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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, review of the facility's job descriptions, and review of the facility's documents and policy, the facility failed to ensure that food was stored in a manner that minimized the risk of foodborne illness for all 78 current facility residents. Observation on 01/07/2026 and review of the facility's Food Temperature logs for 01/01/2026, 01/04/2026, 01/05/2026, and 01/06/2026 revealed the temperature in the facility's walk-in refrigerator/cooler was greater than 41 degrees Fahrenheit (F), the upper limit for the acceptable temperature.The findings include:Review of the undated policy titled, Preventing Foodborne Illness - Food Handling, revealed the functioning of the refrigerator and food temperatures were to be monitored at designated intervals throughout the day and documented according to state-specific requirements. Further review revealed federal standards required that refrigerated food be stored below 41 degrees Fahrenheit (F).Review of the Job Description for the Cook, signed 11/01/2016, revealed duties included inspection of all equipment for proper functioning and safety before and during use; to follow established safety and infection control procedures; to plan, direct, and supervise the food service program including food storage, inspection of all equipment and systems regularly for proper functioning and safety; and to notify maintenance immediately of repair needs. Review of the undated Job Description for the Dietary Manager revealed duties included having knowledge of supplies and equipment used by the department and the care of that equipment. It also revealed the Dietary Manager followed and assured that those dietary personnel followed established safety and infection control procedures. Per the job description, the Dietary Manager planned to ensure education and new training would be implemented and would follow up on that. Review of the poster Hazard Analysis Critical Control Points [HACCP], posted in the kitchen, revealed foods in cold storage should be held at a temperature of 41 degrees F or less. Review of the Food Temperature logs, dated 01/01/2026 to 01/06/2026, revealed printed references for staff to follow. The references stated the expected internal temperature of the walk-in refrigerator was 32 to 41 degrees F, and, in writing, staff was expected to tell the Dietary Manager immediately if temperatures in any area were not in the appropriate range. Further review of entries, dated 01/01/2026 through 01/06/2025, revealed the walk-in refrigerator temperatures were greater than 41 degrees F on 01/01/2026, 01/04/2026, 01/05/2026, and 01/06/2026.Observation on 01/07/2026 at 9:12 AM, during the initial tour of the kitchen, revealed the internal temperature of the walk-in refrigerator, according to the analog thermometer located on the inside shelf near the door, was 48 degrees F. The State Survey Agency (SSA) Surveyor advised the cook of the observation and requested a better placement of the thermometer for a more accurate reading. The SSA Surveyor told the Dietary Manager immediately afterward for her follow-up.Additional observation on 01/07/2026 at 11:15 AM revealed the analog thermometer had been repositioned to the back of the refrigerator, the thermometer had been replaced, but the temperature remained at 48 F. Further observation revealed at that time, the Dietary Manager was in the kitchen, and staff disposed of all refrigerated foods. No food from the refrigerator was used for the midday meal.During an interview on 01/07/2026 at 3:07 PM, the Dietary Manager stated she let the maintenance staff know of the problem, and there had never been a temperature issue with the refrigerator in the past. She stated the refrigerator, freezer, (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dishwasher, and food temperatures were checked daily by the cooks.During an interview on 01/07/2026 at 3:15 PM, [NAME] 3 stated she checked the refrigerator and freezer temperatures on 01/05/2026 and again on 01/06/2026. She stated the acceptable temperature for the walk-in refrigerator was 44 degrees F to 45 degrees F. She stated if food in the refrigerator was not kept cold enough, it could spoil and potentially cause a resident to become ill. She stated she did not inform the Dietary Manager of the temperature that had been obtained on either date. [NAME] 3 stated she had seen the poster HACCP that was posted in the kitchen. However, she stated she did not recall the temperatures that were listed.During an interview on 01/07/2026 at 3:35 PM, the Maintenance Director stated he was made aware of the concern related to the refrigerator temperature, and the repair company he reached out to would be there as soon as possible.During an interview on 01/08/2026 at 9:30 AM with the Registered Dietitian, she stated she performed a monthly audit of sanitation, food tray temperatures, and refrigerator/freezer temperatures for accuracy. She stated she had no previous concerns with any of her findings.During an interview on 01/08/2026 at 11:32 AM with [NAME] 2, he stated an acceptable refrigerator temperature was 32 degrees F to 45 degrees F. He stated if those temperatures were not adhered to, food could go bad and could cause mold or even cause resident illness. He stated if the temperatures were out of range or if there was any concern about temperatures or a need to repair something, he knew to go to the Dietary Manager or Maintenance staff. He stated the temperature he documented on the dinner temperature log on 01/06/2026 was 43 degrees F. [NAME] 2 stated he did not inform anyone about that finding or place a maintenance work order. During an interview on 01/08/2026 at 12:37 PM with [NAME] 4, she stated the temperature in the walk-in refrigerator should be 34 degrees F or lower. She stated she did not notify the Dietary Manager, Maintenance, or any authority, of her documented readings greater than 41 degrees F on 01/01/2026 and 01/04/2026. She stated the risk of foods not kept at the appropriate temperatures was they could go bad, but if they didn't smell bad, it would be okay. She stated she recalled seeing the poster HACCP that was hanging in the kitchen. When reviewing the information regarding the safe temperature of refrigerated foods, she stated she thought the temperature reading was for the freezer. During an interview on 01/08/2026 at 2:40 PM with the Administrator, she stated she was made aware of the temperature readings of the walk-in refrigerator, and the food had to be thrown out. She stated the risk of foods kept at temperatures outside of the safe parameters would be that residents could get sick.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, review of the facility's job descriptions, and review of the facility's documents and policy, the facility failed to ensure essential kitchen equipment was maintained and in safe operating condition for all 78 of the facility's current residents.The findings include:Review of the undated policy titled, Preventing Foodborne Illness - Food Handling, revealed the functioning of the refrigerator and food temperatures were to be monitored at designated intervals throughout the day and documented according to state-specific requirements. Further review revealed federal standards required that refrigerated food be stored below 41 degrees Fahrenheit (F).Review of the Job Description for the Cook, signed 11/01/2016, revealed duties included inspection of all equipment for proper functioning and safety before and during use; to follow established safety and infection control procedures; to plan, direct, and supervise the food service program including food storage, inspection of all equipment and systems regularly for proper functioning and safety; and to notify maintenance immediately of repair needs. Review of the undated Job Description for the Dietary Manager revealed duties included having knowledge of supplies and equipment used by the department and the care of that equipment. Review of the Food Temperature logs, dated 01/01/2026 to 01/06/2026, revealed printed references for staff to follow. The references stated the expected internal temperature of the walk-in refrigerator was 32 to 41 degrees F, and, in writing, staff was expected to tell the Dietary Manager immediately if temperatures in any area were not in the appropriate range. Further review of entries, dated 01/01/2026 through 01/06/2025, revealed the walk-in refrigerator temperatures were greater than 41 degrees F on 01/01/2026, 01/04/2026, 01/05/2026, and 01/06/2026.Review of an invoice from an outside contractor, dated 06/20/2025, revealed the walk-in cooler/refrigerator was running warm and was found to have clogged condenser coils. The invoice stated repairs were made and checked for effectiveness, and no further problems were identified.Review of an invoice from an outside contractor, dated 01/07/2026, revealed the walk-in cooler was warm, and the condenser coils were frozen. The defrost timer was also inconsistent. Per the invoice, the cause of frozen coils was listed as a likely prolonged exposure related to an opened cooler door. Observation on 01/07/2026 at 9:12 AM, during the initial tour of the kitchen, revealed the internal temperature of the walk-in refrigerator, according to the analog thermometer located on the inside shelf near the door, was 48 degrees F. The State Survey Agency (SSA) Surveyor advised the cook of the observation and requested a better placement of the thermometer for a more accurate reading. The SSA Surveyor told the Dietary Manager immediately afterward for her follow-up.Additional observation on 01/07/2026 at 11:15 AM revealed the analog thermometer had been repositioned to the back of the refrigerator, the thermometer had been replaced, but the temperature remained at 48 F. Further observation revealed at that time, the Dietary Manager was in the kitchen, and staff disposed of all refrigerated foods. No food from the refrigerator was used for the midday meal.During an interview on 01/07/2026 at 3:07 PM, the Dietary Manager stated she told maintenance staff the refrigerator was not staying cool enough. She stated the door consistently failed to close well, and staff had to try to keep it closed. She stated the last time she reported that to anyone to evaluate or repair was to a former maintenance man over two years ago, but no repairs were ever made. She stated she did not complete a work order or report the concern to the current Maintenance Director or the Administrator. She stated she did recall, during the past summer, there was a service call for the walk-in cooler/refrigerator for freon or fan repair, but the temperature was never an issue. She stated she could not recall how it was determined there was an issue if the temperature had not been identified as a concern.During an interview on 01/07/2026 at 3:15 PM, [NAME] 3 stated she was aware staff had to make a concerted effort to shut the door to the walk-in cooler. She stated, with heavy use at mealtimes, the door could stay open more than intended.During an interview on 01/07/2026 at 3:35 PM, the Maintenance Director stated he previously had not been made aware of issues concerning the walk-in cooler door. He stated a call (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was made to an outside contractor for repair, and the contractor would be at the facility as soon as possible, adding that it was most often the same day.During an interview on 01/08/2026 at 12:57 PM with [NAME] 4, she stated the door to the walk-in cooler required staff to make sure that it shut correctly. She stated she was not aware of it ever being looked at.During additional interview on 01/08/2026 at 2:04 PM with the Maintenance Director, he stated the problem was identified as a frozen coil because of leaving the walk-in refrigerator door open for a prolonged period of time, possibly overnight. He stated the refrigerator's functions, other than the door, were in good order. He stated he planned to follow up with the Administrator regarding the door and a possible solution. During an interview on 01/08/2026 at 2:40 PM with the Administrator, she stated she was made aware of the walk-in cooler door issue, and the Dietary Manager had staff throw away food that was inside. She stated the Maintenance Director and the service contractor would work toward a solution so there would not be a problem in the future. She stated she expected the dietary staff to let her or the Dietary Manager know if there was any concern, and contact numbers were posted throughout the building. She stated she would make sure staff was educated and given any additional training if needed.

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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 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 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview, record review, and review of the facility's document and policy, the facility failed to ensure appropriate coordination, oversight, communication, and continuity of care related to dialysis services for 1 of 38 sampled residents, Resident (R29). The facility failed to maintain an active contract with the dialysis provider and failed to ensure required dialysis communication was completed, sent, reviewed, and returned to the medical record to support continuity of care and monitor the resident's condition before and after dialysis treatments. This failure placed the resident at risk for unmet medical needs and complications related to dialysis services.The findings Include:Review of the facility's policy titled, Hemodialysis Access Care, revised September 2010, revealed the general medical nurse was expected to document in the resident's medical record every shift and obtain and maintain reports from the dialysis nurse post-dialysis. The facility was unable to provide evidence of an active contract or written agreement with the dialysis provider for R29, who was actively receiving off-site dialysis services.Review of R29's Face Sheet revealed the facility initially admitted the resident on 12/25/2022 with diagnoses including end-stage renal disease, type II diabetes mellitus, hypertension, and dependence on renal dialysis.Review of R29's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/02/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 13 of 15, indicating the resident was cognitively intact. Review of R29's Care Plan, revised 11/06/2025, revealed R29 attended off-site dialysis three days per week and had a left upper arm arteriovenous (AV) fistula.Review of the facility's document Dialysis and Nursing Home Handoff Communication Tool, undated, revealed the section to be completed by the nursing home and sent with the resident for each dialysis treatment was incomplete for 12/29/2025, 12/31/2025, 01/02/2026, and 01/05/2026. However, further review revealed the dialysis center sent those forms back to the facility with R29, with their section completed. During an interview on 01/08/2026 at 4:00 PM, Registered Nurse (RN) 1 stated she forgot to complete the nursing home section of the dialysis communication form for 01/02/2026 that was sent to the dialysis center. She further stated it was important to communicate with dialysis staff to be aware of any changes or complications. During an interview on 01/08/2026 at 4:30 PM, Licensed Practical Nurse (LPN) 3 stated she forgot to complete and send the dialysis communication form on 12/31/2025 with R29. She stated it was important to complete the nursing home section to update the dialysis center of any changes that could impact treatment. During an interview on 01/08/2026 at 3:00 PM, the Director of Nursing (DON) stated she expected nursing staff to complete the nursing home section of the dialysis communication form and ensure the dialysis section was completed and reviewed upon the resident's return from each dialysis treatment to support continuity of care and ensure the facility was aware of the resident's status during and after dialysis.During an interview on 01/08/2026 at 2:00 PM, the Administrator stated the dialysis contract had been misplaced by the nursing facility and the dialysis provider. The Administrator further stated the facility should have an active contract when a resident was receiving dialysis services. The Administrator stated nursing staff should complete dialysis communication forms to ensure effective communication and continuity of care between the facility and the dialysis provider.