Kansas Department on Aging

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 _____	07/01/2021

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
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 by: KAR 26-41-101 (f) (3) (A) (B) (C) (D) (E) (F) The facility reported a censes of 80 residents. The sample included one resident (#1). Based on interview and record review the administrator failed to investigate, report to the department and	S3028		

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

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maintain a written record of the investigation for resident #1, when she left the locked memory care unit and was found by staff outside the building on the sidewalk unattended.

Findings included:

- Record review for resident #1 revealed an admission date of 7/28/2020 with diagnoses of myocardial infarction, essential hypertension, acute respiratory failure with hypoxia, altered mental status, anxiety disorder.

Record review of the functional capacity screen dated 6/28/2021 revealed the resident was independent with walking and mobility. She had impaired short-term memory, long term memory, memory recall and decision making. She was marked with falls and unsteadiness and impaired decision making.

Record review of the combined negotiated service agreement / health service plan identified the resident was independent with mobility and transfers. She was identified as an elopement risk and was on hourly safety checks by staff.

Review of the electronic progress notes revealed the following entries:

6/20/2021 at 4:30 pm the writer was notified on 6/19/2021 at 3:00 pm the resident eloping from the building by licensed nurse A. No information was given to me of the incident being reported to the director of nursing or the executive director. I at this time informed executive director B that we had to report incident and investigate the situation.

6/18/2021 at 5:30 pm (late entry) resident pushed

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the exit door that goes outside at (name of unit), and she was able to exit the unit. Resident was found by 2 staff members while she was standing in front of the door. They notified the charge nurse. The charge nurse came to see the resident and worked together with the 2 staff members who saw the resident and brought her back into the building.....Family member and the director of nursing have been notified. Made a phone call to primary physician's office but the office is closed for the weekend.

1/12/2021 at 10:49 am nurse called resident durable power of attorney related to resident increased elopement attempts.....spoke about moving her to the memory house for resident safety.....

Interview 6/30/2021 at 2:00 pm with corporate compliance officer F confirmed the resident transferred to the locked memory care unit on 1/13/2021. She also confirmed the exit doors on the unit have the egress bars and will open when held down for a continued amount of time. She stated the door alarm will sound and the staff pagers will receive an alert.

Interview on 6/30/2021 with administrator B confirmed he called the director of nursing C and she called the staff involved. He confirmed there were no written statements from staff, written notes on the investigation from himself, and he did not report the incident to the state.

Interview on 6/30/2021 3:20 pm certified staff D stated she was unaware the resident #1 had left the unit. She stated that it was after dinner and resident stated she was going to her room. Certified staff D and another staff member went to the other end of the hall and assisted another

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S3028	Continued From page 3 resident in their room and she stated she did not hear the door alarm sound and did not know the resident had left the unit until licensed nurse E returned with resident #1. Interview on 6/30/2021 staff F at 4:00 pm stated that she was in her car getting ready to drive out of the parking lot when she looked down the parking lot and saw a resident walking around from the end of the building with her walker. She stated she stopped her car, got out and assisted the resident to the front door, while doing so licensed nurse A was in her car leaving and certified staff F asked licensed nurse A to call licensed nurse E out to assist with getting the resident back into the building. Interview on 6/3/2021 with licensed nurse A at 3:25 pm stated she was leaving the facility for the day and she saw staff F with a resident at the facility front door. She confirmed staff F asked her to call licensed nurse E to assist with returning resident #1 back to the building. Interview on 6/3/2021 at 4:45 with licensed nurse E, he confirmed that licensed nurse A did call him to come and assist returning resident #1 back inside the building. The administrator failed to investigate, report to the department and maintain a written record of the investigation for resident #1, when she left the locked memory care unit and was found by staff outside the building on the sidewalk unattended.	S3028		