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 06/01/2026

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 A complaint survey was conducted on 06/01/2026 to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint reference numbers # 3003005, 2983640, and 2997364 were investigated. The facility census on the day of the survey was 57. The sample size included five residents. Based on this survey, deficiencies were identified under 42 CFR Part 483, Requirements for Long Term Care Facilities. The facility's noncompliance with F689 was determined to constitute Substandard Quality of Care as defined at 42 CFR 488.301.	F0000		
F0689 SS = SQC-J	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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to provide adequate supervision and failed to respond appropriately to alarms to prevent the elopement of Resident (R) 1, who was cognitively impaired, had a history of wandering and exit seeking, and was at risk for falls. On 04/26/26 at 01:44 AM, R1 pushed on the Blue-Hall emergency exit door, which sounded the alarm immediately when pushed, then opened after 15 seconds, and R1 exited the facility. Licensed Nurse (LN) G sat at the nurse's station with a clear view of the emergency exit door but did not look up or respond to the door alarm. At 02:05 AM, Certified Nurse Aide (CNA) M approached the nurse's station and asked LN G where the alarm was coming from, and LN G stated	F0689	"Past Noncompliance - no plan of correction required"	

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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F0689 SS = SQC-J	Continued from page 1 it was likely an exit door. CNA M and CNA N immediately started looking for the source of the alarm. They identified Blue-hall emergency exit door as the source and shortly after, LN G heard knocking on a door near the nurse's station and instructed CNA M and CNA N to go through the front door to see who was outside. CNA M and CNA N located R1 outside in front of the building and brought her back inside at approximately 02:09 AM. R1 was unsupervised outside in the dark in 60 degrees Fahrenheit (F) weather for approximately 25 minutes. This deficient practice placed R1 in immediate jeopardy. Findings included: - R1 admitted to the facility on 05/01/24. R1's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) and restlessness and agitation. The "Annual Minimum Data Set" (MDS) dated 04/23/26, documented R1 had a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. R1 had no behaviors. R1 used a walker and required partial/moderate assistance with walking 10 feet, and walking 50 feet with two turns was not attempted due to R1's medical conditions or safety concerns. R1 had one noninjury fall since the last assessment. The "Cognitive Loss/Dementia Care Area Assessment" (CAA) dated 05/05/26, documented R1 had severe cognitive impairment. The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential" CAA dated 05/05/26, documented R1 needed assistance from staff for many ADLs such as dressing, toileting, hygiene, transfers, and mobility. The "Falls" CAA dated 05/05/26, documented R1 was at risk for falls due to a previous history of falls. R1's 06/05/24 "Care Plan" for mobility and fall risk documented the following interventions:	F0689		

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F0689 SS = SQC-J	Continued from page 2 06/05/24- R1 needed supervision when she walked with her walker, and she potentially needed breaks for longer distances. 06/05/24- R1 needed supervision with transfers. R1's 06/15/24 "Care Plan" for behavioral symptoms documented the following interventions: 11/18/24- R1 had dementia and no longer had control over all aspects of her life, which caused her to become restless, agitated, and tearful. Staff involved her family in all care planning and decision making. 11/18/24- Staff monitored R1's behaviors for agitation, crying, and restlessness. Staff documented her behaviors and the results of monitoring for side effects. 11/18/24- Staff helped R1 stay in touch with her son and daughter-in-law. 04/27/26- R1 sometimes worried about where her husband was, and she talked about leaving; because of that, she wore a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering). R1's 02/12/26 "Care Plan" for cognitive loss documented the following interventions: 02/12/26- Staff assessed R1 for acute changes in her condition, such as increased confusion and contacted her primary care provider (PCP) as needed. 02/12/26- Staff introduced themselves to R1 when they entered her room and provided cares. 02/12/26- Staff spoke calmly and directly to R1 when providing her with directions and/or instructions. 02/12/26- Staff used positive verbal and non-verbal communication to encourage R1 to complete tasks and express herself. 02/12/26- Staff reminded R1 of what things took place in the facility multiple times a day and helped her go to the things she needed or wanted to attend.	F0689		

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F0689 SS = SQC-J	Continued from page 3 R1's "Care Plan" did not have resident-specific interventions to direct staff during R1's wandering and exit seeking behaviors. R1's EMR revealed the following: An "Elopement Risk" assessment on 10/14/25, documented an answer of "Yes" to the following questions: history of wandering off unit or elopement, verbalized desire to leave facility or exit seeking, wandered off unit or into other residents' rooms, wandered on her unit, experienced periods of altered perception, experienced periods of restlessness, her mental function varied over the course of the day, she had a diagnosis of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure)/Dementia, and she had a diagnosis of mental illness. The analysis documented R1 had moments of confusion and hallucinations/delusions where she began exit seeking. A "Behavior Note" on 02/28/26 at 01:00 PM, documented R1 continued to pace and walked to the doors, stating she was leaving today. Staff employed redirection and alternative activities with little benefit. Staff administered R1's as needed (PRN) Ativan (medication used to treat anxiety [mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear]) medication. R1 sat in her bed reading her Bible after medication administration. An "Orders- Administration Note" on 03/17/26 at 07:29 PM, documented R1's Ativan fell off of the orders. The order was renewed and administered for R1's pacing and exit seeking. An "Admission/Quarterly/Annual/Significant Change Assessment" on 04/21/26, in section four "Fall Risk," documented "No" to the following questions: ambulated independently, ambulated with assistance, had a visual impairment that could not be corrected, used equipment that could present a hazard, received any of the listed classes of medications, and had any of the listed diagnoses. The assessment documented "Yes" to the following questions: R1 used an assistive device, was incontinent of bowel or bladder, had fallen in the past three months, had issues with her gait or balance, and had confusion.	F0689		

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F0689 SS = SQC-J	Continued from page 4 An “Orders- Administration Note” on 04/25/26 at 01:19 PM, documented R1 was pacing and exit seeking. Staff provided redirection and reorientation, which were ineffective. Staff administered as needed Ativan. R1’s EMR lacked a note regarding the elopement on 04/26/26. An “Orders - Administration Note” on 04/26/26 at 04:33 AM, documented staff administered as needed Ativan. R1 had anxiety and was crying and exit seeking. A late entry “Behavior Assessment Progress Note” effective 4/26/26 at 04:49 AM, created on 04/27/26 at 08:58 AM, documented R1 had anxiety and agitation. Staff provided one-on-one, redirection, and distraction and R1 settled down briefly. Staff reminded R1 that her family did not abandon her. The facility’s “Investigation” dated 04/30/26, documented on 04/27/26 at approximately 08:50 AM, Administrative Staff A and Administrative Nurse D became aware of R1 eloping on 04/26/26 at approximately 01:44 AM. The facility reviewed the security footage, which revealed R1 repeatedly pushed on the exit door at the end of Blue-hall. The audible alarm sounded at 01:44 AM and indicated her exit via the delayed egress door. LN G sat at the nurse’s station desk where he could see down the end of Blue-hall, however, LN G did not look or react to the alarm. The delayed egress alarm continued to sound while LN G looked at the computer. At 02:05 AM, CNA M approached the nurse’s station and asked where the alarm came from, and LN G responded that it was likely an exit door. According to witness statements and interviews, CNA M and CNA N immediately searched for the source of the alarm once they heard it. Staff determined the alarm came from the Blue-hall exit door and shortly after, they heard banging on a door near the nurse’s station. LN G instructed CNA M and CNA N to go through the front door to see who was outside. CNA M and CNA N located R1 outside the building and brought her inside at approximately 02:10 AM. LN G retrieved the alarm key at 02:13 AM and silenced it at 02:15 AM. Nursing staff completed rounds and room checks, and all other residents were accounted for in the building. Staff placed R1	F0689		

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F0689 SS = SQC-J	Continued from page 5 on 15-minute checks. The facility concluded R1 exited the building via the delayed egress function on the door at the end of Blue-hall at approximately 01:44 AM. CNA M and CNA N visualized her on the sidewalk and escorted her back into the facility at approximately 02:09 AM. The temperature outside was 62 degrees F. R1 wore jeans, a long-sleeved shirt, shoes, and she used her walker. It appeared she remained in close proximity to the building the entire time she was outside as she was at an exit door when staff approached, and the limited outdoor video showed her on the sidewalk. Staff assessed her for injuries then took R1 to her room. R1 appeared to not want to stay in her room and she attempted to leave again. According to interviews, staff completed a new elopement assessment, placed a WanderGuard on her, and one staff member monitored her. According to the “Kansas State University Historical Weather” website, the temperature on 04/26/26 was 60.5 degrees Fahrenheit (F) at 01:00 AM and 59.4 degrees F at 02:00 AM. CNA M’s notarized “Witness Statement,” dated 04/28/26, stated on 04/26/26 around 01:30 AM, she finished her first rounds when she heard sirens going off in the facility. She and CNA N checked the doors to see which one went off. She stated LN G alerted her and CNA N that R1 banged on the side exit door near the nurse’s station. CNA M stated they immediately brought R1 inside and checked to see if she was alright, which she seemed to be but was confused about her surroundings. She stated they laid R1 down in her room and when staff went to turn off the exit door around 02:00 AM, she noticed R1 headed towards the exit door again and she stopped her. In an observation on 06/01/26 at 01:04 PM, the nurse’s desk where LN G sat at the time of the incident had a clear view of the Blue-hall exit door. At the Blue-hall exit door, Maintenance U pushed on the door and the alarm beeped a few times before turning into a sustained tone alarm then the door opened after pressed on for about 15 seconds. Upon exiting through the Blue-hall exit door onto the sidewalk, a grassy depression was in front of the sidewalk and the sidewalk turned left. On the left side of the sidewalk were landscaping rocks and the grassy depression continued on the right side until the sidewalk turned to the left again where both sides of the sidewalk were lined with landscaping	F0689		

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F0689 SS = SQC-J	Continued from page 6 rocks. The sidewalk continued in front of the facility towards the front door. There was a parking lot in front of the facility. In an observation on 06/01/26 at 01:09 PM, while at the nurse's desk where LN G sat at the time of the incident, Maintenance U pushed on the Blue-hall exit door again and the alarm sounded. The alarm was heard while standing at the nurse's desk. On 06/01/26 at 01:11 PM, R1 lay in bed with her eyes closed. On 06/01/26 at 02:54 PM, a review of two saved facility surveillance videos on Administrative Staff A's laptop revealed the following: A video, without a time and date stamp, showed a view down the Blue-hall with the exit door visible. R1 walked with her walker into frame to the exit door. R1 had unintelligible speech while she started pushing on the exit door. The door alarm immediately started beeping, then a sustained tone occurred, and the door opened after about 15 seconds. R1 pushed open the exit door and held it open with her left arm while she pushed her walker outside and exited the facility. The door alarm continued to sound. A video, dated 04/26/26 at 01:43:21 AM, showed a view of the front of the nurse's station and LN G sat at the desk that faced Blue-hall. LN G looked at the computer. There was music possibly from a television or radio heard on the video. At 01:44:19 AM, the door alarm began beeping. LN G remained at the nurse's desk and did not look up from the computer. At 01:47 AM, CNA N walked from the front entrance area past the nurse's station out of camera view. She walked back through to the front entrance area. The video ended at 01:50:49 (AM). Administrative Staff A stated she did not save the videos from when staff found R1 outside and brought her back in. On 06/01/26 at 12:50 PM, Administrative Staff A stated the elopement on 04/26/26 happened on a weekend and she found out about it that following Monday. She stated the facility gathered information on the elopement, involved their regional team, started interviews, and collected statements. She stated she asked LN G why he did not report the	F0689		

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F0689 SS = SQC-J	Continued from page 7 elopement, and his answer changed several times. Administrative Staff A stated she reviewed the camera and LN G sat at the nurse's station with a clear view of the Blue-hall door. She stated R1 pushed on the door and the alarm went off, but nobody reacted. She stated she turned the volume up on the video and could hear some noise on the footage like a television, but she still heard the door alarm. Administrative Staff A stated she observed two CNAs going by the nurse's station, but she did not know why it took them so long to respond to the alarm. She stated LN G told the CNAs to go down the hall to look for the location of the alarm. Administrative Staff A stated after seeing LN G's delayed response to the alarm, she suspended him. She stated she asked him if there was any noise that interfered with him hearing the alarm and he stated no. She stated she was unaware if R1 had an exit seeking behavior prior to this elopement. On 06/01/26 at 03:53 PM, CNA O stated R1's typical behaviors included crying, talking about her husband leaving her, and wandering the hallways, especially after dinner. She stated that sometimes R1 was redirectable. CNA O stated when a door alarm sounded, she went to the door to see what happened. If a resident tried to leave, she redirected them and if a resident went out, she went outside to get them back into the facility. CNA O stated if she could not find the resident outside of the door, she walked the perimeter of the facility and went back inside to alert everyone at that point. On 06/01/26 at 04:10 PM, LN H stated R1's behaviors included wandering with her walker, pacing back and forth, and looking for her husband or the man she planned to marry. She stated R1 became restless, and she knew R1 hardly slept at all during the night based on the reports she received. LN H stated if a door alarm sounded, she immediately looked at the cameras located at the nurse's station. She stated that if she was in the hallway, she went to the door. LN H stated from where she sat at the nurse's station when she worked on Blue-hall, she could hear which direction the alarm went off. She stated if a resident eloped, she went to the door, scanned outside for the resident, had staff do a room search and headcount, had staff do a perimeter sweep, and notified the on-call manager immediately. On 06/01/26 at 04:31 PM, Administrative Nurse D stated when he arrived at work on 04/27/26, LN G	F0689		

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F0689 SS = SQC-J	Continued from page 8 was still at the desk, and he made a comment that he was going to text Administrative Nurse D but LN G never said what for. Administrative Nurse D stated a staff member asked him if he heard about what happened that weekend and they told him about the elopement. He stated he asked LN G if the elopement occurred and LN G confirmed it did. Administrative D stated he initiated elopement protocol including informing the State Agency (SA) and their regional team. The regional team gave the facility an outline of things to look for. He stated he completed an elopement assessment on R1, placed a WanderGuard on her, and completed elopement and sentinel event reporting education with staff. Administrative Nurse D stated if a door alarm went off, he expects staff to see who set it off and redirect them away from the door then turn off the alarm. He stated if staff did not see a resident near the door, he expected them to walk to the door alarm and go outside to look for the resident outside. If staff could not find the resident, he expected staff to come back inside and complete a headcount. Administrative Nurse D stated he expected the nurse to initiate the full elopement protocol and notify him or Administrative Staff A immediately and notify law enforcement if the resident was not located. He stated staff continued to do headcounts and outside perimeter checks until the resident was found. On 06/02/26 at 10:50 AM, CNA M was unavailable for interview. On 06/02/26 at 11:06 AM, CNA N stated around 01:30 AM, she answered a resident's call light on the other hall and was in their room when she heard the alarm go off. She stated the alarm sounded for maybe 10 to 20 minutes before she exited the resident's room and went to the nurse's station. CNA N stated LN G sat at the computer at the nurse's station and he told her and CNA M to walk around to see where the sound came from. She stated there was no television or radio playing at the nurse's station to block the door alarm sound. CNA N stated she last saw R1 a little after 12:00 AM when R1 tried to go to Red-hall and CNA N walked R1 back to her room. She stated when a door alarm sounded, she was supposed to stop what she was doing and check the doors and check all the residents. On 06/02/26 at 01:10 PM, LN G stated on 04/26/26, R1 was in bed and talking to herself but then she	F0689		

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F0689 SS = SQC-J	Continued from page 9 had become quiet, and he thought she went back to sleep. He stated he did not remember what time that was. LN G stated eventually, he heard the alarm sound, and it alarmed for about 15 minutes before a CNA figured out it was on Blue-hall. He stated he sat at the nurse's desk and had one of the CNAs run back and forth to the front entrance to see where the alarm came from because it sounded like it was up front. LN G stated that staff thought it was the WanderGuard alarm but after they put the code in, the alarm did not stop. He stated one of the CNAs realized the alarm was on Blue-hall and that the door had been opened. He stated while they were checking resident rooms, he went back to the desk and heard tapping on a window. LN G stated he saw R1 in the window and he called for the CNAs to bring her inside. He stated when she came back inside, she immediately tried to go straight back to the Blue-hall exit door. LN G stated prior to the alarm sounding, he was charting and did not pay attention to the end of the Blue-hall hallway. He stated he thought R1 was still sleeping and had hoped it would be an uneventful night for R1 because she usually got up and wandered at night. LN G stated he did not get up to check the alarm when it initially sounded due to having a hard time getting around and needing a walker. The facility's "Elopement" policy, revised 11/28/17, directed the facility to ensure each resident received adequate supervision and devices to deter elopement. The policy directed the facility updated the resident's care plan to include wandering and the potential for elopement interventions. The policy directed the facility utilized an elopement monitoring bracelet if the facility determined a resident was at risk for elopement. On 06/01/26 at 04:00 PM, Administrative Staff A was presented with the "Immediate Jeopardy [IJ] Template" and was notified of the facility's failure to provide adequate supervision to prevent the elopement of R1 on 04/26/26, constituted immediate jeopardy at F689. The facility identified, implemented, and completed the following corrective measures: 1. The facility updated R1's care plan to include her WanderGuard usage on 04/27/26. 2. The facility completed a new Elopement Assessment on R1 and any independently mobile	F0689		

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F0689 SS = SQC-J	Continued from page 10 residents on 04/27/26. 3. The facility completed elopement, door alarm responses, and reporting elopements with all staff from 04/27/26 to 04/29/26. Due to the facility's completion of all corrective actions prior to the onsite visit, the deficient practice was deemed past noncompliance at a scope and severity of a “J” (isolated, immediate jeopardy).	F0689		