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	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Ridge Retirement Community	4851 Harvard Road Lawrence, KS 66049

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 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 [DATE]. 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 [DATE], 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: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 (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	placed R1 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 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 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 (continued on next page)

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