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	175445	A. BUILDING _____ B. WING _____	C 03/19/2025

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PIONEER RIDGE RETIREMENT COMMUNITY	**4851 HARVARD ROAD LAWRENCE, KS 66049**

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F 000	INITIAL COMMENTS	F 000		

The following citations represent the findings of complaint investigation (s) KS00194060, KS00193900, and KS00194069.

On 03/07/25 at 06:30 PM, the staff provided R1 a peanut butter cookie with his dinner and the staff failed to verify his documented allergies on his meal ticket. R1 had an anaphylaxis allergic reaction to the peanut butter that resulted in vomiting. The facility could not provide epinephrine to R1 to prevent further potential anaphylaxis-related symptoms and the facility transferred R1 to the hospital. R1 received the epinephrine at the hospital and was admitted to the hospital on 03/07/25 for anaphylaxis. This deficient practice placed R1 in immediate jeopardy and any resident with a food allergy at risk to their health and safety.

On 03/19/25 at 05:04 PM Administrative Staff A was provided a copy of the IJ template and notified the facility failured to provide R1 with a meal that aligned with his dietary restrictions in regard to his peanut allergy and caused him to suffer an anaphylaxis allergic reaction and hospitalization, placed the resident in immediate jeopardy.

The facility implemented and completed the following corrective actions related to this incident:
1. R1 was immediately assessed and provided emergency medical treatment. 03/07/25
2. The facility identified all at-risk residents with potential food allergies. 03/07/25
3. The facility provided in-service education for all staff related to reviewing meal cards, dietary

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.

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F 000	Continued From page 1 requirements, and allergies. 03/08/25 4. The facility provided one-to-one education for the Dietary Staff CC and DD. 5. The facility completed interviews with three identified residents with potential food allergies. 03/11/25 6. The facility will provide ongoing routine in-services related to food services to all staff. Due to the corrective actions completed on 03/11/25, prior to the onsite visit on 03/19/25, the deficient practice was deemed past non-compliance at a "J" (isolated, actual harm) scope and severity. The 2567 was sent electronically on 04/01/25.	F 000		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		

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F 726	Continued From page 2	F 726		

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 61 residents. The sample included nine, with one reviewed for competent staffing. Based on interviews and record reviews, the facility failed to ensure staff possessed the appropriate skills and knowledge to identify the available epinephrine (medication used to alleviate symptoms of severe allergic reactions) during Resident (R) 1's anaphylaxis episode. This deficient practice placed R1 and all residents with allergies at risk for impaired quality of care.

Findings included:

- The "Medical Diagnosis" section within R1's Electronic Medical Records (EMR) included diagnoses of Parkinson's Disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), blindness of right eye, acute kidney failure, and fracture (broken bone) of the right femur (thigh bone).

R1's EMR indicated he was admitted on 03/06/25 for therapy services related to his recent right

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F 726	Continued From page 3	F 726		

femur fracture.

R1's EMR indicated a Minimum Data Set (MDS) was not completed. No Brief Interview for Mental Status (BIMS) or Care Area Assessments (CAAs) were completed.

R1's "Care Plan" completed 03/06/25 indicated he was admitted to the facility for therapy services and would return to his home upon discharge. The plan noted he had vision and hearing impairments. The plan noted he had allergies to peanut-based foods. The plan noted he required assistance from one staff for personal hygiene, toileting, dressing, bathing, transfers, bed mobility, and walking. The plan noted he was alert and cognitively intact. The plan noted he was on a regular diet and preferred to eat in his room.

R1's EMR under "Progress Note" revealed a "Communication Note" completed by Licensed Nurse (LN) H on 03/07/25 at 06:45 PM. The note indicated she was in the hallway and was notified by R1's Representative that R1 had an allergic reaction to a peanut butter cookie he was served for dinner. LN H noted that R1 had facial swelling and had vomited. The note indicated his breathing was non-labored and regular. The note revealed that R1 was transported to an acute care facility for emergency treatment.

A "Facility Incident Report" #4060 completed on 03/11/25 indicated R1 was sent out for emergency medical treatment on 03/06/25. The report indicated LN H responded to R1's room for an allergic reaction to a peanut butter cookie he was served on his dinner plate. The report indicated the nurse was not able to find an epinephrine injectable pen (Epi-pen -

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F 726	Continued From page 4	F 726		

spring-loaded injection pen for immediate administration) in the facility's emergency medication kit (E-kit) during the episode and called for emergency medical services. The note indicated EMS arrived and immediately transported R1 to an acute medical facility for emergency treatment. The report noted that R1 received epinephrine while at the acute care facility.

A "Staff Witness Statement" was completed on 03/12/25 by LH N. LN H noted in the report she responded to R1's severe allergic reaction. She noted that R1 reported eating part of the peanut butter cookie and felt unwell. LN H noted left-side facial swelling, but unlabored breathing. The report noted R's representative informed LN H that R1 kept an Epi-pen at home for emergencies. LN H noted she went to the medication room to look for an Epi-pen. LN H noted she was unable to find an Epi-pen in the E-kit. LN H noted she returned to R1's room and found him vomiting. LN H noted she called for emergency medical services (EMS). LN H noted EMS arrived and immediately transported R1 to an acute care facility.

On 03/19/25 at 03:35 PM, an inspection of the facility E-kit revealed the facility supplied epinephrine in vials instead of injectable pens. A review medication record revealed the facility had epinephrine vials in the E-kit during the episodes. The E-kits medication list identified the kit contained a one-milligram by one-milliliter vial of epinephrine for emergency administration. An inspection of the facility revealed one E-kit in each medication room (two total).

On 03/19/25 at 03:00 PM, LN G stated each

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F 726	Continued From page 5 medication kit came with a list that noted all the medications within the kit. She stated nurses would quickly identify the medications on the list during an emergency to save time. She stated the kits included epinephrine and emergency-based medications. On 03/19/25 at 03:30 PM, Administrative Nurse D stated each medication room contained an E-kit. He stated each E-kit had an attached list of medications within the kits that included epinephrine. He stated LN H may not have looked at the list due to the emergency. He stated staff were expected to check the medication listed or ask when unable to find medications. The facility failed to provide a policy related to staff competencies as requested on 03/19/25. The facility failed to ensure staff possessed the appropriate skills and knowledge to identify the available epinephrine during R1's anaphylaxis episode. This deficient practice placed R1 and all residents with allergies at risk for impaired quality of care.	F 726		
F 806 SS=J	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice;	F 806		

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F 806	Continued From page 6 This REQUIREMENT is not met as evidenced by: The facility reported a census of 61 residents, with 9 sampled. Based on observation, interview, and record review the facility failed to ensure the staff provided Resident (R) 1 a peanut-free meal, per his reported allergies upon admission. On 03/07/25 at 06:30 PM, the staff provided R1 a peanut butter cookie with his dinner and the staff failed to verify his documented allergies on his meal ticket. R1 had an anaphylaxis allergic reaction to the peanut butter that resulted in vomiting. The facility could not provide epinephrine to R1 to prevent further potential anaphylaxis-related symptoms and the facility transferred R1 to the hospital. R1 received the epinephrine at the hospital and was admitted to the hospital on 03/07/25 for anaphylaxis. This deficient practice placed R1 in immediate jeopardy and any resident with a food allergy at risk to their health and safety. Findings Included: - The "Medical Diagnosis" section within R1's Electronic Medical Records (EMR) included diagnoses of Parkinson's Disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), blindness of right eye, acute kidney failure, and fracture (broken bone) of the right femur (thigh bone). R1's EMR indicated he admitted on 03/06/25 for therapy services related to his recent right femur fracture. R1's EMR indicated a "Minimum Data Set" (MDS)	F 806	Past noncompliance: no plan of correction required.	

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F 806	Continued From page 7	F 806		

was not completed. No Brief Interview for Mental Status (BIMS) or Care Area Assessments (CAAs) were completed.

R1's "Care Plan" completed 03/06/25 indicated he was admitted to the facility for therapy services and would return to his home upon discharge. The plan noted he had vision and hearing impairments. The plan noted he had allergies to peanut-based foods. The plan noted he required assistance from one staff for personal hygiene, toileting, dressing, bathing, transfers, bed mobility, and walking. The plan noted he was alert and cognitively intact. The plan noted he was on a regular diet and preferred to eat in his room.

R1's EMR under "Assessments" revealed his "Admission Assessment" completed on 03/06/25 noted he had peanut allergies.

R1's EMR under "Progress Note" revealed a "Nutrition Note" completed on 03/07/25 at 10:00 AM. The note indicated he was admitted on 03/06/25 with an order for a regular diet. The note indicated he ate in his room without assistance or adaptive equipment. The note indicated he had no issues with chewing or swallowing. The note indicated he was allergic to peanuts.

R1's provided "Meal Ticket" dated 03/07/25 for his dinner meal indicated he was served pork tenderloin on a bun, sweet potato puffs, creamy coleslaw, and an assorted dessert. The ticket noted he had peanut allergies.

R1's EMR under "Progress Note" revealed a "Communication Note" completed 03/07/25 at 06:45 PM. The note indicated R1's nurse was notified by his representative that R1 had an

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F 806	Continued From page 8	F 806		

allergic reaction to a peanut butter cookie he was served for dinner. The note revealed R1 had facial swelling and vomited. The note revealed R1 was transported to an acute care facility for emergency treatment.

R1's EMR under "Progress Note" revealed a "Communication Note" completed 03/07/25 at 11:45 PM. The note revealed R1 was admitted to the acute care facility for anaphylaxis.

A "Facility Incident Report" #4060 completed on 03/11/25 indicated R1 was sent out for emergency medical treatment on 03/06/25. The report noted Licensed Nurse (LN) H responded to R1's room for an allergic reaction from a peanut butter cookie he was served on his dinner plate. The note indicated the nurse failed to locate an epinephrine injection pen during the episode and called for emergency medical services. The note indicated EMS arrived and immediately transported R1 to an acute medical facility for emergency treatment.

The "Staff Witness Statement" completed on 03/11/25 by Dietary Staff CC noted on 03/07/24 at 05:30 PM Dietary Staff CC went to the "Rapid Recovery" hall to assist with meal delivery. The statement noted as she delivered R1's meal tray she noticed his tray had no dessert. The statement noted Dietary Staff DD placed a cookie on his tray as Dietary Staff CC delivered the food to the room. The statement noted Dietary staff DD did not see what kind of cookie it was before delivery.

The "Staff Witness Statement" completed on 03/13/25 by Dietary Staff DD documented Dietary Staff DD assisted in plating the food in the dining

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hall for room delivery. The statement noted she accidentally put a peanut butter cookie on R1's tray instead of a raisin cookie.

During an observation on 03/19/25 at 12:05 PM, dining hall service began for lunch. An inspection of prepared meal trays revealed each tray had a ticket. Dietary Staff EE inspected the meal tickets as he plated the food. The meal tickets remained on the tray as they were delivered to the residents.

On 03/19/25 at 03:35 PM, an inspection of the facility's emergency medication kit (E-Kit) revealed the facility supplied epinephrine in vials instead of injectable pens. A review medication record revealed the facility had epinephrine in the facility during the emergency.

On 03/19/25 at 02:15 PM, Dietary Staff BB stated the facility used an electronic meal ticket system that printed out the daily meals for each resident. She stated the tickets contained the type of diet, menu, allergies, and resident information. She stated staff were expected to use the tickets to verify the correct diet for plating food and during delivery to the resident. She stated all staff were expected to inspect the meals upon delivery to verify the correct diet and food allergies.

On 03/19/25 at 02:45 PM, Certified Nurse Aide (CNA) M stated meal tickets were provided for each resident during meal service. She stated staff were expected to check the meal tickets before serving the food to ensure the residents received the correct diet and avoided potential food allergies. She stated the tickets clearly identified what food allergies each resident had and their dietary needs.

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F 806	Continued From page 10 On 03/19/25 at 03:30 PM, Administrative Nurse D stated all staff were expected to verify the diet and potential food allergies with the food being served during meal service. The facility's "Meal Identification / Resident Meal Card" policy revised on 04/13/20 indicated the facility safely provided meal services. The policy noted staff was to utilize meal cards to identify each resident's food preferences, dietary orders, food allergies, and other nutritional needs. The facility failed to follow R1's dietary restrictions related to his peanut allergy. This deficient practice resulted in a severe allergic reaction and hospitalization for anaphylaxis. On 03/19/25 at 05:04 PM Administrative Staff A was provided a copy of the IJ template and notified the facility failured to provide R1 with a meal that aligned with his dietary restrictions in regard to his peanut allergy and caused him to suffer an anaphylaxis allergic reaction and hospitalization, placed the resident in immediate jeopardy. The facility implemented and completed the following corrective actions related to this incident: 1. R1 was immediately assessed and provided emergency medical treatment. 03/07/25 2. The facility identified all at-risk residents with potential food allergies. 03/07/25 3. The facility provided in-service education for all staff related to reviewing meal cards, dietary requirements, and allergies. 03/08/25 4. The facility provided one-to-one education for the Dietary Staff CC and DD.	F 806		

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F 806	Continued From page 11 5. The facility completed interviews with three identified residents with potential food allergies. 03/11/25 6. The facility will provide ongoing routine in-services related to food services to all staff. Due to the corrective actions completed on 03/11/25, prior to the onsite visit on 03/19/25, the deficient practice was deemed past non-compliance at a "J" (isolated, actual harm) scope and severity.	F 806		