, threatened to break her glasses, repeatedly yelled profanities, and stated, I'm going to wring my neck. Interventions included one-to-one supervision, physician notification, family notification, transfer to the emergency room for evaluation, and assist the resident in identifying safer coping mechanisms.Further review of R2's undated Care Plan revealed a behavior focus initiated on 02/19/2026, after the resident became agitated when asked to move to allow another resident access through an area, yelled and cursed, hit and kicked a wall and closet, threw items in her room, and made statements of self-harm. Interventions included one-to-one supervision, physician notification, family notification, psychiatric consultation, and allowing the resident to calm down in her room. Continued review revealed an additional behavior focus was initiated on 03/10/2026 for poor impulse control, yelling and cursing at others when she did not get her way, becoming easily agitated, anxious, and upset. Interventions initiated on 03/10/2026 included assisting the resident in developing appropriate coping mechanisms, identifying triggers, de-escalating behaviors, removing the resident from situations as necessary to protect the rights and safety of others, offering diversion activities, redirecting the resident to her room, and removing the resident to a quieter area when upset.Further review of R2's undated Care Plan revealed a behavior focus was initiated on 04/13/2026, after the resident became agitated and combative with staff and others. Interventions included 15-minute checks, psychiatric consultation, maintaining the resident in view of the staff, and redirecting the resident to her room. Continued review revealed a behavior focus was initiated on 05/13/2026, after the resident cursed and spat at another resident. Interventions included 1:1 supervision, redirection, encouraging involved residents to sit apart in the dining room, changing 1:1 supervision to 15-minute checks, and separating residents in the dining room.Review of a Physician Note, dated 01/27/2026, revealed the resident had recently been sent for psychiatric evaluation in the local (ED) Emergency department after a resident cut in line in the cafeteria line in front of her, and R2 began threatening the other resident and stating, I will kill you, you bitch. Documentation revealed the resident was transferred to the emergency room to be evaluated by psychiatric services and discharged back to the facility that day. The physician further documented the facility would closely monitor the resident and seek to avoid similar situations. Review of R2's Progress Notes, dated 01/30/2026 at 3:04 PM and written by Licensed Practical Nurse (LPN) 6 revealed R2 became agitated while sitting at the nurses' station when another resident attempted to pass through the area. Documentation stated R2 leaned forward and then threw herself backward in her wheelchair while yelling, I hate you bitch. The note further documented R2 continued yelling profanities until staff redirected her to her room and turned on the television.Review of R2's Progress Notes, dated 01/30/2026 at 3:15 PM and written by Registered Nurse (RN) 2, revealed R2 was yelling, I hate you bitch. Documentation stated R2 threw items from her bedside table, removed and threw her eyeglasses across the room, kicked, threw herself backward into her wheelchair, and punched the side rail of her bed. The note documented staff attempted redirection and interventions for safety; however, R2 continued cursing, screaming at staff, and punching the bed rail.Review of (continued on next page)

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	05/27/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Progress Notes, dated 02/03/2026 at 11:01 AM and written by RN2, stated R2 slammed her bedroom door, kicked the footboard of her bed, thrashed in bed, threatened to break her glasses, and repeatedly yelled profanities. Per the note, R2 stated, I'm going to wring my neck, while pulling covers over her face. Staff attempted redirection; however, R2 remained agitated. RN2 further documented R2 was sent to the emergency department (ED) of a local hospital for an evaluation.Review of R2's Progress Notes, dated 02/17/2026 at 5:20 PM and written by RN2, revealed R2 became upset when staff was assisting her roommate to bed. The note stated R2 pulled the privacy curtain, slammed the room door, and screamed profanities while propelling herself in a wheelchair up and down the hallway in the unit.Review of R2's Progress Notes, dated 02/19/2026 at 6:49 AM and written by LPN1, stated R2 became upset when staff requested she move to allow another resident access to the nurses' station. Per the note, R2 was punching the wall with her fist, yelling profanities as she propelled herself down the hallway, and stated, I will kill myself. Review of R2's Progress Notes, dated 02/19/2026 at 1:39 PM and written by LPN1, revealed R2 propelled herself in her wheelchair toward her room while shouting profanities, including I hate you bitches and I'm never coming back. The note revealed once R2 entered her room, she kicked her closet door off track, punched the heater, and threw personal belongings throughout the room. Review of a psychiatric Progress Note, from an inpatient psychiatric hospital dated 02/20/2026 at12:45 PM, revealed the nursing facility staff reported increased aggressive behaviors toward others. The note stated R2 engaged in self-injurious behaviors, including bruising herself during behavioral outbursts, and had a history of verbal aggression, yelling, cursing, and making statements suggestive of self-harm. It further revealed that R2 had moments of anger due to feeling ignored or overlooked.Review of R2's Progress Note, dated 02/28/2026 at 3:05 PM and written by LPN9, revealed LPN9 notified the Medical Director of R2's increased behaviors with no new orders documented in the progress note. Review of R2's Progress Notes, dated 03/12/2026 at 3:22 PM and written by RN2, revealed other residents had politely asked R2 to allow them to pass her in the hallway when she began screaming profanities and punching and kicking the walls as she propelled herself down the hallway to her room. Review of R2's Progress Notes, dated 04/13/2026 at 4:46 PM and written by LPN9, revealed R2 became upset in the dining room when another resident sat at a table she believed was her seat. Per the note, R2 attempted to spit on other residents, spit on staff multiple times, threw a water bottle at staff, screamed profanities, attempted to throw her wheelchair, struck multiple staff members in the back and legs, attempted to kick at a resident who was sitting in the hallway, and hit LPN9 in the buttocks. The note described R2 as very combative and un-redirectable. Physician notification occurred, and orders were obtained to send R2 for further evaluation.Review of R2's Progress Note, dated 04/26/2026 at 1:20 PM and written by LPN9, revealed R2 was positioned in the hallway when another resident attempted to pass through the area. Per the note, staff asked R2 to move back so the other resident could pass. The note documented R2 attempted to back her wheelchair but bumped into another resident's leg. R2 became upset and stated, You're making me mad, I'm going to go off, and I hate it here. Documentation further revealed R2 propelled her wheelchair down the hallway, grabbed a meal tray from a dietary cart, threw it onto the floor, threw her glasses, and began swinging at Certified Nursing Assistants (CNA) who were attempting to shield other residents in the hallway from her punches. The note further stated R2 screamed profanities, including calling others whores and bitches, attempted to throw a wheelchair, overturned a wheelchair, and swung a wheelchair armrest at staff. Per the note, R2 entered another resident's room, slammed the door, kicked and struck the door, and then returned to her room where she continued screaming, slamming items, and exhibiting aggressive behaviors. Review of R2's Progress Note, dated 05/13/2026 at 1:34 PM and written by the Director of Nursing (DON), revealed R2 started screaming while in her room. Documentation indicated the Social Worker, DON, and Unit Manager responded. R2 attempted to slam her door but became upset when a curtain interfered with the door closing. Staff redirected R2, provided sips of water, and administered Tylenol for pain. Documentation indicated R2 was later observed sitting calmly on the side of her bed.Review (continued on next page)

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	05/27/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of R2's Progress Note, dated 05/13/2026 at 1:38 PM and written by the DON, revealed R2 was observed in the hallway attempting to pick up and throw her wheelchair. Documentation indicated the wheelchair tipped backward; however, anti-tip devices prevented it from overturning. Per the note, the DON responded and offered to take R2 outside to the courtyard. Review of R2's Progress Note, dated 05/13/2026 at 4:40 PM and written by LPN6, revealed R2 became agitated while seated with other residents in the dining room during supper and began cursing at another resident. Documentation indicated staff separated the residents and moved them to different tables. The note identified the precipitating factor as another resident making faces at R2.Review of R2's Progress Note, dated 05/13/2026 at 4:47 PM and written by LPN6, revealed the Medical Doctor (MD) was notified of R2's behaviors. Documentation revealed the MD agreed for R2 to be placed on 15-minute checks related to behaviors.Review of the facility's investigation Long Term Care Facility-Self Reported Incident Form, completed and signed by the Administrator, dated 05/13/2026 at 4:33 PM, revealed R1 and R2 were involved in a verbal altercation in the dining room prior to supper. Further review revealed R2 became increasingly agitated, verbally threatened R1, and spit at R1 during the altercation. The investigation revealed staff witnessed R2 spit at R1 and acknowledged the residents had prior verbal altercations before the incident. 2. Review of R1's admission Record revealed the facility admitted the resident to the facility on [DATE] with diagnoses of cerebral infarction, vascular dementia, and generalized anxiety. Review of R1's quarterly MDS, with an ARD of 02/23/2026, revealed the facility assessed the resident to have a BIMS score of 14 out of 15, which indicated R1 was cognitively intact.During an interview on 05/19/2026 at 3:00 PM, R1 stated she did not feel safe in the facility due to R2's outbursts. Review of a Grievance/Complaint Form, filed by R7 and dated 04/13/2026, revealed R7 reported not feeling safe in the facility due to R2's behaviors, including hitting, kicking, and spitting at staff and other residents. The Administrator documented in the grievance resolution that residents were provided a handout What To Do If You See Another Resident Having Behaviors, which instructed residents, to avoid engaging with residents exhibiting behaviors, seek a safe place (your room, dining room, or near staff), loudly say, ?I need help!,' take deep breathes, notify staff of what happened when it is safe, and remember staff were here to help keep everyone safe.3. Review of R7's admission Record revealed the facility admitted R7 on 11/15/2023 with diagnoses of chronic obstructive pulmonary disease (COPD), anxiety disorder, and depression. Review of R7's quarterly MDS, with an ARD of 04/20/2026, revealed the facility assessed R7 to have a BIMS score of 15 out of 15, which indicated R7 was cognitively intact.During an interview on 05/19/2026 at 11:05 AM, R7 stated he did not feel safe around R2, and he had previously informed the facility's administration he believed R2 would eventually hurt someone. R7 stated he avoided the dining room due to R2's behaviors and would go to other residents' rooms to protect them during R2's outbursts of behavior. R7 stated he felt he had to walk on eggshells when around R2. He further stated he was fearful that R2's behavior would cause him to beat the hell out of R2 to protect himself and other residents. R7 further stated she had observed R2 throw wheelchairs in the hallway and observed other aggressive and disruptive behaviors that involved R2 hitting staff so hard with her fist that staff had fallen to the floor. 4. Review of R11's admission Record revealed the facility admitted R11 on 06/21/2024 with diagnoses of chronic inflammatory demyelinating polyneuritis and anxiety disorder. Review of R11's quarterly MDS, with an ARD of 04/07/2026, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated R11 was cognitively intact.During an interview on 05/20/2026 at 3:00 PM, R11 stated she hid behind the wall in her room when she heard R2 screaming because she was afraid R2 would hurt her. During an interview on 05/21/2026 at 2:30 PM, Licensed Practical Nurse (LPN) 6 stated staff attention was frequently redirected to R2 to prevent behavioral outbursts which prevented staff from meeting the needs of other residents. LPN 6 further stated the facility could not meet R2's needs, and the facility was not an appropriate placement for R2. In an additional interview, on 05/20/2026 at 4:00 PM, R11 stated she did not feel safe around R2. R11 stated she was wheelchair dependent and feared R2 would hurt her. R11 stated when R2 became (continued on next page)

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	05/27/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	upset, screamed, or exhibited behaviors, she would hide in her room because she was afraid of R2. R11 stated she altered her routes within the facility to avoid R2 and would not remain alone with R2. R11 further stated she observed R2 become upset, scream, and throw items, which caused her to discontinue a therapy session because she was nervous and unable to continue participation.During an interview with CNA9 on 05/18/2026 at 4:32 PM, CNA9 stated R2 had physically assaulted her on multiple occasions. CNA 9 stated R2 had struck her while she was positioning herself between R2 and other residents to protect the residents from being hit. CNA9 stated R2 had thrown items at her, hit her, and struck her with a closed fist to her chest, arms, and back. CNA 9 further stated R2 frequently threw items, including meal trays and wheelchairs, during behavioral episodes and expressed concern for the safety of other residents when R2 became agitated.During an interview on 05/21/2026 at 3:00 PM, CNA 1 stated R2 became upset when care was delayed and preferred that staff remain near her during care. CNA1 stated R2 became upset when she did not get her way.During an interview on 05/21/2026 at 3:25 PM, LPN6 stated multiple residents had reported they did not feel comfortable or safe around R2 following the incident with R1 on 05/13/2026. LPN6 further stated R2 required significant staff attention and supervision. LPN 6 stated R2's care needs frequently required staff intervention and, at times, affected staff's ability to provide care to other residents.During an interview with the Social Worker (SW) on 05/18/2026 at 2:30 PM, the SW stated the facility had not attempted to identify or secure an alternative placement for R2 despite ongoing concerns regarding R2's behaviors and reports from other residents that they did not feel safe in the facility. The SW stated no referrals had been made to other facilities, and no placement efforts had been initiated.During an interview with the Administrator on 05/21/2026 at 4:45 PM, she stated staff frequently contacted her for assistance in calming R2 during behavioral outbursts. The Administrator stated she believed R2 would benefit from a smaller group setting and had observed the dining room environment to be overstimulating for R2, frequently resulting in behavioral outbursts. The Administrator further stated, It is not my expectation for any of the residents to hide or live in fear in their home.During an interview with the Medical Director on 05/27/2026 at 2:30 PM, he stated his expectation was that residents should feel safe in the facility and not be fearful of other residents. The Medical Director stated he believed R2 would benefit from more focused, individualized care. He stated R2 might experience fewer behavioral outbursts if staff members were able to provide more attention to address her needs.The facility submitted an acceptable IJ Removal Plan on 05/27/2026, alleging removal of the IJ on 05/27/2026 as follows verbatim: Root cause of the immediate jeopardy:The facility failed to implement interventions to protect the residents' right to be free from abuse byResident #2.Resident(s) affected by the IJ:-Resident #2 has been attending day program 2x a week since 4/7/2026. Resident #2 attends this outpatient activity program from Approx. 8am to 430pm on the scheduled days. Beginning the 1st week of June the resident will go to the day program 3x a week. She attends this outpatient activity program from approx 8am to 430pm on the scheduled daysResident #2 had a verbal altercation with Resident #1 on 5/13/26 in the dining room and was observed to spit on Resident #1.-Resident #2 was placed on 1:1 then Q 15 min. checks on 5/13/26 to 5/15/2026-Resident #2 was placed on 1:1 when out of room and on 15 minute checks when in room starting on 5/21/2026.-A medication review was completed by the attending MD with the addition of increasing Rexulti to 2mg started on 5/16/2026, with noted improvement as of 5/21/2026.Resident(s) the facility identified at risk for IJ:-All residents are at risk for the cited deficiency-All interviewable residents were interviewed on 5/22/2026 by the Social Worker, with the question: Do you feel a sense of safety and security in facility. Residents interviewed had a BIMS 8 or greater with a total number of 46 residents interviewed by Social Worker on 5/22/2026 and a total number of 49 interviewed on 5/25/2026 by Administrator. All residents excluding 4 indicated they did not have any safety concerns in the last 7 days. 1 out of 4 residents baseline is feeling of fear unrelated to facility, 2 out of 4 residents stated they felt safe with exceptions and 1 out 4 residents state noise makes her nervous. 3 out of 4 residents declined interventions with 1 out of 4 residents with intervention in (continued on next page)

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	05/27/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	place and felt like intervention worked. R1 was offered a stop sign for door and declined and stated understanding that staff were for assistance. R7 currently has stop sign for door and states is effective. R11 declined stop signfor [sic] door for interview compelted [sic] on 5/22/2026. All residents interviewed on 5/25/2026 felt safe in the facility excluding one resident who's [sic] baseline is fearful.-Uninterviewable residents were assessed with a OV PHQ9 on 5/26/2026 by the Social Worker, Unit Nurse managers and Wound nurse. OV PHQ9 assessments completed on 24 residents with no concerns noted.Training:All staff have received in-serviced education on the regulatory requirements for F600 including but not limited to: the need to monitor, intervene and immediately report residents who demonstrate behaviors that present a risk to themselves or other residents; to immediately report all allegations of abuse; and to protect residents involved in an allegation of abuse from further abuse as completed by Administrator, Social worker, DON, Unit Nurse Coordinators, MDS and Wound Nurse by 5/24/2026. All staff members employed by Pioneer Trace have received in-service. Human Resources will be responsible for training of new hires and agency if facility were to use agency staff. Facility will continue to do bi-annually abuse and prevention education and testing as preformed by the social worker. Facility compelted inservice education to staff on 5/24/2026. Daily polling of staff to be completed by Administrator or DON to verify competency starting 5/25/2026. Questions will be asked: What do you do when you witness a resident having behaviors, what are some examples of Deescalation strategies, when do you report abuse.Systems Implemented:-The resident continues on Rexulti 2 mg with noted continued improvement in behaviors.-Resident #2 is still on 1:1 when out of room and 15min. Checks when in room.-Resident #2 ordered noise reduction earphones as tolerated implemented on 5/14/2026-The facilities Social Worker contacted the resident's day program on 5/22/2026 to determine the types of activities the resident is engaging in, and has added a selection of these to the facility activity program for the resident.-The facilities Social Worker contacted the PASSR agency on 5/22/2026 to determine if any other services are available for the resident.-An Ad Hoc QAPI meeting on 5/22/2026 was conducted with Medical Director, DON and Administrator. The meeting was held to discuss findings, interventions and impleme11tation related to the citation for abuse and care plans.Monitoring:-The QAPI audit tool for the monitoring of compliance with the F 600 requirements including but not limited to protecting residents from abuse, immediately reporting of abuse allegations, and implementation of care plan interventions for residents with behaviors that may pose a risk of abuse to others.-Interviewable resident will be interviewed daily during IJ period, regarding any-safety concerns in the facility and then every 2 weeks for 1 month, then monthly for 2 months, and then quarterly to determine if there are any resident behavior or other potential risks for abuse that need to be addressed as completed by Social Worker or Administrator. Social Worker or Administrator will be responsible for reporting results.-During IJ period Administrator or Social Worker to interview residents with the question: Do you feel a sense of safety and security in facility. Interviews will be conducted on a period of Mondays -Fridays starting on 5/25/2026 and will conclude after IJ period and review with QAPI agrees.-Facility to complete daily AD HOC QAPI meetings daily starting 5/25/2026 during IJ period.Alleged removal date:5/27/2026

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	05/27/2026

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 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview, record review, review of the facility's investigation, and review of the facility's policy, the facility failed to ensure residents' care plans were revised to include interventions needed to provide person-centered care related to supervision and monitoring to ensure safety for 1 of 28 sampled residents, Resident (R) 5.Interviews with staff revealed that on 05/02/2026 at approximately 5:55 PM, staff observed the resident exiting the facility and they were able to intervene and return the resident back to the facility. However, the facility failed to revise the resident's care plan to include interventions that would increase the resident's supervision and/or monitoring. Review of the facility's investigation revealed R5 eloped from the facility on 05/02/2026 at approximately 8:11 PM and was found outside near the back facility entrance roadway by Dietary Aide 1 who was taking out trash. The investigation revealed R5 traveled approximately 286 feet from the facility's entrance, in her wheelchair over an uneven surface, without staff awareness or supervision. Immediate Jeopardy (IJ) was identified on 05/21/2026 in the area of 42 CFR 483.21 Comprehensive Person-Centered Care Plans and was determined to exist on 05/02/2026. The facility submitted an acceptable IJ Removal Plan on 05/27/2026. The immediacy was determined to be removed on 05/27/2026, prior to exit. Refer to F689The findings include:Review of the facility's policy titled, Care Plans - Comprehensive, undated, revealed areas of concern identified during resident assessments were to be evaluated using specific assessment tools before interventions were added to the care plan. The review further revealed assessments were ongoing, and care plans were to be revised as information about the resident and the resident's condition changed. The policy further revealed the interdisciplinary team (IDT) was responsible for reviewing and updating care plans when there was a significant change in the resident's condition, when the desired outcome was not met, when the resident was re-admitted to the facility after a hospital stay, and at least quarterly.Review of R5's admission Record revealed the facility admitted the resident on 11/04/2025 with diagnoses including Wernicke's encephalopathy (caused mental status changes and confusion) and agitation.Review of R5's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/29/2026, revealed the facility assessed R5 to have a Brief Interview for Mental Status [BIMS] score of nine out of 15, indicating moderate cognitive impairment.Review of R5's MDS Ancillary Assessment, dated 11/11/2025, 02/02/2026, 04/29/2026, and 05/04/2026 revealed R5 was assessed as high risk for wandering/elopement. Review of R5's undated Care Plan Report revealed a focus area for wandering/exit-seeking behaviors. The care plan documented exit-seeking behaviors on 11/09/2025, 01/06/2026, 02/16/2026, and 04/10/2026. The care plan noted R5 was easily redirected and frequently verbalized wanting to go home. The care plan revealed interventions including monitoring every shift and application of a WanderGuard bracelet initiated on 11/09/2025. Additional interventions initiated on 01/29/2026 included scheduled hydration one hour prior to bedtime, assisting R5 to bed immediately on second shift if pacing or exit-seeking behaviors continued, providing care in a calm and reassuring manner, reorientation to surroundings and environment, and reminding R5 frequently to notify staff with needs. Fifteen-minute location checks were implemented following documented exit-seeking behaviors. Further review revealed the interventions for scheduled hydration, assisting R5 to bed immediately on second shift if pacing or exit-seeking behaviors continued, providing care in a calm and reassuring manner, reorientation to surroundings and environment, reminding R5 frequently to notify staff with needs, and fifteen-minute location checks were marked as resolved. The care plan did not identify dates these interventions were resolved. The ongoing interventions identified in the care plan were monitoring every shift and use of a WanderGuard bracelet. The care plan continued to document exit-seeking behaviors on 01/06/2026, 02/16/2026, and 04/10/2026.Review of R5's Physician's Orders, dated 11/09/2025 revealed an order for a WanderGuard bracelet related to wandering behaviors.Review of the facility's investigation form Long Term Care Facility Self-Reported Incident (continued on next page)

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	05/27/2026

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 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Form, completed and signed by the Administrator, dated 05/02/2026 at 8:12 PM, revealed R5 was found near the back facility entrance roadway by Dietary Aide 1 while taking out trash at approximately 8:11 PM. During an interview with the Administrator on 05/20/2026 at 4:00 PM, she stated when she documented the investigation of the incident that occurred on 05/02/2026 at 8:11 PM, she was unaware of the resident's exit seeking behaviors or prior attempts on that day, 05/02/2026.During an interview on 05/18/2026 at 7:58 AM, Certified Nursing Assistant (CNA) 2 stated she was aware R5 had been exhibiting exit-seeking behaviors. CNA2 further stated day shift staff had reported that R5 and another resident had been discussing ways to leave the facility earlier that day. During an interview on 05/21/2026 at 2:00 PM, CNA3 stated R5 had a history of attempting to leave the facility. CNA3 stated R5 made multiple attempts to exit the facility on 05/02/2026 and was determined to leave the facility. She stated the nurses working at the time were aware of the incident.During an interview on 05/20/2026 at 12:41 PM, CNA1 stated R5 tailgated visitors through the facility's front entrance at approximately 5:55 PM on 05/02/2026. CNA1 stated R5 exited the facility in her wheelchair through the front entrance doors and traveled approximately 60 feet from the facility's entrance before staff intervened and returned R5 to her unit near the nurses' station. She stated the nurses working at the time were aware of the incident.Further review of R5's undated Care Plan Report revealed no documented evidence to suggest the facility revised the resident's care plan to include the resident's attempt to elope at 5:55 PM on 05/02/2026. Review of Licensed Practical Nurse (LPN) 3's Health Status Progress Note, dated 05/02/2026 at 8:56 PM, revealed R5 eloped from the facility and was found by dietary staff at 8:11 PM. The note further revealed administration was notified at 8:12 PM, and R5 was placed on 1:1 supervision.During an interview on 05/20/2026 at 11:21 AM, LPN3, the nurse assigned to R5 at the time of 05/02/2026 attempted elopement at 5:55 PM and the elopement at 8:11 PM, stated day shift staff had not communicated to her that R5 had exhibited exit-seeking behaviors on their shift on 05/02/2026. She stated she had not implemented additional interventions related to R5's elopement risk behavior on 05/02/2026 at 5:55 PM. She stated she was not aware R5 was exit seeking prior to the elopement and had not been told by the CNAs about the tailgating incident at 5:55 PM.During an interview on 05/21/2026 at 1:00 PM, the Minimum Data Set (MDS) Coordinator stated when a resident began demonstrating exit-seeking behaviors, new interventions should be immediately implemented and added to the care plan. The MDS Coordinator stated 1:1 supervision and 15-minute checks would have been appropriate interventions following R5's exit-seeking behaviors and attempts to leave the facility on 05/02/2026 prior to the actual elopement. The MDS Coordinator further stated all licensed nurses were able to enter new interventions into the care plan and were responsible for updating the care plan when new interventions were implemented. During an interview with the Director of Nursing (DON) on 05/20/2026 at 12:11 PM, she stated the nurse working at the time of an exit-seeking incident was expected to immediately implement interventions. She stated then, the interdisciplinary team (IDT), whose members included the Administrator, herself (DON), the Unit Managers, the MDS Coordinator, and the Dietary Manager, would review the resident's care plan the following day to determine whether additional interventions were needed.During continued interview with the Administrator on 05/20/2026 at 4:00 PM, she stated staff was expected to identify exit-seeking behaviors and immediately implement interventions to prevent residents from leaving the facility unsupervised and to ensure resident safety. The Administrator stated interventions should be initiated as soon as exit-seeking behaviors were observed. The facility provided an acceptable IJ Removal Plan on 05/27/2026 which alleged removal of the IJ on 05/27/2026 as follows verbatim:Root cause of the immediate jeopardy: The facility failed to review/revise the care plan for Resident #5 related to wander risk behaviors. MDS and DON reviewed Resident #5 careplan on 5/21/2026 for appropriate interventions, intervention of 15min checks to remain continuously. Resident(s) affected by the IJ:Resident #5 exited the facility on 5/2/26.-The resident was returned into the facility on 5/2/26 and received a head-to-toe skin assessment with no injuries noted. Vitals within normal range. Vitals and (continued on next page)

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	05/27/2026

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 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	assessments completed by resident's nurse, the resident was placed 1:1 until bedtime and 15-minute checks were initiated and continuous. Resident #5 care-plan was revised to include interventions of 1:1 until bedtime and 15-minute check continuously.Resident(s) the facility identified at risk for IJ:All residents identified with wander risk behaviors had the potential to be affected. 100 % audit was completed by unit nurse coordinators for the last 30 days of charted wandering/exit seeking behaviors, 21 residents identified. Care-plans were reviewed/revised with any indicated interventions, completed by unit nurse managers and MOS on 5/22/2026 for all 21 residents identified with wander/exit seeking behaviors. Floor nurses are responsible for adding care-plans on residents with exit seeking behaviors to include interventions which may include increased supervision.Training:All staff have received in-service education on the facility policy/protocol for wander risk management including but not limited to:-Consistent implementation of resident specific care plan interventions for the monitoring and prevention of residents exiting the facility unsupervised.-All staff in-serviced on the procedure for checking outside of a door when the alarm system sounds and for completing a head count to determine that all residents are accounted for.-The increased monitoring process for residents that demonstrate exit seeking behaviors.-All Staff in-serviced on the importance of notifying the DON/Nurses Management/Administrator if wander risk interventions are not effective or if any new wander risk behavior residents are identified so that care plans may be reviewed and revised as needed.-Disciplinary actions that will be implemented for staff that fail to follow the facility protocol for response to door alarms.-Education on care planning, reporting incidents per chain of command and documenting.This training was provided by Administrator, Social worker, DON, Unit Nurse Coordinators, MDS and Wound Nurse by 5/24/2026. All staff members employed by Pioneer Trace have received inservice.Human Resources will be responsible for training of new hires and agency if facility were to use agency staff. Facility completed inservice education to staff on 5/24/2026. Daily polling of staff to be completed by Administrator or DON to verify competency starting 5/25/2026. Questions will be asked: When should you implement an intervention related to exit seeking, When do you implement a care-plan related to exit seeking, what are some examples of interventions for exit seeking.Systems implemented-100 % audit was completed by unit nurse managers and MDS for the last 30 days of charted wandering/exit seeking behaviors. Care-plans were reviewed/revised with any indicated interventions, completed by unit nurse managers and MDS on 5/22/2026.-Disciplinary action was implemented for immediate staff involved the day of the elopement for failure to notify and implement interventions.-Ad Hoc QAPI meeting on 05/22/2026 conducted with Medical Director, DON and Administrator. The meeting was held to discuss interventions and implementation related to elopement and care planning.Monitoring:-Unit nurse managers will audit care-plan documentation for residents identified with wander risk/ behaviors weekly x 4 weeks to determine any need for revisions and will then utilize the QAPI audit tool as outlined below.-Unit nurse managers to review progress notes every morning from the previous day Monday - Friday (weekends to be reviewed following Monday) to identify any wander risk behaviors and will determine that they have been addressed on the care plan.-Facility to complete daily AD HOC QAPI meetings daily starting 5/25/2026 during IJ periodAlleged Removal Date: 5/27/26

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	05/27/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review, review of the website https://www.localconditions.com, review of the facility's investigation, and review of the facility's policies, the facility failed to have an effective system in place to ensure each resident received adequate supervision and monitoring. The facility failed to implement interventions and adequate supervision for 1 of 20 sampled residents to prevent unsafe wandering and elopement, Resident (R) 5.Review of the facility's investigation revealed R5 eloped from the facility on 05/02/2026 at approximately 8:11 PM and was found outside near the back facility entrance roadway by Dietary Aide 1, who was taking out trash. The investigation revealed R5 traveled approximately 286 feet from the facility entrance, in her wheelchair, over an uneven surface, without staff awareness or supervision.Immediate Jeopardy (IJ) was identified on 05/21/2026 in the area of 42 CFR 483.25 Quality of Care and was determined to exist on 05/02/2026. Substandard Quality of Care (SQC) was also determined to exist. The facility submitted an acceptable IJ Removal Plan on 05/27/2026. The immediacy was determined to be removed on 05/27/2026, prior to exit. The findings include: Review of the facility's policy titled, Wander Monitoring System, undated, revealed staff was required to promptly respond to door alarms, redirect residents away from alarmed areas, and reset alarms only after determining the area was clear. Review of the facility's policy titled, Wander Monitoring System-Sounding, undated, revealed staff was required to immediately respond when the alarm sounded, identify the source of the alarm, search the area of the activated door, and complete a resident head count if the source of the alarm could not be identified. Review of the facility's policy titled, Elopements, undated, revealed staff was required to promptly report a resident suspected of being missing, initiate a search of the building and premises, and notify administration. Review of the local weather conditions at https://www.localconditions.com, dated 05/02/2026, revealed at approximately 8:00 PM the outdoor temperature of 47 degrees Fahrenheit, with wind gusts up to 10.7 miles per hour. 1. Review of R5's admission Record revealed the facility admitted R5 on 11/04/2025 with diagnoses including Wernicke's encephalopathy, lack of coordination, muscle weakness, and age-related physical debility. Review of R5's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/29/2026, revealed the facility assessed R5 to have a Brief Interview for Mental Status [BIMS] score of nine of 15, indicating moderate cognitive impairment. Review of R5's undated Care Plan Report revealed a focus area for wandering/exit-seeking behaviors. The care plan documented exit-seeking behaviors on 11/09/2025, 01/06/2026, 02/16/2026, and 04/10/2026. The care plan noted R5 was easily redirected and frequently verbalized wanting to go home. The care plan revealed interventions including monitoring every shift and application of a WanderGuard bracelet initiated on 11/09/2025. Additional interventions initiated on 01/29/2026 included scheduled hydration one hour prior to bedtime, assisting R5 to bed immediately on second shift if pacing or exit-seeking behaviors continued, providing care in a calm and reassuring manner, reorientation to surroundings and environment, and reminding R5 frequently to notify staff with needs. Fifteen-minute location checks were implemented following documented exit-seeking behaviors. Further review revealed the interventions for scheduled hydration, assisting R5 to bed immediately on second shift if pacing or exit-seeking behaviors continued, providing care in a calm and reassuring manner, reorientation to surroundings and environment, reminding R5 frequently to notify staff with needs, and fifteen-minute location checks were marked as resolved. The care plan did not identify dates these interventions were resolved. The ongoing interventions identified in the care plan were monitoring every shift and use of a WanderGuard bracelet. The care plan continued to document exit-seeking behaviors on 01/06/2026, 02/16/2026, and 04/10/2026. Review of R5's Elopement/Wander Risk Evaluation, dated 11/11/2025 at 12:10 PM and completed by Licensed Practical Nurse (LPN) 8, revealed R5 scored 16, which identified the resident as a mild risk for elopement if the score was (continued on next page)

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	05/27/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	between 15 and 18. Documentation identified the resident had a history of exit-seeking behavior, cognitive impairment, and impaired safety awareness. Review of R5's Elopement/Wander Risk Evaluation, dated 05/04/2026 at 3:07 PM and completed by the Minimum Data Set (MDS) Coordinator, revealed R5 scored 16, which identified the resident as mild risk for elopement. However, review of R5's MDS Ancillary Assessment, dated 11/11/2025, 02/02/2026, 04/29/2026, and 05/04/2026 revealed R5 was assessed as high risk for wandering/elopement. Review of R5's Physician's Orders, dated 11/09/2025 at 2:43 PM, revealed the physician ordered, Secure wander alert to left ankle. Monitor every day and night. Review of the facility's investigation form Long Term Care Facility Self-Reported Incident Form, completed and signed by the Administrator, dated 05/02/2026 at 8:12 PM, revealed R5 was found near the back facility entrance roadway by Dietary Aide 1 while taking out trash at approximately 8:11 PM. The investigation revealed R5 traveled approximately 286 feet from the facility entrance, in her wheelchair, over an uneven surface, without staff awareness or supervision. Further investigation revealed at least two residents, including a resident who wore a WanderGuard bracelet, knew the code to silence the WanderGuard door alarms. Staff interviews further revealed the WanderGuard alarms frequently sounded during evening hours, and alarms were not always immediately responded to if staff was providing resident care. The investigation further revealed the facility was experiencing increased visitor traffic due to the local high school prom, and the facility's door alarms frequently sounded between 6:00 PM and 8:30 PM due to resident smoking times and shift change activities. Review of R5's Progress Notes, dated 05/02/2026 at 8:56 PM and written by LPN3, revealed R5 eloped the building and was found at 8:11 PM the same evening.During an interview on 05/20/2026 at 12:41 PM, Certified Nursing Assistant (CNA) 1 stated R5, who wore a WanderGuard bracelet (a device worn by residents to prevent elopement that caused the door with an alarm to sound when the resident exited the door) tailgated visitors out the facility door on two occasions at approximately 5:55 PM on 05/02/2026. CNA1 stated during the second attempt, R5 exited the facility in her wheelchair and traveled approximately 60 feet from the front entrance before staff intervened and returned R5 to her Unit near the nurses' station.During an interview on 05/20/2026 at 5:05 PM, LPN5 stated she responded to the facility door alarm at approximately 7:45 PM on 05/02/2026 and observed another resident coming through the door. LPN5 stated she entered the code to reset the alarm and did not look outside because she assumed the resident coming through the door had activated the alarm. During an interview on 05/19/2026 at 2:30 PM, Dietary Aide 1 stated while taking trash from the building on 05/02/2026, he discovered R5 outside near the facility's roadway. Observation on 05/19/2026 at 2:30 PM with the Maintenance Director and Dietary Aide 1 revealed the distance from the facility's front entrance to the location where R5 was found measured approximately 286 feet. During an interview with R5 on 05/18/2026 at 3:00 PM, she stated she could not recall the elopement event. Observation of R5 on 05/18/2026 at 10:00 AM, 12:15 PM, 2:15 PM, and 5:30 PM revealed she remained near the facility's front entrance and close to the exit door. During an interview on 05/18/2026 at 5:39 PM, CNA21 stated R6 and R7 knew the facility's front door access code and independently utilized the code to enter and exit through the facility's front entrance prior to the elopement incident. CNA21 stated the facility door access code was changed following R5's elopement incident. 2. Review of R6's electronic health record (EHR) revealed the resident was wearing a WanderGuard bracelet due to an elopement risk. During an interview on 05/19/2026 at 2:00 PM, the Administrator stated the facility's Quality Assessment and Performance Improvement (QAPI) committee and administration was aware residents knew the facility's front door access code prior to the elopement incident. She stated the two residents (R6 and R7) heard staff telling someone else the code to get in and started using it. The Administrator further stated the facility was unable to independently change the code, and the door access company was not contacted to change it until after R5's elopement. The Administrator stated no additional monitoring of the entrance doors or residents was implemented prior to the elopement incident despite the facility's awareness that residents knew the front door access code. During an interview on 05/20/2026 at (continued on next page)

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	05/27/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12:41 PM, CNA1 stated, on 05/02/2026 at approximately 5:55 PM, R5 exited the facility through the front entrance by tailgating visitors. She stated staff then observed R5 approximately 60 feet from the entrance and redirected her back inside the facility. CNA1 further stated the facility did not increase R5's monitoring. During an interview with Housekeeper 22 on 05/20/2026 at 12:20 PM, she stated R5 had a smoking break on 05/02/2026, which began around 6:50 PM and ended at approximately 7:20 PM. She stated she routinely assisted residents outside during these times and saw R5 near the front entrance during the evening smoking break. She stated staff often did not respond to door alarms during these periods. 3. During an interview on 05/19/2026 at 7:00 PM, R7 stated, on the evening of 05/02/2026, the facility door alarm sounded for an extended time without staff response. R7 stated he told LPN3 he would check the alarm and saw LPN5 enter the code to silence it without verifying the exterior. R7 stated he routinely signed himself out and accessed the facility grounds independently for smoking breaks and, therefore, knew the front entrance door code. During an interview on 05/20/2026 at 4:37 PM, CNA5 stated between 7:00 PM and 8:00 PM on 05/02/2026, she heard the facility door alarm but did not respond, assuming the nursing staff had already addressed it.During an interview on 05/20/2026 at 5:05 PM, LPN5 stated, at approximately 7:45 PM on 05/02/2026, she responded to the facility door alarm by entering the code to reset it but did not check outside to determine the cause of the alarm activation. During an interview on 05/20/2026 at 11:21 AM, LPN3 stated on 05/02/2026, R7 informed her he was going to check the alarm and later told her another nurse had reset it. During continued interview on 05/19/2026 at 2:00 PM, the Administrator stated staff was expected to immediately respond to door alarm activations, determine the cause of the activation, inspect the exterior area, and complete a resident count if the cause of the alarm could not be determined. The Administrator stated, once a resident with a WanderGuard bracelet exited the door, the alarm would continue sounding until staff entered the code to reset the system. During an interview on 05/27/2026 at 2:10 PM, the Medical Director stated he expected all staff, regardless of department, to immediately respond to door alarm activations. The Medical Director stated the facility needed to gain control of the front entrance door system to prevent residents at risk for elopement from leaving the facility. The facility submitted an acceptable IJ Removal Plan on 05/27/2026 alleging IJ removal on 05/27/2026 as follows verbatim:Root cause of the immediate jeopardy:The facility failed to implement interventions to prevent Resident #5 from exiting the facility without supervision. All residents who have exit seeking behaviors are at risk.Resident(s) affected by the IJ:Resident #5 exited the facility on 5/2/26.The resident was returned into the facility on 5/2/26 and received a head-to-toe skin assessment with no injuries noted. Vitals within normal range. Vitals and assessments completed by resident's nurse, the resident was placed 1:1 until bedtime and 15-minute checks were initiated and continuous.Resident(s) the facility identified at risk for IJ:All residents identified with wander risk behaviors had the potential to be affected. 100 % audit was completed by unit nurse coordinators for the last 30 days of charted wandering/exit seeking behaviors, 21 residents identified. Care-plans were reviewed/revised with any indicated interventions, completed by unit nurse managers and MDS on 5/22/2026 for all 21 residents identified with wander/exit seeking behaviors. Floor nurses are responsible for adding care-plans on residents with exit seeking behaviors to include interventions which may include increased supervision.Training:-The Facility provided re-education for all staff on elopement and wandering, responding to door alarms as well as completing a headcount and area search, on 5/4/2026 - 5/8/26 and again beginning 5/22/26 and was completed on 5/24/2026. Staff in serviced that only staff may have knowledge of Door Alarm code on 5/8/2026 and completed again on 5/24/26. Staff educated that if door code is shared with any non-employed staff of Pioneer Trace, that employee would face disciplinary actions up to termination.Education was completed 5/24/2026. This training was provided by Administrator, Social worker, DON, Unit Nurse Coordinators, MDS and Wound Nurse by 5/24/2026. All staff members employed by Pioneer Trace have received inservice. Human Resources will be responsible for training of new hires and agency if facility were to use agency staff. Facility completed inservice education to (continued on next page)

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	05/27/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	staff on 5/24/2026. Daily polling of staff to be completed by Administrator or DON to verify competency starting 5/25/2026.Questions will be asked: When should you respond to a door alarm, should you check outside when responding to a door alarm, what do you do if you do not locate a resident when responding to a door alarm.Systems implemented-The Facility did a complete accounting for all residents, all residents in the building and or accounted for, this occurred on 5/2/2026. Completed by floor staff on shift.-Polling of residents completed on 5/2/2026. Questions related to asking residents if they wanted to go outside, would they know what to do and questions related to asking residents if it is hard to stay inside or ask for help when they want to go somewhere. Residents who expressed not knowing were educated, no other concerns noted. Completed by facility nurses.-All residents received an updated assessment for elopement on 5/4/2026 (Resident #5 previously identified as elopement risk and continues to be at risk). Completed by nursing management.-Maintenance Director contacted door alarm company to change master door code on 5/4/2026, door alarm company responded to facility on 5/5/2026 at 8am and successfully changed master door code and the secondary door code.-On 5/4/2026 all keypads were updated with signage for staff use only completed by the Administrator.-On 5/4/2026 important safety notice was given to residents explaining keypads are to be used by staff only and to ask for assistance when needing to use doors. Facility Administrator wrote safety notices and activities department delivered to residents.-On 5/4/2026 important safety notice to all visitors was posted on the front doors, notice will be kept up for four weeks and then moved to guest sign in area. Administrator wrote safety notice and placed it on front door.-Ad Hoc QAPI meeting on 5/5/26 conducted with Medical Director, DON and Administrator. The meeting was held to discuss interventions and implementation related to elopement.-On 5/21/26 the facility initiated a second staff member to assist with all smoke breaks. This process also included that when all smoke breaks are completed, smoking assisting staff will notify nurses on duty that smoke break have concluded to eliminate the confusion on door alarms associated with smoke breaks.Monitoring:-The Facility conducted an elopement drill on 5/6/2026 and again on 5/22/26 with no concerns noted, completed by Maintenance Director. Facility to conduct elopement drills 2x a day for both shifts daily starting Monday 5/25/2026 and continue while facility is in IJ period, will conclude after IJ period and review with QAPI agrees. Elopement drills will be conducted by Administrator, Maintenance Director or DON.-Facility to complete daily AD HOC QAPI meetings daily starting 5/25/2026 during IJ period.