STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00181162. The 2567 was sent electronically on 08/02/23.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1	F 550		

resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 51. The sample included 13 residents with two reviewed for dignity. Based on interviews and record review, the facility failed to provide dignified care for Residents (R)206 and R30. This deficient practice placed the residents at risk for decreased psychosocial well-being.

Findings Included:

- The "Medical Diagnosis" section within R206's Electronic Medical Records (EMR) included diagnoses of spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), hemiplegia (left sided paralysis of one side of the body), hemiparesis (left sided muscular weakness of one half of the body), major depressive disorder (major mood disorder), insomnia (difficulty sleeping), and Parkinson's Disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

R206 admitted to the facility on 07/07/23 for respite care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2	F 550		

R206 had not had a "Minimum Data Set (MDS)" and Brief Interview for Mental Status (BIMS) assessment completed due to her recent admission to the facility.

R206's "Care Plan" initiated 07/10/23 indicated she was dependent of staff for all activities of daily living (ADLs). The plan indicated she was incontinent of bowel and bladder. The plan noted she required staff assistance with all toileting needs.

On 07/17/23 at 08:45AM R206 slept in her bed. R206 had a low air loss mattress set to her approximate weight, pancake style call-light, and fall mat placed on the right side of her bed.

At 09:07AM staff were heard out in the "Rapid Recovery" hallway discussing the unit's incontinent residents. An unidentified staff member then loudly stated "I checked on [R206], [R206] is dry" down the hall to another staff member before leaving the area.

On 07/19/23 at 01:45PM Certified Nurse's Aide (CNA) M stated staff should never discuss a resident's care or private information in public areas. She stated staff should go to an office or private area to pass on care related information.

On 07/19/23 at 02:00PM Licensed Nurse (LN) H stated staff should never yell out or talk about personal information in front of other residents or visitors. She stated most staff relay information in the resident's room during turnover (shift change) or at the nurse's station.

On 07/19/23 at 02:23PM Administrative Nurse D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3	F 550		

stated staff were expected to respect each resident's privacy and dignity. Staff should move to another area away from residents and visitors to discuss care concerns and information.

The facility did not provide a policy related to dignity as requested on 07/19/23.

The facility failed to provide dignified care for R206. This deficient practice placed the residents at risk for decreased psychosocial well-being.
- On 07/17/23 at 08:30AM R30 was heard yelling in the "Red Hall." Certified Medication Aide (CMA) R was heard saying "Stop Yelling" and was observed walking away from R30's room. R30 continued to yell for staff to assist him. At 08:41AM Certified Nurse Aide (CNA) N asked R30 why he continued to yell. R30 stated to her that he needed a Kleenex for his nose.

On 07/17/23 at 09:05AM R30 reported he had difficulty hearing and communicating. He stated he kept asking staff for Kleenex due to his nose being "stopped up." He stated staff kept walking past his room and no one would give him one.

On 07/19/23 at 01:32 PM CNA M stated that if a resident was yelling, she would talk to the resident to find out why. She stated that she would not just tell them to stop yelling.

On 07/19/23 at 01:46 PM Licensed Nurse (LN) H stated that even if a resident was yelling or talking loudly, it was not ok for a staff member to tell that resident to stop yelling. She stated that staff should speak with the resident and find out why they were yelling.

On 07/19/23 at 02:14 PM Administrative Nurse D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 stated that the expectation for staff was staff should find out why a ersident was yelling or calling out. She stated that it would not be ok for a staff member to simply tell the resident to stop yelling. The facility did not provide a policy on dignity. The facility failed to ensure R30 was treated in a dignified manner. This deficient practice placed the resident at risk for decreased psychosocial well-being.	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 5	F 582		

facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 51 residents. The sample included 13 residents with three residents reviewed for beneficiary notices review. Based on observation, record review, and interviews, the facility failed to provide Resident (R)6 with an "Notice of Medicare Non-coverage" (NOMNC CMS-form 10123) and "Advanced Beneficiary Notice" (ABN CMS-10055) with Medicare-Part A days remaining. This deficient practice placed R6 at risk for delayed care and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 6	F 582		

missed services.

Findings Included:

- A review of R6 EMR revealed an "Medicare End of Stay Minimum Data Set (MDS) completed on 04/14/23 noting she was being discharge for Medicare part A services but expected to remain in the facility.

A review of R6's EMR indicated her last covered day for Medicare part A services was 04/15/23.

On 07/19/23 R6's "Beneficiary Notification Review" was completed. The review indicated the facility-initiated her discharge from therapy services but R6 was not provided an ABN or NOMNC form. A review of the Centers for Medicare and Medicaid Services (CMS) requirements indicated the facility was required to issue both forms when R6 remained in the facility after her facility-initiated discharge from services with days remaining.

On 07/19/23 at 01:30PM Social Service X reported the facility had interdisciplinary meetings Tuesday to discuss upcoming discharges. She stated the facility completes NOMNC and ABN paperwork three days prior to the last covered date. She stated she was out of the facility the week R6 was due to be discharged and does not know why R6 never received the forms.

The facility did not provide a policy related for beneficiary notices.

The facility failed to provide R6 with ABN and NOMNC forms upon her facility-initiated discharge from Medicare-Part A services. This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 582	Continued From page 7 deficient practice placed R6 at risk for delayed care and missed services.	F 582		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility identified a census of 51 residents. The sample included 13 residents. Based on observation, record review, and interviews, the facility failed to complete an accurate Minimum Data Set (MDS) assessment for Resident (R) 9 for special treatment and programs when the MDS documented she received dialysis (a process of removing excess water, solutions, and toxins from the blood) during the look back period. This deficient practice placed R9 at risk for inappropriate care planning and care needs. Findings included: - R9's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing), and major depressive disorder (major mood disorder). The "Significant Change Minimum Data Set" (MDS) dated 07/20/22 documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented that R9 required extensive	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 8	F 641		

assistance of one staff member for activities of daily living (ADLs). The MDS documented R9 received hospice services.

The "Quarterly MDS" dated 04/20/23 documented a BIMS score of nine which indicated moderately impaired cognition. The MDS documented that R9 required extensive assistance of two staff members for ADLs. The MDS documented R9 had received hospice services and dialysis.

R9's "ADL Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 08/05/22 documented R9 was on hospice care and a decline in ADLs was anticipated.

R9's "Care Plan" revised on 02/02/22 documented R9 was incontinent of bowel and bladder and would need assistance with completing peri-care.

On 07/18/23 at 01:46 PM R9 sat in wheelchair next to her bed. She smiled and was cheerful during a conversation.

On 07/17/23 at 07:56 AM Administrative Nurse D stated the facility had no residents on dialysis services.

On 07/19/23 at 11:45 AM Administrative Nurse E stated R9's quarterly MDS on 04/20/23 had been marked in error for dialysis services. Administrative Nurse E stated R9 had never been on dialysis.

The facility's "Minimum Data Ser (MDS)" policy last revised 11/28/17 documented the facility would conduct a comprehensive assessment (Minimum Data Set) according to Federal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 9 regulations and Medicare guidelines. The data gathering may be done by a licensed nurse or other member of the interdisciplinary team and reviewed by a registered nurse for completion. The facility staff would follow the current Resident Assessment Instrument (RAI) manual for proper procedures on completing the MDS. The facility failed to accurately reflect the status of R9 during the look back periods. This placed residents at risk for inappropriate care planning and care needs.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 10	F 657		

(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 51 residents. The sample included 13 residents with two residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to revise Resident (R) 42's comprehensive care plan to include administration of oxygen. This deficient practice placed R42 at risk for the potential alteration of continuous care among nursing home staff, that could result in adverse consequences related to respiratory distress and adverse side effects.

Findings included:

- R42's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), sleep apnea (disorder of sleep characterized by periods without respirations), and major depressive disorder (major mood disorder).

The "Annual Minimum Data Set" (MDS) dated 04/13/23 documented a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. The MDS documented that R42 required extensive assistance of two staff members for activities of daily living (ADLs). The MDS documented R42 received oxygen therapy during look back period.

R42 's "ADL Functional/Rehabilitation Potential

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 11	F 657		

Care Area Assessment" (CAA) dated 04/26/23 documented R42 required assistance of staff for ADLs.

R42's "Care Plan" lacked direction to nursing staff for oxygen therapy.

Review of the EMR under "Orders" tab revealed physician orders:
Oxygen per nasal cannula at bedtime two liter per minute dated 04/18/22.

On 07/17/23 at 09:27 AM R42 laid on the bed, with the head of bed was elevated. She was awake and had the nasal cannula in her right hand.

On 07/19/23 at 01:33 PM Certified Nurse Aide (CNA) M stated all the staff had access to the Kardex (a medical information system used by nursing staff as a way to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change) which has the information on each resident and individualized information. CNA M stated if a resident was on oxygen therapy, that infomration should be on the Kardex.

On 07/19/23 at 01:46 PM Licensed Nurse (LN) H stated everyone had access to the Kardex which comes from the information the care plan. LN H stated the care plans were updated by the director of nursing and the MDS coordinator. LN H stated care plan/Kardex should contain direction for a resident who was on oxygen therapy.

On 07/19/23 at 02:14 PM Administrative Nurse D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 12 stated everyone had access to the care plan /Kardex for each resident. Administrative Nurse D stated that her and the MDS coordinator updated the care plans with any new updates. Administrative Nurse D stated oxygen therapy should be placed on the care plan. The facility's "Care Plan" policy last revised 11/28/17 documented a care plan would be developed for each resident that includes measurable objectives to meet a resident's medical, nursing, mental and psychosocial needs and are consistent with the resident's desires and preferences. The care plan should be updated on an ongoing basis as the resident achieves goals and progresses toward discharge. The facility failed to revise R42's comprehensive care plan to include her use of oxygen therapy. This deficient practice placed R42 at risk for the potential alteration of continuous care among nursing home staff, that could result in adverse consequences related to respiratory distress.	F 657		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 13	F 679		

by:
The facility identified a census of 51. The sample included 13 residents. Based on interviews and record review, the facility failed to provide activities on the weekends which reflected the residents' interests, and preferences. This placed the residents at risk for boredom, isolation, and decreased quality of life.

Findings included:

- A review of the facility's activity calendars for April, May, June, and July 2023 indicated church services on Sundays and "Always Available Items" marked for Saturdays. The calendars noted no other activities on the weekends.

The activity calendar for April, May, and June 2023 revealed no activities scheduled on any Sunday except afternoon church services.

In a confidential interview with the resident council on 07/18/2023, several residents reported that though there were weekday activities, the facility did not provide any structured activities on most Saturdays and Sundays. The council reported they had church on Sundays, but the rest of the day had no scheduled activities.

On 07/19/2023 at 01:20pm Activities Staff Z reported the facility provided the residents with movies on the weekends. She stated the direct care staff were responsible for assembling the residents for the movie-time. She reported that games, puzzles, and other items were also left out on weekends for the residents to complete "self-initiated" activities for resident who were able. She stated cognitively impaired residents received one-one activities and attention based

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 14 on their needs assessment. She stated the facility provided sensory activities and objects for them to use. On 07/19/2023 at 01:30pm Certified Nurse's Aide (CNA) M reported the facility did not have organized activities due to the Activities Staff Z being off on the weekends, but staff would still take the residents outside or watch television or movies. On 07/19/2023 at 01:40pm Licensed Nurse (LN) H stated a lot of self-activities occurred on the weekends. She stated games and activities pages were provided to the residents. She stated sometimes movies and sports events would be played on the big television at the end of the hall. A review of the facility's "Activities" policy revised 04/2018 indicated the facility would provide ongoing program to support the choice of activities and interest. The policy noted consistent facility sponsored group activities would be provided to meet the needs of the residents. The facility failed to provide activities on the weekends which reflected the residents' interests, and preferences. This placed the residents at risk for boredom, isolation, and decreased quality of life.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 15	F 684		

that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 51 residents. The sample included 13 residents. Based on observation, record review and interview, the facility failed to ensure that physician ordered daily weights were obtained and monitored for Resident (R) 45 who had congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid). This deficient practice placed R45 at risk for unwanted weight/fluid gain and possible complications.

Findings included:

- The electronic medical record (EMR) for R45 documented diagnoses of CHF, chronic kidney disease (condition characterized by a gradual loss of kidney function over time), biventricular heart failure (a condition of both left and right-sided heart of the resulting in shortness of breath and a build-up of fluid), and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The "Admission Minimum Data Set" (MDS) dated 06/12/23 documented R45 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated intact cognition. R45 required extensive assistance of one staff member for her activities of daily living (ADLS) and utilized the use of a walker and wheelchair to aide in ambulation. R45 was on a urinary training program and had occasional urinary incontinence. R45 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16	F 684		

shortness of breath and required the use of supplemental oxygen. R45 had a history of falls. R45 had unhealed pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) that were present on entry R45 was on a prescribed weight loss regimen. R45 was on an anticoagulant (medications that prevent blood clots) and a diuretic (medication to promote the formation and excretion of urine to remove excess fluid build-up in the body).

The "Nutritional Care Area Assessment" (CAA) dated 06/18/23 documented R45 had recent diuresis (increased formation and secretion of urine) in the hospital for a 20-pound weight gain/fluid overload.

The "Cardiac (Diuretic) Care Plan" initiated 06/30/23 for R45 directed staff to administer diuretic medication as prescribed. Staff was to monitor lab work as ordered by physician. Staff was to observe for any edema (swelling) and report changes to physician.

Under the "Orders" tab of the R45's EMR documented a physician's order dated 05/20/23 to weigh daily per physician orders every day shift notify physician if weight gain more than three pounds in one day or five pounds in one week.

Under the "Orders" tab of the EMR R45 had a physician's order dated 05/20/23 for fluid restriction of two liters or 2000 milliliters (ml) per day.

Under the "Orders" tab of the EMR R45 had a physician's order dated 05/22/23 for Lasix (a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17	F 684		

diuretic medication) 20 milligrams (mg) tablet give 20 mg by mouth one time only related to CHF. This order was discontinued 05/22/23.

Under the "Orders" tab of the EMR R45 had a physician's order dated 05/22/22 Lasix 20 mg give 20 mg by mouth in the morning related to CHF. This order was discontinued 06/05/23.

Under the "Orders" tab of the EMR R45 had a physician's order dated 06/05/23 for Lasix to give 80 mg by mouth two times a day for edema. This order was discontinued on 07/18/23.

Under the "Orders" tab of the EMR R45 had a physician's order dated 06/13/23 for daily weight, needs to be accurate as possible per physician, get weight before breakfast per provider related to CHF.

Under the "Orders" tab of the EMR R45 had a physician's order dated 07/18/23 Lasix 40mg give on tablet by mouth two times a day related to CHF.

Upon review of the May 2023 "Medication Administration Record/Treatment Administration Record" (MAR/TAR) for R45 revealed R45's physician ordered daily weight was not obtained on six (05/20/23, 05/24/23, 05/26/23, 05/27/23, 05/28/23 and 05/31/23) of 12 opportunities, and R45 refused to be weighed on 05/25/23.

Upon review of R45's June 2023 MAR/TAR revealed R45's physician ordered daily weight was not obtained on seven (06/05/23, 06/12/23, 06/20/23, 06/25/23, and 06/26/23) of 26 opportunities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18	F 684		

Upon review of R45's July 2023 MAR/TAR revealed R45's physician ordered daily weight was not obtained on 10 (07/05/23 through 07/11/23, 07/13/23, 07/17/23, and 07/18/23) of 18 opportunities.

Review of R45's "Progress Notes" in the EMR lacked documentation to reflect that R45's weight had not been obtained on the above noted dates nor had the physician been notified of the missed daily weight being obtained. The record lacked evidence of refusals for the dates listed.

On 07/18/23 at 10:40 AM R45 laid in bed, head of bed elevated, no sign/symptoms of distress or shortness of breath. R45 stated at times she had not felt like getting out of bed to be weighed so staff would come in with the lift and weight her that way. R45 stated obtained her weight that day after she returned from her morning doctor's appointment.

On 07/19/23 at 01:28 PM Certified Nurse Aide (CNA) M stated the aides were given a list daily of which residents were a daily weight or needed to be weighed. CNA M stated R45 had never refused getting her weight that she could recall, but she had to get the lift and use that to obtain the weight on occasion. CNA M stated R45's weight was typically obtained before breakfast and the weights were then given to the charge nurse.

On 07/19/23 at 01:46 PM Licensed Nurse (LN) H stated each morning the charge nurse would hand the aides a list of residents that were to be weighed that day. LN H stated R45 was a daily weight but normally would not refuse to get her weights done. LN H stated R45 had not felt like

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19 getting out of bed at times so staff would have to bring in the lift scale to get her weight. LN H stated the nurse was expected document the daily weight on the MAR/TAR and document a progress note and notify the physician when R45's daily weight had not been obtained. On 07/19/23 at 02:14 PM Administrative Nurse D stated the charge nurse would hand out a list of who was to be weighed each day. Administrative Nurse D state she could not say for fact who all the daily weights were but did know that R45 was to be weighed each morning before breakfast. Administrative Nurse D stated that the aides documented monthly weights in their "point of care" (POC), but the nurses had to document daily weights on the MAR/TAR. Administrative Nurse D stated she would expect the nurses to document a progress note and notify the physician when a daily weight was not obtained. The facility did not provide a policy related to CHF. The facility failed to ensure that staff obtained physician ordered daily weights and failed to notify the physician when ordered daily weight was not obtained for R45 who had CHF. This deficient practice placed R45 at risk for unwanted weight/fluid gain and possible complications due to disease process.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20	F 689		

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 51 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure care planned fall interventions were followed for Resident (R) 1 after a fall on 06/25/23. This deficient practice placed R1 at risk for additional falls and possible injury.

Findings included:

- The electronic medical record (EMR) for R1 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), peripheral vascular disease (PVD-abnormal condition affecting the blood vessels), osteoarthritis (chronic arthritis without inflammation), and constipation (difficulty passing stools).

The "Annual Minimum Data Set" (MDS) dated 06/08/23 for R1 documented a Brief Interview for Mental Status (BIMS) score of nine which indicated moderately impaired cognition. R1 required extensive assist of one staff for activities of daily living (ADLs). R1's balance was not steady and was only able to stabilize with staff assistance. R1 utilized the use of a walker and a wheelchair for mobility. R1 was frequently incontinent of bowel and bladder. R1 had a history of falls and has had two or more falls without injury since the prior assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21	F 689		

The "Falls Care Area Assessment" (CAA) dated 06/22/23 documented R1 had a history of falling. R1 had advanced dementia and occasionally rejected cares. R1 was able to make simple needs known, R1 sometimes understood others and had hearing and vision loss.

The "Falls/Mobility Care Plan" last revised 06/29/23 directed staff R1 used her wheelchair for locomotion and needed assistance of a staff member to propel her to/from the bathroom, R1 may not always remember to use call light so if staff saw R1 up staff was to assist her. Staff was to assist and provide guidance for R1 before she sat on the toilet to prevent from missing the toilet. An intervention was put in place 06/27/23 directing staff to start a three-day voiding diary to help determine her toileting schedule.

A "Un-witnessed Fall Report #1021" dated 06/25/23 for R1 documented at approximately 03:00 PM staff reported that R1 was on the floor of her bathroom. R1 was observed lying on the floor on her right side with her head up against the wall. R1 was assisted back to her wheelchair with assist of three staff and use of a gait belt. A head-to-toe skin assessment revealed a hematoma (swelling) to back of her head. R1 was unable to give a description of the incident. R1 was placed in the commons area next to the nurse's station and neurological checks were initiated. Staff was educated to ensure that R1 was not to be left in her room in her wheelchair.

A "Note" dated 06/27/23 added to Un-witnessed Fall Report #1021 documented R1 was laying on her bathroom floor on her back and her head against the wall, the call light was not used. R1 was using her walker, non-skid socks were in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 22	F 689		

place and her brief was wet. R1 was unable to state what happened. A head-to-toe assessment was performed and R1 was noted to have a four centimeter (cm) by 4.5 cm hematoma to the posterior (back) left side of her head. R1 was assisted up to the toilet and a three-day voiding diary needed to be initiated to help determine appropriate voiding schedule in an attempt to better predict when R1 would need to be assisted.

R1's clinical record lacked evidence a three-day voiding diary, or an assessment and analysis of R1's voiding patterns, was completed.

On 07/18/23 at 10:30 AM R1 was resting in her recliner in her room, call light within reach.

On 07/19/23 at 01:07 PM R1 sat in her recliner in her room resting.

On 07/19/23 at 10:54 AM Administrative Nurse D stated she was unable to locate or find any indication that the voiding diary for R1 had been completed.

On 07/19/23 at 01:32 PM Certified Nurse Aide (CNA) M stated R1 had dementia and would not always remember to use her call light when she needed to go to the bathroom. CNA M stated R1 was known for trying to take herself to the bathroom without calling for staff assistance. CNA M stated R1 had several falls while in the bathroom. CNA M said she was not aware of or did not know about R1 having a three-day voiding diary recently.

On 07/19/23 at 01:46 PM Licensed Nurse (LN) H stated the nurses did have access to update the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23 care plan with new interventions after a fall or something new was needed, but typically the MDS Coordinator or Administrative Nurse D would put new interventions in the care plan or update the care plan. LN H stated she did not know about a voiding diary for R1, that would be something that Administrative Nurse D would have initiated after R1's fall. On 07/19/23 at 02:14 PM Administrative Nurse D stated at the time of R1's fall on 06/25/23 she had been working from home and had told staff to initiate the three-day voiding diary for R1 but upon her return to the facility she had noted that there was no documentation to reflect that the voiding diary had been completed or documented. Administrative Nurse D stated that was an error that the voiding diary had not been completed. The facility policy "Occurrences" documented any incident or occurrence was thoroughly investigated to rule out abuse and neglect and to determine a root cause. Appropriate interventions were developed based on the root cause analysis. The facility failed to ensure staff followed a post-fall intervention to complete a three-day voiding analysis for R1 who had a history of falls while attempting to go to or be toileted. This placed R1 at increased risk of falls and/or injury.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 24	F 692		

enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 51 residents. The sample included 13 with two reviewed for nutrition. Based on observation, interviews, and record review, the facility failed to provide consist weekly weight monitoring as identified on Resident (R)14's nutritional care plan. This deficient practice placed R14 at risk for complication related to weight loss and malnutrition (condition that develops when the body is deprived of vitamins, minerals and other nutrients).

Finding included:

- The "Medical Diagnosis" section within R14's Electronic Medical Records (EMR) included diagnoses of protein-calorie malnutrition, legal blindness, dementia (progressive mental disorder characterized by failing memory, confusion), and spondylosis (age-related condition where the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 25	F 692		

joints and cartilage lined discs of the neck are affected).

R14's "Annual Minimum Data Set (MDS)" completed 06/08/2023 noted a Brief Interview for Mental Status (BIMS) assessment was not completed due to severe cognitive impairment. The MDS indicated she required extensive assistance from two staff for transfers, bed mobility, locomotion, dressing, personal hygiene, toileting, and bathing. The MDS indicated she required extensive assistance from one staff for meals. The MDS indicated her weight was 103 pounds (lbs.). The MDS indicated no significant weight loss.

R14's "Dementia Care Area Assessment (CAA)" completed 06/22/23 indicated she had severe dementia and staff were to anticipate her needs.

R14's "Nutritional CAA" completed 06/22/23 noted her oral intake was adequate. The CAA noted she had a puree diet and took supplements when offered. The CAA indicated she was dependent on staff for meals. The CAA noted she would maintain her current weight.

R14's "Activities of Daily Living CAA" was not triggered.

R14's "Care Plan" revised 06/24/21 indicated she was legally blind. The plan indicated she required extensive assistance from staff for bathing, meals, toileting, dressing, and personal hygiene. The plan noted she required assistance from two staff for transfer and repositioning (side to side) in bed. The plan noted she required a Hoyer lift (full body mechanical sling-lift) for transfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 26	F 692		

R14's "Care Plan" 07/02/20 noted her nutritional status needed to be assessed at least once yearly or with changes in condition. The plan noted her diet be provided as ordered. The plan instructed staff to monitor her weight weekly.

R14's EMR under "Physician's Order" revealed an order started 06/04/20 and discontinued 07/06/20 instructing staff weigh her one time weekly for four weeks.

R14's EMR under "Weight History" revealed periods of weight loss between 04/25/22 to 07/13/22 (13.6 lbs. loss), 1/4/23 to 02/09/23 (nine-pound loss), and 05/01/23 to 05/15/23 (six-pound loss).

R14's "Weight History" between 02/01/2023 through 07/19/23 (170 days reviewed) indicated she was being weighed on Mondays. A review of the history revealed no weekly weights on seven occasions (3/27, 4/17, 5/29, 6/12, 6/26, 7/10, and 7/17).

A "Dietary Note" completed 07/06/22 indicated R14 had a recent weight loss and instructed staff to continue with her nutritional plan of offering assistance and protein supplementation. The instructed continued monitoring of R14's weight and oral intake.

R14's "Annual Dietary Assessment" completed 06/02/22 indicated she was at risk for weight loss due to her medical diagnoses. The assessment indicated her weight was 95.6 lbs. The assessment noted her "Nutritional Plan" included protein supplementation, fortified foods, and monitoring weights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 27	F 692		

A "Dietary Note" completed 05/04/23 indicated R14's documented weight loss may have been an inaccurate entry. The note instructed staff to continue to weigh R14 weekly and aid/supplementation as ordered.

R14's "Annual Dietary Assessment" completed 06/02/23 indicated she remained underweight due to her diagnosis of protein calorie malnutrition. The assessment indicated her weight was 96.4lbs. The assessment indicated no changes in her dietary plan would be made. The plan indicated weight loss and oral intake changes were to be expected.

On 07/17/23 at 11:50AM R14 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline) near the back area of the dining room. R14's food arrived at 12:03PM. R14's food was pureed protein, mashed potatoes, and pureed green vegetables. Staff placed clothing protector on R14 and sat to her right side. Staff assisted R14 with her meal and juice.

On 07/19/23 at 01:45PM Certified Nurse's Aide (CNA) M indicated she worked with R14 and frequently weighed her when she was on the provided weight list. She stated the unit nurse would provide the list needed for daily weights to the direct care staff in the morning. She stated she was not sure what weight schedule R14 was on, and could not remember if she was weekly or monthly. She stated all direct care staff had access to review the care plans.

On 07/19/23 at 02:00PM Licensed Nurse (LN) H stated she was not sure when R14 was to be weighed. She stated residents with identified weight loss or at risk should have an order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 28 entered signifying when they were to be weighed. She stated at risk resident were usually weighed weekly unless on a medication requiring daily monitoring. She stated the care plan would also show if a resident required additional weight interventions. She stated R14 was at risk for weight loss due to her inability to feed herself and dementia. On 07/19/23 at 02:23PM Administrative Nurse D stated she expected staff to follow the orders and recommendations related to the resident's nutritional plans and weight monitoring. She stated staff should be reviewing the weights taken and reporting to the dietician and physician of changes. A review of the facility's "Weight Loss Prevention" policy revised 04/2020 indicated residents identified at risk for weight loss would be provided with nutritional interventions and dietary consults. The policy indicated care planned interventions will be implemented and followed per recommendations. The facility failed to provide consist weekly weight monitoring as identified on R14's nutritional care plan. This deficient practice placed R14 at risk for complication related to weight loss and malnutrition.	F 692		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 29 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 51 residents. The sample included 13 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the physician was notified when antihypertensive medication (class of medication used to treat hypertension (high blood pressure) was not administered for Resident (R) 39 and blood sugars were outside of parameters for R7. This deficient practice placed these residents at risk for unnecessary medication use and possible unwarranted side effects. Findings included: - R39's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 30	F 757		

tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), major depressive disorder (major mood disorder), and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Data Set" (MDS) dated 04/27/23 documented a Brief Interview of Mental Status (BIMS) score of 11 which indicated moderately impaired cognition. The MDS documented that R39 required extensive assistance of two staff members for activities of daily living (ADLs). The MDS documented R39 had received anticoagulant (class of medications used to prevent the formation of blood clots) for seven days, antipsychotic (class of medications used to treat psychosis {any major mental disorder characterized by a gross impairment in reality testing} and other mental emotional conditions) for six days, and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) for four days during the look back period.

R39's " Psychotropic Drug Use Care Area Assessment" (CAA) dated 05/12/23 documented R39 did not have an increase in behaviors.

R39's "Care Plan" dated 04/17/21 documented R39 received medication that had a black box warning (BBWs-the most serious medication warning put in the labeling of prescription medications by the U.S. Food and Drug Administration when there is reasonable evidence of an association of a serious hazard with the drug). The nursing staff would monitor and notify the physician if indicated.

Review of the EMR under "Orders" tab revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 31	F 757		

physician orders:
Cozaar tablet (antihypertensive) 50 milligrams (mg) give one tablet by mouth in the morning for hypertension (elevated blood pressure) dated 10/09/21.

Review of the Medication Administration Record (MAR) revealed in June 2023 (30 days) cozaar was held due to R39 was asleep on the following dates (six days): 06/07/23, 06/17/23, 06/18/23, 06/22/23, 06/29/23, and 06/30/23. The MAR documented resident had refused medication on the following dates (eight days): 06/02/23, 06/03/23, 06/08/23, 06/10/23, 06/12/23, 06/24/23, 06/25/23, and 06/27/23.

R39's clinical record lacked documentation of physician notification of resident refusal of antihypertensive medication or the resident's inability to take the medication related to being asleep.

On 07/18/23 at 10:14 AM R39 sat in a wheelchair next to the bed; the bedside table was out of her reach, and her left shoe was on the floor in front of the wheelchair. She was not wearing Thrombo-Embolic-Deterrent (T.E.D. hose-specialized compression stockings designed to help manage swelling of the feet/legs).

On 07/19/23 at 01:46 PM Licensed Nurse (LN) H stated the physician should be notified when antihypertensive medication was held or refused frequently. LN H stated the notification would be documented in the clinical record under the "Progress note" tab.

On 07/19/23 at 02:14 PM Administrative Nurse D stated she expected the physician to be notified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 32	F 757		

of a resident's continued refusal or if staff had a medication frequently. Administrative Nurse D stated the notification would be documented in the clinical record under the "Assessment "or "Progress Note" tab.

The facility's "Clinical Notification" policy last revised 11/28/17 documented it was the policy that notification of physicians and other clinicians would be done on a timely basis. The resident's physician and/or other pertinent clinicians would be notified if a need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment). Decision making regarding notification parameters for clinical signs and symptoms would be based on physician orders and physician specific parameters.

The facility failed to ensure the physician was notified when antihypertensive medication were not consistently administered as ordered for R39. This deficient practice placed her at risk of risk for unnecessary medication use and possible unwarranted side effects.
- R7's Electronic Medical Record (EMR) documented diagnoses of type two diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and dementia (progressive mental disorder characterized by failing memory, confusion).

R7's "Annual Minimum Data Set (MDS)" dated 04/13/23, documented a Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. R7 received insulin (hormone that lowers the level of glucose in the blood)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 33	F 757		

seven days in the seven-day look back period.

The "Falls Care Area Assessment (CAA)" dated 04/13/23, documented R7 had a diagnosis of dementia.

The "Care Plan" with interventions dated 05/26/21, directed staff to notify R7's provider if her blood glucose level was greater than 300 milligrams per deciliter (mg/dl) or less than 70 mg/dl and to monitor her blood glucose as ordered by her physician and as needed.

A "Physician's Order" with a start date of 04/28/21, directed staff to monitor R7's blood glucose four times a day for diabetes mellitus and to notify the physician if her blood glucose was greater than 400 mg/dl or less than 70 mg/dl.

Review of R7's EMR revealed a blood glucose level below 70 mg/dl with no evidence of physician's notification documented for the following days:
02/05/23 - 62 mg/dl
02/13/23 - 67 mg/dl
02/14/23 - 61 mg/dl
02/25/23 - 48 mg/dl
02/26/23 - 68 mg/dl
02/27/23 - 60 mg/dl
02/28/23 - 51 mg/dl
03/07/23 - 69 mg/dl
03/20/23 - 67 mg/dl
03/26/23 - 52 mg/dl
04/03/23 - 67 mg/dl
04/10/23 - 68 mg/dl
04/20/23 - 68 mg/dl
04/22/23 - 64 mg/dl
04/26/23 - 68 mg/dl
05/02/23 - 67 mg/dl

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 34	F 757		

05/04/23 - 53 mg/dl
05/16/23 - 66 mg/dl
05/17/23 - 69 mg/dl
05/27/23 - 66 mg/dl
05/28/23 - 61 mg/dl
06/17/23 - 44 mg/dl
06/18/23 - 68 mg/dl
07/01/23 - 61 mg/dl
07/17/23 - 68 mg/dl

On 07/18/23 R7 sat in her wheelchair, in her room, and watched TV.

On 07/19/23 at 11:16 AM Licensed Nurse (LN) G stated that if she had to report a blood glucose level that was outside of ordered parameters to the physician, she would enter that information into a progress note after the physician had been notified. She stated that she did not believe there was another location to chart physician notifications.

On 07/19/23 at 01:46 PM LN H stated that staff were supposed to call the doctor and then enter a progress note if they checked a resident's blood glucose level and found that it was outside of ordered parameters. She stated that a progress note should be entered regardless of whether the results were called or faxed to the doctor.

On 07/19/23 at 02:14 PM Administrative Nurse D stated that if a staff member checked a resident's blood glucose and found it to be outside of ordered parameters, once the doctor was notified, staff were expected to enter a nurses note or an eINTERACT notification in the resident's chart.

The facility's "Clinician Notification" policy revised

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 35 on 11/28/27, documented that it is the policy that notification of physicians and other clinicians will be done on a timely basis. The facility failed to ensure staff notified R7's physician for blood glucose readings below 70 mg/dl as directed by R7's orders. This placed the resident at risk for unnecessary complications related to her DM and insulin use.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 36	F 758		

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 51 residents. The sample included 13 residents with five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 9 did not receive antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) for an extended duration when staff failed to change a scheduled dose in response to a physician ordered gradual dose reduction (GDR) and failed to ensure the as needed (PRN) antipsychotic medication did not extend for a duration longer than 14 days without physician visit and rationale. The facility further failed to ensure an appropriate indication, or the required physician documentation, for continued use for R36's Seroquel (antipsychotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 37	F 758		

medication). This deficient practice placed R9 and R36 at risk for unnecessary psychotropic (alters mood or thought) medications and adverse side effects.

Findings included:

- R9's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion), unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing), and major depressive disorder (major mood disorder).

The "Significant Change Minimum Data Set" (MDS) dated 07/20/22 documented a Brief Interview of Mental Status (BIMS) score of nine which indicated moderately impaired cognition. The MDS documented that R9 required extensive assistance of one staff member for activities of daily living (ADLs). The MDS documented R9 had received antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) for six days, and antipsychotic (class of medications used to treat psychosis {any major mental disorder characterized by a gross impairment in reality testing} and other mental emotional conditions) seven days during the look back period.

The "Quarterly MDS" dated 04/20/23 documented a BIMS score of nine which indicated moderately impaired cognition. The MDS documented that R9 required extensive assistance of two staff members for ADLs. The MDS documented R9 had received antidepressant medication for seven days, antipsychotic medication for six days, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 38	F 758		

opioid (a class of medication used to treat pain) for one days during the look back period.

R9's "Psychotropic Drug Use Care Area Assessment" (CAA) dated 08/05/22 documented R9 was on hospice services and had received comfort medications.

R9's "Care Plan" dated 05/27/21 documented staff would administer psychotropic medication as ordered by the physician. The "Care Plan" documented nursing staff would verify with the physician and have him document the benefit of R9's psychoactive medication outweighed the risk if the physician indicated a dose reduction should not be done.

Review of the "Monthly Medication Review" (MMR) for May 2023 revealed a physician order dated 05/25/23 to change Seroquel to 12.5 milligram (mg) by mouth at hour of sleep as needed for agitation/sundowning. Notify if worsening condition.

Review of the "Medication Administration Record" for May 2023 and June 2023 revealed Seroquel was administered daily from 05/25/23 to 06/28/23 (35 days).

Review of the EMR under "Orders" tab revealed physician orders:
Seroquel tablet 25mg give 12.5 mg by mouth every 24 hours as needed for anxiety/ risk of harm to themselves or others hospice provides give at approximately hour of sleep. Physician aware of off-label use, call physician if increased in behaviors with this change dated 07/10/23.

Seroquel tablet 25mg give 12.5 mg by mouth at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 39	F 758		

bedtime for agitation, threatening others, physician aware of the off-label use, call if increase in behavior with this change dated 07/11/23.

On 07/18/23 at 01:46 PM R9 sat in wheelchair next to her bed. She smiled and was cheerful during a conversation. No behaviors noted.

On 07/19/23 at 11:24 AM Administrative Staff B stated all as needed antipsychotic medication should have a 14 day stop date. Administrative Staff B stated the facility was unable to locate the order for the continued Seroquel for daily administration. Administrative Staff B stated the facilty was unable to locate the documentation for the as needed Seroquel dated for 07/10/23.

The "Unnecessary Medications" policy revised on 11/28/17, documented antipsychotic medications are indicated for the treatment of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), Tourette's (disorder that involves repetitive movements or unwanted sounds that can't be easily controlled), and Huntington's (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder). The use of antipsychotic medications for any other diagnosis must include physician documentation of the rationale.

The facility failed to ensure R9 did not receive antipsychotic medication for an extended duration when staff failed to change a scheduled dose in response to a physician ordered GDR and failed to ensure the PRN antipsychotic medication did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 40	F 758		

not extend for a duration longer than 14 days without physician visit and rationale. This deficient practice placed R9 at risk for unnecessary psychotropic medications and adverse side effects.
- R36's Electronic Medical Record (EMR) documented diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and psychotic disturbance (psychosis - any major mental disorder characterized by a gross impairment in reality testing).

The "Significant Change Minimum Data Set (MDS)" dated 05/30/23, documented a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment. R36 received antipsychotic (class of medications used to treat psychosis and other mental emotional conditions) medications seven days in the seven-day look back period.

The "Cognitive Impairment/Dementia Care Area Assessment (CAA)" dated 05/30/23, documented R36 had a BIMS score of 10, had a diagnosis of dementia and that he had an order for Seroquel (antipsychotic medication) for psychosis.

The "Psychotropic Drug Use CAA" dated 05/30/23, documented R36 continued taking Seroquel 25 milligrams (mg) daily and that the dosage had been decreased from 37.5mg on 05/30/23.

The "Care Plan" with an intervention dated 06/05/23 documented R36 was confused at times and had difficulty making his needs known. It

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 41	F 758		

directed staff to allow R36 to have time to talk while communicating with him.

The "Care Plan" with an intervention dated 06/05/23 documented R36 took Seroquel to manage his behaviors and for staff to administer it as ordered.

The "Orders" tab of R36's EMR documented an order with a start date of 06/29/23 for Seroquel 25mg to be given in the evening for psychotic disturbance related to dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety.

Two "Note to Attending Physician/Prescriber" pharmacy recommendations dated 05/18/23 documented that R36 was taking Seroquel 37.5mg and that the order lacked a Food and Drug Administration (FDA) approved indication for continued use. The pharmacy recommendations also requested that the Seroquel dosage be reduced to 25mg. Both pharmacy recommendations were signed by the provider on 05/24/23 and marked that the provider agreed with the pharmacy recommendation statement, the dosage was decreased; however, the indication was not changed to an FDA approved indication for continued use and no rationale was provided.

A "Consultant Pharmacist's Medication Regimen Review" dated for recommendations created between 04/21/23 and 05/23/23, documented a request for clarification for the indication of the Seroquel order and further documented that the current indication was listed as dementia without behaviors and was not appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 42	F 758		

R36's clinical record lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic.

On 07/18/23 at 12:55 PM R36 sat in a wheelchair in his room and spoke with staff.

On 07/19/23 at 01:46 PM Licensed Nurse (LN) H stated that she knew that there was certain diagnosis required to take a medication such as Seroquel; however, she stated that other than schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), she was not sure what other diagnoses were acceptable. She stated that she did not believe dementia was an acceptable diagnosis for Seroquel.

On 07/19/23 at 02:14 PM Administrative Nurse D stated that schizophrenia, Huntington's (rare abnormal hereditary condition characterized by progressive mental deterioration; a disabling central nervous system movement disorder) and Tourette's (disorder that involves repetitive movements or unwanted sounds that can't be easily controlled.) were appropriate diagnosis for Seroquel and that dementia would not be considered and appropriate diagnosis.

The "Unnecessary Medications" policy revised on 11/28/17, documented antipsychotic medications are indicated for the treatment of schizophrenia, Tourette's, and Huntington's. The use of antipsychotic medications for any other diagnosis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 43 must include physician documentation of the rationale. The facility failed to ensure that R36 had an appropriate diagnosis or required physician documentation for antipsychotic medication usage. This deficient practice had the risk for unnecessary medication use and unwarranted physical complications.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 51 residents with one kitchen. Based on observation, record review, and interviews, the facility failed to maintain sanitary dietary standards related to food storage. This deficient practice placed the	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 44	F 812		

residents who received food from the facility kitchen at risk related to food borne illnesses and food safety concerns.

Findings included:

- On 07/17/23 at 07:40 AM an observation in the kitchen's dry food storage room revealed one opened bag of marshmallows. The bag was open to air and undated.

On 07/17/23 at 07:42 AM an observation in the kitchen's dry food storage room revealed one opened bag of elbow macaroni. The bag was undated.

On 07/17/23 at 07:43 AM an observation in the kitchen's dry food storage room revealed one opened package of spaghetti noodles. The package was undated.

On 07/17/23 at 07:46 AM an observation in the kitchen's dry food storage room revealed one plastic storage container of rice. The container was not labeled and lacked a date.

On 07/17/23 at 07:48 AM an observation in the main kitchen area revealed a plastic storage container of brown sugar. The container was not labeled and lacked a date.

On 07/17/23 at 07:50 AM an observation in the kitchen's walk-in freezer revealed two opened bags of frozen veggie burger patties. The bags were undated.

On 07/17/23 at 07:51 AM an observation in the kitchen's walk-in freezer revealed one opened box of frozen beef patties. The box was open to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 45 air and the patties were uncovered. On 07/19/23 at 12:54 PM Dietary BB stated that he was taking the course to become a certified dietary manager (CDM). He reported that Administrative Staff C and Administrative Staff A were both CDMs and provided oversight while he took the CDM course. He stated that opened food items should be labeled and dated. He further stated that plastic storage containers of food items such and rice and flour should be labeled and dated. He reported that staff were expected to put a date on the cap when opening milk and to use it within five days. On 07/19/23 at 01:03 PM Administrative Staff C stated that he checked in with Dietary BB in the kitchen almost every day. He stated that food items should be labeled and dated no matter what it is. He further stated that food, such as flour and rice, stored in plastic containers, should have a label and date of when the food was placed in the container. The facility's "Food Storage" policy revised 04/06/20, documented under general storage guidelines to be followed: label all food items. The label must include the name of the food and the date it was opened or prepared, or the date it should be sold, consumed, or discarded. The facility failed to maintain sanitary dietary standards related to food storage. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns.	F 812		
F 851 SS=C	Payroll Based Journal CFR(s): 483.70(q)(1)-(5)	F 851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 46 §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each	F 851		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 47	F 851		

individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(q)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(q)(5) Submission schedule.
The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 51 residents. Based on interview, and record review the facility failed to submit accurate staffing hours to the federal regulatory agency through Payroll Based Journaling (PBJ), when the facility failed to accureately submit staffing hour data for all nursing personnel as required.

Findings included:

- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2022 Quarters three and four documented the facility failed to have Licensed Nursing Coverage 24 hours a day during quarter three and four (05/14/22, 05/15/22, 05/28/22, 06/03/22, 07/03/22; 07/10/22; 07/24/22; 07/31/22, 08/07/22, and 08/21/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 851	Continued From page 48 On 07/19/23 at 11:15 PM Administrative Staff A provided a list of LN's punch times for the requested dates above. The list revealed that there was 24-hour LN coverage on each of the days noted above on the PBJ report. On 07/19/23 at 02:14 PM Administrative Nurse D stated she made out the scheduled for the nurses but she was not certain who submitted the nursing hour but that was done by the corporate office. On 07/19/23 at 02:25 PM Administrative Nurse B stated the corporate office was responsible for keeping track of the nursing hours and submitting staffing hours for the PBJ report and was unable to state what might have happened during those quarters where inaccurate data might have been submitted. The facility did not provide a PBJ policy. The facility failed to ensure accurate staffing hours information was submitted to the federal regulatory agency in a timely manner through PBJ, when the facility failed to accurately report staffing hours for FY 2022 quarters three and four.	F 851		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 49	F 880		

diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 50	F 880		

must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 51 residents. Based on observations, record review, and interviews, the facility failed to ensure proper infection control standards were followed related to hand hygiene, medical equipment storage/cleaning, and catheter care. This deficient practice placed the residents at risk for complications related to infectious diseases.

Findings Included:

- On 07/17/23 the facility reported no residents were on transmission-based precautions.

On 07/17/23 at 0709 AM an inspection of the "Blue Hall" revealed an oxygen tank (cylindrical tank used to provide supplemental oxygen), tubing, and nasal cannula (tubing that delivers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 51	F 880		

oxygen directly through both nostrils of the nose) stored on the back of a wheelchair outside Resident (R)45's room. The nasal cannula and tubing hung down the back of the wheelchair and rested against the back of wheelchairs seat. No storage bag or protective barrier was present. The oxygen tank's gauge meter was in the red (empty). The tubing was not dated and labeled.

On 07/17/23 at 07:11AM an inspection of the "Blue Hall" transfer equipment storage area revealed a Hoyer (full body mechanical lift)sling placed on a chair. The sling strap dangled off the seat and rested on the floor.

On 07/18/23 at 11:01 AM Certified Nurse Aide (CNA) M and CNA O donned gloves and asked R18 if she was ready to get into her recliner. CNA M pulled the privacy curtain and explained the procedure to R18. CNA M unfastened R18's brief and wiped with wipe in a downward motion one time to R18's perineal (genital)area, CNA O assisted CNA M with turning R18 onto her left side. CNA M removed the soiled brief and cleaned R18's rectal area. CNA M placed soiled brief into the trash can. Wearing the same gloves, CNA M placed a clean brief under R18, CNA M doffed gloves and donned new gloves with no hand hygiene between glove change. CNA M wiped in a downward motion with wipes to R18's perineal area and around catheter (tube inserted into the bladder to drain urine) tubing. CNA M fastened the clean brief, doffed gloves, and hand sanitized. CNA M donned new gloves and assisted CAN O with positioning R18 onto the sling. CNA O and CNA M transferred R18 into the recliner. CNA O removed the Hoyer lift from the room and placed the lift back into the hallway corridor storage area without disinfecting the lift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 52 On 07/19/23 at 01:45PM CNA M stated hand hygiene should be completed before, during, and after providing care to residents. She stated hand hygiene should be completed in between glove changes. She stated medical equipment should be sanitized before and after use with the disinfectant wipes. She stated oxygen equipment should be stored in plastic bags when not in use. On 07/19/23 at 02:00PM Licensed Nurse (LN) H stated shared equipment was disinfected in between uses. Staff used the sanitary wipes to clean before and after using the transfer equipment. She stated oxygen tubing was stored in plastic bags hung off the machines or tanks. She stated hand hygiene should be completed upon taking off gloves and before putting new ones. On 07/19/23 at 02:23PM Administrative Nurse D stated staff were expected to completed hand hygiene before, during, and after cares were provided to the residents. She stated facility holds annual in-services and she provided routine training regarding hand hygiene, equipment maintaining/cleaning, and personal protective equipment. She stated hand hygiene and proper disinfecting of equipment was essential for preventing transmission of infectious diseases. She stated shared equipment should have been disinfected in between use and cleaned using the sanitizing disinfectant wipes. A review of the facility's "Oxygen Safety and Management" policy revised 03/2019 indicated all equipment will be used and maintained in a safe and sanitary manner. The policy indicated tubing and cannulas will stored in plastic bags when not	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 53 in use to prevent contamination. A review of the facility's "Hand Hygiene" policy revised 11/2017 indicated staff were required to complete hand hygiene before during, and after resident/environmental contact. The policy indicated hand hygiene was to be completed after removing personal protective equipment (PPE). The facility did not provide policies related to "Catheter Care" as requested on 07/19/23. The facility failed to ensure proper infection control standards were followed related to hand hygiene practices, medical equipment storage/cleaning, and catheter care. This deficient practice placed the residents at risk for complications related to infectious diseases.	F 880		