STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175445	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD , LAWRENCE, Kansas, 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
F0000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #2583696, 2590446, 2590505, and 2572590. The 2567 was sent out electronically on 09/03/25.	F0000		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 67 residents. The sample included three residents. Based on observations, record review, and interviews, the facility failed to	F0609		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0609 SS = D	Continued from page 1 report an allegation of abuse between staff and Resident (R) 1 to the State Agency (SA) as required. This deficient practice placed R1 at risk for unidentified and ongoing abuse. Findings included: - R1's Electronic Medical Record (EMR) documented diagnoses of pain, insomnia (inability to sleep), and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The "Admission Minimum Data Set (MDS)" dated 02/20/25, documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The "Quarterly MDS" dated 05/15/25, documented R1 had a BIMS score of 15, which indicated intact cognition. The "Functional Abilities Care Area Assessment (CAA)" dated 02/25/25, documented R1 had intact cognition and was able to let staff know his needs and wants. R1's "Care Plan" dated 07/25/25, documented staff provided R1 with medications and other measures to maintain his comfort per his pain care plan. R1's plan of care documented hospice provided the medications associated with pain. Review of the facility's grievances for the last 60 days revealed a "Resident Grievance/Complaint Investigation Report Form" dated 08/13/25 for R1. The grievance documented Licensed Nurse (LN) G went into R1's room to give him his 03:00 AM pain medication. R1 stated in the grievance that he held his hand out and LN G jabbed him with his walking stick two times. He R1 stated he told LN G that he had his hand out and LN G jabbed him three more times. R1 stated LN G gave him his medicine then walked out. The grievance documented Administrative Nurse D noticed the mark that morning and when R1's representative visited that afternoon, the mark was not visible. The grievance form documented the corrective action taken was Administrative Staff A spoke with LN G. Further action taken included LN G no longer cared for R1 and if he was scheduled then another staff member took over R1's care. The facility's "Initial Report- Alleged Physical Altercation" investigation, not dated, documented on 08/12/25, Administrative Nurse D notified Administrative Staff A around 10:00 AM of an allegation. Administrative Staff A immediately visited R1 to discuss the incident. R1 reported that at	F0609		

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F0609 SS = D	Continued from page 2 approximately 03:00 AM on 08/12/25, LN G attempted to wake R1 up by jabbing him with a stick. R1 stated that this occurred during the administration of his pain medication. R1 stated his eyes were not closed while he laid in bed at that time, and he was alone in his room during the incident. The investigation documented an interview with LN G on 08/12/25 who stated he did not poke R1 with a stick but gently tapped R1's knee to get his attention. He stated R1 rolled over and took his medication and gave no indication of pain when LN G tapped him. LN G stated he brought his walker in with him to assist him with walking, and he did not use it to poke R1. The investigation documented the facility reviewed video surveillance on 08/12/25 that revealed at approximately 03:06 AM, LN G grabbed pills from the medication cart and proceeded to R1's room with his walker and entered R1's room with the walker at 03:07:41 AM. LN G exited R1's room at 03:08:26 AM with his walker. The video and audio surveillance did not reveal any voices or sounds heard during the time LN G entered R1's room. The investigation documented immediate protective actions included LN G did not work during the investigation, and moving forward, LN G would not interact with R1 or handle his medications. R1's EMR revealed a "Communication Note" on 08/19/25 at 10:27 AM that documented the facility put a call out to R1's representative in regard to a grievance filed. Staff let R1's representative know of the facility's findings and that the staff member involved would no longer care for R1. On 08/20/25 at 01:12 PM, R1 laid in his bed and watched television. He stated LN G carried his walker in with him on the incident date and jabbed him without saying a word. R1 stated it hurt when LN G jabbed him, and he showed Administrative Nurse D the next morning. He stated he was really scared and wanted LN G kept far away from him. On 08/20/25 at 12:01 PM, Administrative Staff A stated the facility did not turn R1's allegation towards LN G into the SA. She stated that when staff reported the allegation, she sent the information on to the regional team and immediately started investigating. Administrative Staff A stated she asked R1 what happened, and he stated LN G jabbed him with his stick at 03:00 AM, and R1's eyes were open. She stated R1 reported LN G poked his stomach and caused him pain, then stated he did not want LN G in his room. Administrative Staff A stated she called all of the staff who worked that night, and nobody heard any stories of LN G being abusive. She stated LN G stated he used a walker, but it was not a stick that could	F0609		

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F0609 SS = D	Continued from page 3 poke. LN G stated he tapped R1 on his knee to give him pain medication. Administrative Staff A stated she received a recommendation not to report the allegation to the SA because it was not believed R1 was actually harmed. She stated the facility was required to report all allegations of abuse, and she confirmed R1's report was an allegation. On 08/20/25 at 02:04 PM, LN H stated if she received an allegation of abuse, she reported it to Administrative Nurse D. On 08/20/25 at 02:09 PM, Administrative Nurse D stated R1 reported the allegation to the hospice nurse, and he overheard it while he walked to his office. He stated he notified Administrative Staff A who followed up with LN G and R1. Administrative Nurse D stated he assessed R1 but did not see any marking or bruising on his abdomen. He stated when an allegation was made, typically they gathered all the information and sent it to the regional consultants who analyzed it and made suggestions. Administrative Nurse D stated allegations of abuse, neglect, and exploitation were reported to the SA. He stated the facility was required to report within 24 hours or two hours for more serious allegations. The facility's "Abuse, Neglect, and Exploitation" policy, revised 11/28/17, directed the facility reported all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property to the SA no later than two hours after the allegation was made if the allegation involved abuse or resulted in serious bodily injury or no later than 24 hours if the allegation did not involve abuse and did not result in serious bodily injury.	F0609		