STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N105018	A. BUILDING: _____ B. WING _____	C 07/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PIPER ALF	2300 NORTH 113TH TERRACE KANSAS CITY, KS 66109

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints #164149, 163904, and 163734 of the above named facility conducted on 7/22/2021 and 7/26/2021.	S 000		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced	S3028		

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

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S3028	Continued From page 1 by: KAR 26-41-101 (f) (3) (E) The facility reported a census of 77 residents. The sample included 3 residents (#'s 1,2, and 3). Based on record review and interview the administrator failed to report an allegation of rape for resident #1 to the department within 24 hours of being made aware of the allegation and failed to submit the completed investigation to the department within 5 working days of the initial report. Findings included: - Record review on 7/22/2021 at 1:00pm for resident #1 revealed an admission date of 7/27/2021, with diagnoses of essential hypertension, malignant neoplasm of endometrium, unspecified dementia, dizziness, giddiness and acute kidney failure. Record review on 7/22/2021 of the functional capacity screen dated 3/4/2021 revealed the resident was unable to perform her own bathing, she required physical assistance with dressing and toileting, and she required supervision with transferring and mobility. She had impaired short-term memory, memory recall and decision making. She was marked with falls, impaired vision, impaired decision making, and required a walker for mobility. Record review on 7/22/2021 of the negotiated service agreement dated 3/11/2021 (and continuously updated) informed/instructed staff to physically assist resident with bathing and stand by assist with toileting. Resident #1 has moderate disorientation or difficulty recalling/retaining information and required cueing. Resident is to be	S3028		

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S3028	Continued From page 2	S3028		

checked on every 1 hour.

Record review on 7/22/2021 of the electronic nursing communications revealed the following entries:

5/11/2021 at 8:53 pm - "resident called nephew to notify him resident had been raped. This nurse asked resident what happened. Resident stated "a man broke into my room, grabbed me and threw me on the bed and raped me. I feel so dirty". This nurse examined room, no signs that anyone had been thrown on the bed, the bed was neatly made. This nurse did full head to toe assessment on resident, no scratches, brises or marking of any kind, no redness or bleeding from vaginal or anal area noted. This nurse called nephew at 7:00 pm and notified him there was no evidence showing resident had been raped. Director of nursing notified via phone...." signed by licensed nurse A.

5/12/2021 at 12:26 pm - "nurse assessed resident this morning, she gave no mention of conversations from last night. Resident stated that she was feeling fine and has no complaints of pain or discomfort. Nurse practitioner notified of events from last night. Medication review completed and new orders for Buspirone 5 milligrams in the evening an increased Donepezil to 10milligrams at bedtime were written. Call to power of attorney made and informed of new orders. Power of attorney reported he was out to see resident #1 this morning and she appeared to be back to herself. Power of attorney noted that he has seen a decline in resident #1 since she fell and broke her hip a few months ago. will have staff encourage resident to go to activities. Resident has been noted to self-isolate and only comes out for meals, spending most of her time

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in her apartment, laying on the couch. Will increase safety checks on resident to hourly, especially when in apartment alone. Executive director notified of conversation with power of attorney, service plan updated with changes." signed by director of nursing B.

Late entry made on 5/12/2021 at 12:26 pm for 8:53 pm 5/11/2021 - "after being notified by licensed nurse A of resident's claim, I contacted power of attorney, asked if he would like for resident to be sent to the emergency room for evaluation and he responded no. Power of attorney stated that in the evening she calls him numerous times and is agitated and confused. He would like to see resident participate in more activities to possibly help wear her out so she can sleep at night. He also requested that resident's mediations be looked at by the nurse practitioner to see if there was anything that may need to be changed or added. Reported my conversation with Corporate manager and executive director."

Review of witness statement on 7/22/2021 provided by staff C, revealed the following: Resident #1 power of attorney called staff and asked staff to check on the resident. The resident had reported to the power of attorney that she had been raped. The staff "reported it to the nurse on staff right away...". The witness statement lacked a time of events.

Review of the incident report on 7/22/2021 revealed the following: the time of the incident was at 6:45 pm and took place in the resident bedroom. Resident called power of attorney saying she was raped. Resident told the nurse a man came into her room, threw her on bed and raped her. No signs of rape noted. Power of attorney was notified, at 7:00 pm. The incident

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S3028	Continued From page 4 report is signed by licensed nurse A and director of nursing B. Review of a typed document titled follow up investigation into resident #1 report of being raped provided by regional nurse D revealed the following: on 5/14/2021 at 9:38 am she called power of attorney, identified herself and was following up on the incident with resident #1. Power of attorney stated he spoke with 3 staff members that evening and is satisfied with interventions and outcome. The regional nurse asked him about whether he wanted resident #1 to be examined that night and he stated "no", he did not see the need as staff had examined resident #1. He stated, "I think she was needing some attention". Interview with regional nurse D and administrator E revealed the allegation of resident #1 being raped was not reported to the department within 24 hours of being made aware of the incident, and the investigation of the incident was not reported to the department within 5 days of the initial report. The administrator failed to report an allegation of rape for resident #1 to the department within 24 hours of being made aware of the allegation and failed to submit the completed investigation to the department within 5 working days of the initial report.	S3028		