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 07/07/2026

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 The following citations are the result of an abbreviated survey and complaint investigations 3052905, 3043471, and 3044396. The census was 61; the sample included three residents.	F0000		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure Resident (R) 1 remained free from verbal abuse and mistreatment when Licensed Nurse (LN) G used an expletive and other derogatory language toward R1. Findings Included: - R1's Electronic Medical Record (EMR) documented diagnoses of dementia with other behavioral disturbance (a progressive mental disorder characterized by failing memory, and confusion, with changes in their mood, personality, or actions), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and	F0600	"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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F0600 SS = D	Continued from page 1 irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The “Quarterly Minimum Data Set (MDS)” dated 03/26/2026 for R1 documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severe cognitive impairment. The MDS documented R1 required substantial to maximal assistance for oral and personal hygiene, showers or bathing, bed mobility, and transfers to the toilet or shower. The MDS documented R1 was dependent on staff for toileting hygiene, lower body dressing, moving from a seated to standing position, and chair or bed transfers. The “Cognitive Loss/Dementia Care Area Assessment” (CAA) dated 10/23/2025 documented R1 had a dementia diagnosis. The CAA documented R1 had clear speech, was sometimes able to make herself understood, and was sometimes able to understand others. The CAA documented staff may need to anticipate R1’s needs at times. R1's 06/17/2025 “Care Plan” documented R1 had behavioral symptoms. The plan documented the following interventions: 06/30/2025 – documented R1 took Celexa (antidepressant) for depression with behaviors of tearfulness. R1's 01/13/2026 “Care Plan” documented R1 had cognitive loss. The plan documented the following interventions: 01/13/2026 – directed staff to introduce themselves to R1 whenever they entered R1’s room and when providing R1 with care. 01/13/2026 – directed staff to provide R1 with reminders for safety, with reorientation to R1’s surroundings, and with cues as needed. 01/13/2026 – directed staff to use positive verbal and non-verbal communication to encourage R1 to complete tasks and express herself. 01/13/2026 – documented sometimes R1 would get confused and had difficulty making her needs known. The intervention directed staff to allow R1 time to talk to staff when R1 was communicating.	F0600		

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F0600 SS = D	Continued from page 2 The facility's investigation 3044396, documented on 06/15/2026 at approximately 09:30 AM, Administrative Staff A received a report from LN H stating that while providing care to R1, LN G placed her hand over R1's mouth. The investigation recorded upon receipt of the allegation; the facility immediately initiated an investigation and removed LN G from resident care duties pending the outcome of the investigation. The investigation recorded R1 had significant cognitive impairment, including a BIMS score of four. The investigation document further recorded R1 attempted to get out of bed and required staff assistance. Certified Nurse Aide (CNA) M requested assistance from LN G to provide care and assist R1 with repositioning and a brief change. The investigation recorded witness statements consistently described R1 as physically combative during care. CNA M reported seeing LN G place her hand on R1's mouth while R1 was spitting. CNA M reported that R1 bit LN G's finger. The investigation recorded following the interaction, CNA M transported R1 to the Rapid Recovery unit to separate R1 and LN G. The investigation recorded CNA N was interviewed and reported that CNA M had brought R1to the Rapid Recovery area and requested assistance with R1's care. CNA N stated that CNA M informed her of the incident involving LN G and R1. The investigation recorded CNA N further reported observing tension between LN G and R1 after the incident and reported hearing LN G make inappropriate and derogatory comments toward R1. The investigation recorded available security camera footage was reviewed and confirmed the presence of CNA M and LN G in R1's room during the timeframe and confirmed that R1 was transported to the Rapid Recovery area. The investigation recorded camera footage did not provide a direct visual recording of the care interaction occurring inside the resident's room. Portions of verbal exchanges could be heard; however, the footage did not conclusively establish the nature of the physical contact alleged to have occurred inside the room. The investigation substantiated that LN G engaged in inappropriate verbal interactions with R1 following the incident. The investigation recorded witness interviews identified that derogatory language was directed toward R1, which was inconsistent with the facility's standards of professional conduct and resident-centered care. An unnotarized, undated, witness statement for LN H recorded on or about 06/15/2026 between 01:30 AM	F0600		

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F0600 SS = D	Continued from page 3 to 02:00 AM he observed CNA M come out of R1's room while pushing R1 in a wheelchair toward the Rapid Recovery Hall. LN H recorded LN G also came out of R1's room and asked LN H where CNA M took R1. LN H recorded he told LN G that CNA M took R1 to the Rapid Recovery Hall, and LN G went that same direction. LN H recorded he assisted CNA M and CNA N with putting R1 to bed around 04:00 AM. LN H recorded that at approximately 04:40 AM CNA M pulled him aside and stated she wanted to report the incident to him. LN H recorded CNA M told him when she passed him in the hallway with R1 she was going to hide R1 from LN G. LN H recorded CNA M told him while she and LN G were putting R1 to bed, R1 scratched LN G's chest and bit LN G's finger. LN H recorded CNA M told him LN G responded by putting her hand over R1's mouth and squeezed it. LN G recorded CNA M told him LN G later followed them into a Rapid Recovery room, while she was with CNA N, and LN G said unkind words to R1 again. A notarized witness statement, dated 06/16/2026, for CNA N documented she was on the Rapid Recovery unit at the nurses' station when CNA M came over with R1. CNA N documented R1 was in a T-shirt, and a brief that was halfway complete. CNA N documented CNA M asked for help with fixing R1's brief and putting some pants on R1. CNA N documented CNA M told her that LN G had harmed R1 after R1 scratched LN G on the chest. CNA N documented per CNA M, LN G grabbed R1's mouth, screamed insults at R1, and R1 responded by biting LN G's finger. CNA N documented CNA M reported she brought R1 over to separate LN G and R1. CNA N documented she, CNA M, and LN G went to put R1's pants on her and R1 began to cuss LN G out and kept telling LN G to go away. CNA N documented R1 was getting angry, stopped doing what they needed her to do to help her, and LN G became upset with R1. CNA N documented she witnessed LN G yelling and insulting R1. CNA N documented she witnessed LN G call R1 stupid, dumb, and an [expletive]. CNA N documented CNA M asked LN G to step out of the room and LN G refused and got upset. CNA N documented they finished with R1 and wheeled her back to the nurses' station. A notarized witness statement, dated 06/15/2026, for CNA M documented she had seen R1 trying to climb out of bed at 01:00 AM. CNA M documented she asked LN G to help put R1 back in bed. CNA M documented she and LN G placed a brief on R1 and	F0600		

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F0600 SS = D	Continued from page 4 R1 began kicking and scratching the two of them. CNA M documented R1 began spitting at them and LN G grabbed R1's mouth and pushed down. CNA M documented R1 then bit LN G on the finger near her mouth. CNA M documented that they got R1 back in her wheelchair and CNA M documented she decided R1, and LN G needed time away from each other. CNA M documented she took R1 over to Rapid Recovery. A notarized witness statement, dated 06/15/2026, for LN G recorded she was helping CNA M with R1 when R1 began kicking, and hitting them. LN G documented R1 was spitting and had LN G's pointer finger in her mouth and bit down on it. LN G documented she pushed R1's head away instinctively as she tried to get her finger out of R1's mouth. LN G documented CNA M got R1 in a wheelchair and took her down to the Rapid unit. On 07/07/2026, attempts made to contact LN G, LN H, CNA M, and CNA N via phone for interview. Voice messages left for each of them. No phone calls were returned. On 07/07/2026 at 01:30 PM R1 sat in her wheelchair, in the dining room, near a table. On 07/07/2026 at 01:29 PM, Social Services X stated she had followed up with R1 the last two weeks related to the incident. She stated there wasn't too much she could get from R1 and R1 was not able to answer questions. She stated she would also follow up with nursing staff to find out if there were any changes in R1's behaviors. She stated she had not noticed and had not heard of any behavior changes from R1 related to the incident. She stated R1's behaviors were usually related to staff providing cares. Social Services X stated R1 may not always understand what staff was trying to do and would get agitated when they provide cares. On 07/07/2026 at 01:37 PM, LN I stated she heard about the incident but was not at work when it occurred. She stated she has not observed any changes in behaviors from R1 since the incident. She stated R1 is confused all the time but does have some lucid moments. LN I stated she felt R1 was at a good place with her medication and that it has helped. LN I stated R1 does get defensive if staff come at her all at once when doing cares. She	F0600		

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F0600 SS = D	Continued from page 5 stated R1's behavior was dependent on how staff approached her. She stated if staff were calmer during their approach, then R1 was more likely to be cooperative. She stated she had not noticed R1 being fearful of anyone of tearful after the incident. On 07/07/2026 at 02:14 PM, Administrative Nurse D stated he was on vacation during the time the incident occurred. Administrative Nurse D stated he reviewed the camera footage when he returned, and he stated he saw CNA M take R1 to the rehab side of the facility. He stated he saw CNA M and CNA N with R1, and he saw LN G walk into camera view. Administrative Nurse D stated LN G was in front of R1 at that time and had referenced R1 biting her. Administrative Nurse D stated he was pretty sure he heard LN G reference R1 being an evil [expletive] related to biting her. He then stated he heard CNA N say that was not very nice. Administrative Nurse D stated he felt the response from CNA N was used to attempt to deescalate the situation but could not tell who CNA N's comment was directed towards. Administrative Nurse D stated there was a shouting match between LN G and R1, he stated they told each other to shut up back and forth. He stated LN G eventually went back to the side she was scheduled on and CNA M and CNA N stayed with R1. He stated he felt the CNAs handled the situation appropriately by trying to remove R1 from the abuser, updating the nurse, and making sure R1 was okay. Administrative Nurse D stated LN G followed CNA M and R1 over to the other side and he did not understand why she would do that. He stated LN G was suspended and then terminated. On 07/07/2026 at 02:32 PM, Administrative Staff A stated she was the one that completed the investigation related to this incident. She stated she reviewed the camera footage as well. Administrative Staff A stated when she reviewed the camera footage, she was unable to hear everything that was said while they were in R1's room. She stated she saw CNA M go into R1's room first, and LN G went in after. She stated she could not tell if it was the resident not wanting care or if it was LN G getting hit. She stated the door was slammed shut. She stated she could hear some commotion in the room but wasn't sure exactly what was said. Administrative Staff A stated the door then opened, and CNA M came out of the room and pushed R1 in the wheelchair. She stated LN G came out of the room later. She stated the camera footage revealed CNA M took R1 down the Rapid Recovery Hall and CNA M met up with CNA N. She stated at first, she	F0600		

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F0600 SS = D	Continued from page 6 did not hear anything on the camera, and they went into another room. She stated they later came out and she saw LN G coming down the hallway to Rapid Recovery. Administrative Staff A stated she then heard them all talking, and she could hear LN G using inappropriate language that staff should not say to a resident. Administrative Staff A stated she could not remember what was said, but that it caught her off guard and she was pretty sure LN G was cursing. Administrative Staff A stated LN G was saying R1 “you bit me” and R1 said something back that did not make sense. Administrative Staff A stated R1 was angry, and she believed R1 stated she did not bite LN G and LN G kept saying “yes you did” to R1. She stated the two other CNAs were right there and LN G was facing all three of them. Administrative Staff A stated LN G kept saying “she bit me” and was cursing at R1. Administrative Staff A stated they all went into a room and changed R1 and after they left the room, CNA M took R1 to the nurses’ station. Administrative Staff A stated CNA M reported the incident to LN H and LN H texted Administrative Nurse D, who was on vacation. She stated she was later notified, she believed around 08:00 AM to 09:00 AM and she told the team she needed to investigate the situation. Administrative Staff A stated they suspended LN G and later terminated her. She stated LN G did not work any other shifts after suspension. Administrative Staff A stated Social Services X followed up with R1 for psychosocial and made note of any behavior changes. Administrative Staff A stated as of now no one has reported any behavior changes from R1 and R1 has not had any incidents of going after staff like she did with LN G. Administrative Staff A stated they did not cover this incident in the QA meeting for June as it happened after. She reported it will be covered in July’s meeting and will be followed up until resolved. Administrative Staff A stated Social Services X has provided updates as have nursing staff. She stated Administrative Nurse D has also followed up on the incident as well. Administrative Staff A stated they provided education to LN H and CNA M related to reporting incidents of abuse in the future to ensure it is reported timely. She stated they also provided abuse and dementia care and communication education for all staff after the incident. The facility’s “Abuse, Neglect, and Exploitation” policy, with a revision date of November 28, 2017, documented the resident has a right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation, misappropriation of resident property	F0600		

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F0600 SS = D	Continued from page 7 and injuries of unknown origin. Verbal Abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to: (1) threats of harm, and/or (2) making statements to frighten a resident. On 06/17/2026, the facility completed corrective actions which included an all-staff in-service on preventing abuse, neglect, and exploitation, understanding dementia, and communicating with residents with dementia education. CNA M and LN H completed additional reporting abuse education. LN G was suspended and terminated. The corrective actions were completed prior to the onsite survey therefore the deficient practice was cited as past noncompliance at a scope and severity of "D."	F0600		