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	N105018	A. BUILDING: _____ B. WING _____	C 06/10/2021

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S 000	INITIAL COMMENTS The following citations represent the findings of an abbreviated survey for complaints # 159237, 160571, 161277, and 162290, of the above named facility conducted on 6/3/2021, 6/7/2021, 6/8/2021, 6/9/2021 and 6/10/2021.	S 000		
S3026 SS=D	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101 (f) (1) (B) The facility reported a census of 68 residents. The sample included 6 residents. Based on observation, interview and record review for 1 (Resident #8) of 6 sampled residents, the administrator failed to ensure the resident was not subjected to neglect when facility staff failed to provide services reasonably necessary to ensure the resident's safety and to avoid physical or mental harm. Resident #8, a cognitively impaired resident who resided on a secured memory care unit was taken outside for a walk along an unsecured sidewalk by a non-certified staff member and was left unattended after the resident complained of knee pain and stated she was unable to walk any further. The non-certified	S3026		

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

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staff member failed to provide appropriate assistance and support when the resident complained of pain and the staff member left her sitting unsupervised. Shortly after, the resident was observed laying on the ground by a staff member from inside of the facility. Resident #8 was taken to the hospital emergency room with admitting diagnoses unwitnessed fall, left eye brow abrasion, abrasions to her cheek. The resident additionally sustained abrasions to the bilateral palms of her hands, dorsal fingers and the right knee was bruised with 2+ swelling.

Findings included:

- Record review on 6/3/2021 for resident #8 revealed an admission date of 3/15/2019 with diagnoses of other amnesia, hypertension, occlusion and stenosis of right carotid artery, and major depressive disorder.

Record review of the functional capacity screening dated 12/15/2020 revealed the resident was independent with bathing, dressing, toileting, transferring, walking and eating. She required physical assistance with her medications. She had impaired short- and long-term memory, memory recall and impaired decision making. Current problems/risks identified included impaired vision and impaired decision-making. She did not use an assistive device.

Record review of the negotiated service agreement revealed the following entries:

3/15/2019 escort needed to/from activities and or dining room.
3/15/2019 fall interventions are: keep pathways clear and nonskid foot wear.
3/15/2019 is at risk for falls due to impaired

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cognition.
3/15/2019 has bilateral hearing loss
3/15/2019 speak slowly and clearly
3/15/2019 has mild memory loss, requires reminders for activities and meals.

The negotiated service agreement lacked updates for the year 2020, and the next update was 5/7/2021 when the negotiated service agreement was cancelled.

Record review of the facility level of care/functional assessment dated 1/7/2020 revealed the resident required an escort to and from activities and or dining room. She required reminders to go to meals and she had impaired short-term memory, memory recall and impaired decision making. She was marked at risk for falls/unsteadiness and impaired hearing.

The electronic record lacked a facility level of care/functional assessment dated for 2021.

Record review of the Morse fall assessment dated 5/30/2020 scored the resident at a high risk for falls: She scored 90. High risk = 45 and higher; Moderate risk = 25-44; Low risk = 2-24.

Record review of the electronic progress notes: Nursing progress notes revealed resident adjusted to facility after admission on 3-15-2019. Progress notes documented complaints of right knee pain, assessments revealed right knee to be swollen and resident "is limping badly". The Nurse practitioner was notified and ordered x-rays which revealed resident to have arthritis of the right knee. Resident received orders for Biofreeze and Tylenol every 6 hours as needed. Ultimately in November 2019, resident received a Medrol (steroid) dose pack for inflammation and

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swelling on her right knee. Resident had been in pain and had been limping around, (family member was afraid of resident falling). The record documented falls in her room on 5/29/2020 and 05/30/2020. Note: the record lacked documentation from 11/23/2020 until 4/30/2021.

4/30/2021 at 3:55 pm: "Approximately 2:30 PM, Nurse was notified by (administrative staff E) that resident was on the ground outside. Nurse went to assess and observed resident laying on her back, on the sidewalk. Resident noted to have abrasion on her face and both hands. Resident has complaints of knee and back pain that are chronic in nature. She was able to move all extremities independently and without sign of pain or discomfort. Resident assisted up with the assistance of 3 staff members. Asked that she take a few steps and she was able to do that without difficulty. Resident able to state name and where she was. No changes in level of consciousness noted. Resident denied pain in back at that time, but does state that she still has knee pain. Resident able to ambulate back into the building with assistance of 2 staff members. Once inside resident sat in a chair and was offered water. She was later assisted back to her apartment where treatment was given to her injuries. (Family member) notified of incident.." Signed by Licensed Nurse C.

4-30-2021 at 4:28 PM: "Notified that family was going to take resident to (hospital) for evaluation. (Family members) to transport to (hospital) related to her head injury. Report called to (hospital) and given to Registered Nurse." Signed by Licensed Nurse C.

Record review of personnel A witness statement

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dated 4/30/2021 revealed the following: personnel A revealed "some of the ladies" asked her to take them out for a walk. She stopped and asked resident #8 if she would like to go with them for a walk. Personnel A writes "as we started out the door" she noticed resident #8 was "wobbly", she asked the resident if she would like to just sit and enjoy the sun. She writes resident #8 said ok. Personnel A continues to write that she told resident #8 if she got to warm to get up and "just go back to the door", otherwise she would be back to het her. Personnel A continues to write that when she went back to get resident #8 the resident was "gone"

Record review of administrator B witness statement revealed at approximately 2:15 p.m. on 4/30/2021 a former staff member informed him that a resident was outside on the ground. Operator B continues to write he immediately went to assist the resident and the front desk receptionist, and one other person was attending to the resident. At approximately 2:25p.m. the director of nursing provided additional aide to the resident and the resident was escorted back into the building.

Record review of the incident report filled out by licensed nurse C on 4/30/2021 indicated the resident was alone, risk factors included that the resident was impulsive, had chronic knee pain, and impaired gait. Injuries marked on the form are abrasions, there are no location of abrasions listed on the diagram provided. The additional comment revealed there would be an assessment for physical therapy and request for the nurse practitioner to assess the patient for pain in the knees.

Record review of licensed nurse D follow up

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investigation notes revealed that personnel A did take 4 memory care residents out of the building for a walk. Personnel A did leave resident #8 sitting by herself. Personnel A stated that resident #8 had become "wobbly" when they were going out the door. Personnel A continued to state that she had taken the 3 other memory care residents for a walk around the building to the front door.

Record review personnel A's signed job description on 12/7/2020 revealed the following: she is employed as a homemaker with job duties of dining services, with support duties related to housekeeping and laundry support. As cook, the homemaker will prepare food for house hold meals and snacks that are healthy and appetizing and served in a timely manner. Plan and facilitates activities for residents and the household that involve food preparation or other activities specific to the kitchen. Performs housekeeping duties to maintain cleanliness and neatness of household surroundings.

Interview on 6/3/2021 with vice president of operations E confirmed personnel A, a non-certified employee had taken 4 residents off of the locked memory care unit for a walk around the building on 4/30/2021. She confirmed personnel A stated she left resident #8 unattended while she and the 3 remaining memory care residents proceeded to the front door of the building. Personnel E identified the area at the back of the building where personnel A and the residents exited the building.

Written statement dated 06/09/2021 from certified staff G stated: "I always go in my shift at 2 PM ... Between 2-3 as I was helping one of the residents in the dining area, something caught my eye as I looked through the window like a flying

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white plastic bag. I got curious and moved out the back door to know what was happening. I saw a person laying on the pavement. I called the nurse phone and couldn't reach her, so I decided to act quickly and moved out and came to front office and asked for help and together we ran out and found the lady down. She contacted the nurse and ___ of the management and they swiftly responded. The nurse assessed the resident. She could talk and only complained of back pain. She was helped to get up and I left to go back to my work place." Signed by certified staff G.

Observation on 6/3/2021, the area identified where resident #8 was left by personnel A was approximately 15 feet from a back door with office windows looking out to the sitting area.

Observation on 6/3/2021, the area identified by personnel E was approximately 30 yards from where she was left unattended.

Written plan received on 6/3/2021 at 12:58 p.m. to ensure this does not occur again by administrator included the following:
Residents will be supervised by staff during resident scheduled and /or independent activities. Purpose: to ensure resident safety during all activities whether scheduled or not. Procedures: All resident are encouraged to attend scheduled activities. Staff will assist activities director with getting resident to the designated activity location. Residents from locked memory care and memory care - lite households will be sufficiently supervised by staff during transfer to activities within the building. Do Not Take Off Unit! If going outside, please stop by the concierge and let them know you are taking residents out of building and your planned route. Let concierge

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S3026	Continued From page 7 know when you return and/or if you need help with the resident. There should be sufficient staff ratio to resident when taking outside. If more than two resident, two staff members must be present to take residents outside. Non-skilled staff can not take residents out of facility or unit by themselves but can be the second staff member if taking more than 2 residents. Staff should take personal our house phone with them when taking residents out of building to have a way to call for help if needed. If any of the resident are a fall risk, take a wheelchair as a precaution. Make sure all residents are well hydrated and/or take bottle of water for resident during outside activities. For Resident #8, the administrator failed to ensure the resident was not subjected to neglect when facility staff failed to provide services reasonably necessary to ensure the resident's safety and to avoid physical or mental harm.	S3026		
S3080 SS=D	26-41-201 (a) (b) Functional Capacity Screen on Admission a) On or before each individual ' s admission to an assisted living facility or residential health care facility, a licensed nurse, a licensed social worker, or the administrator or operator shall conduct a screening to determine the individual ' s functional capacity and shall record all findings on a screening form specified by the department. The administrator or operator may integrate the department ' s screening form into a form developed by the facility, which shall include each element and definition specified by the department. (b) A licensed nurse shall assess any resident whose functional capacity screening indicates the	S3080		

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S3080	Continued From page 8 need for health care services. This REQUIREMENT is not met as evidenced by: KAR 26-41-201 (a) The facility reported a census of 68 residents. The sample included 6 residents. Based on record review and interview for 1 (Resident #3) of 6 sampled residents sampled residents', the administrator failed to ensure the resident functional capacity screening was conducted on or before the time of admission to determine the indivudual's functional capacity for resident # 3. Findings included: - Record review for resdient #3 revealed an admission date of 3/22/2021 with admitting diagnoses of dementia with behavioral disturbances, chronic kidney disease, anemia, thrombocytopenia and presence of a pacemaker. The electronic resident record lacked the department approved functional capacity screening. Review of the service plan in the electonic record revealed the resident was independent with bathing, dressing, toileting, and transferring and he lacked the ability to manage his own medications. Review of the facility document level of care/functional Assessment revealed the resident was independent with bathing, dressing, he was independent with mobility and used a straight cane or walker.	S3080		

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S3080	Continued From page 9 Interview on 6/9/2020 at with licensed nurse D and licensed nurse K revealed the resident electronic record lacked the functional capacity screening. The administrator failed to ensure the resident functional capacity screening was conducted on or before the time of admission to determine the indivudual's functional capacity for resident # 3.	S3080		
S3085 SS=D	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (a) (1) (2) (3) The facility reported a census of 68 residents. The sample included 6 residents. Based on	S3085		

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record review and interview for 1 (Resident #4) of 6 sampled residents the administrator failed to ensure the negotiated service agreement identified the outside provider for physical/occupational therapy, the description of services physical/occupational therapy would provide, and the responsible financial party who would provide payment for the physical/occupational therapies for resident #4.

Findings included:

- Record review for resident #4 revealed an admission date on 11/26/2020, with admitting diagnoses of dementia without behavioral disturbances, osteoarthritis, essential tremor, and hypertension.

Record review of the functional capacity screening dated 12/15/2020 revealed the resident required supervision with bathing, dressing, toileting and transferring. She had impaired cognition with short- and long-term memory, memory recall and decision making. She was marked with falls/unsteadiness, wandering socially inappropriate disruptive behavior, and impaired decision making.

Record review of the negotiated service agreement/service plan dated 11/16/2020 instructed staff to assist resident with all bathing needs, dressing, and toileting. She was at risk for falls and interventions included a 2 hour safety check by staff on the resident.

Review of the electronic progress notes revealed the following entries:

1/3/2021 at 6:36 p.m. a trauma case manager called report at 2:00 p.m. the resident had a

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displaced fracture of the left humerus and plans for inpatient admission. She would notify resident's daughter of fracture and plans for admission. Verified resident was a full code. 2/9/2021 at 1:49 p.m. resident readmission to facility from a rehabilitation facility by private medical transport. Resident was treated and rehab for humerus fracture, left with physical and occupational therapy services. resident is alert and oriented x 2, with confused cognitive state, and can ambulate independently.

Review of the discharge paperwork in the electronic record under the miscellaneous tab revealed an order dated 2/17/2021. The order stated in two weeks resident can begin pendulum motions of the left arm and range of motion as tolerated. Referral details state referral to physical or occupational therapy, reason: specialty services required.

Review of the discharge instructions from the rehabilitation facility include the name of the provider for physical/occupational therapy.

Interview 6/9/2021 with licensed nurse D confirmed resident #4 is receiving physical therapy services and the electronic record and negotiated service agreement/service plan lacked the name, services to be provided and person responsible for payment.

The administrator failed to ensure the negotiated service agreement identified the outside provider for physical/occupational therapy, the description of services physical/occupational therapy would provide, and the responsible financial party who would provide payment for the physical/occupational therapies for resident #4.

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S3092	Continued From page 12	S3092		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202 (d) (1) The facility reported a census of 68 residents. Based on interview and record review for 1 (Resident #8) of 6 sampled residentst, the administrator failed to ensure the negotiated service agreement was reviewed every 365 days for resident #8. Findings included: - Record review on 6/3/2021 for resident #8 revealed an admission date of 3/15/2019 with diagnoses of other amnesia, hypertension, occlusion and stenosis of right carotid artery, and major depressive disorder.	S3092		

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S3092	Continued From page 13 Record review of the annual functional capacity screening dated 12/15/2020 revealed the resident was independent with bathing, dressing, toileting, transferring, walking and eating. She required physical assistance with her medications. She had impaired short- and long-term memory, memory recall and impaired decision making. Record review of the negotiated service agreement revealed the following entries: 3/15/2019 escort needed to/from activities and or dining room. 3/15/2019 fall interventions are: keep pathways clear and nonskid foot wear. 3/15/2019 is at risk for falls due to impaired cognition. 3/15/2019 has bilateral hearing loss 3/15/2019 speak slowly and clearly 3/15/2019 has mild memory loss, requires reminders for activities and meals. The negotiated service agreement lacked updates for the year 2020, and the next update was 5/7/2021 when the negotiated service agreement was cancelled. Interview on 6/3/2021 with licensed nurse C revealed this was the only negotiated service agreement in the electronic record. The administrator failed to ensure the negotiated service agreement was reviewed every 365 days for resident #8.	S3092		
S3165 SS=D	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services	S3165		

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 06/10/2021

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
S3165	Continued From page 14 to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204 (d) The facility reported a census of 68 residents. The sample included 6 residents'. Based on record review and interview for 3 (#2, 7 and 8) of the 6 sampled residents' the administrator failed to ensure the licensed nurse responsible for implementation and supervision of the health service plan was updated on the resident negotiated service agreement for resident's #2, 7 and 8. Findings included: - Record review on 6/7/2021 for resident #2 revealed an admission date of 11/22/2016, with diagnoses of unspecified dementia without behavioral disturbances. Record review of the annual functional capacity screening dated 12/17/2020 revealed the resident required physical assistance with bathing, and was unable to perform dressing, toileting, transferring, or walking. She was incontinent, had impaired long-term memory, was marked with falls, impaired vision, impaired hearing and used a wheelchair mobility device. Record review of the negotiated service agreement/service plan instructed staff to escort resident by wheelchair to and from activities and or dining room. She required total assistance for	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3165	Continued From page 15	S3165		

showers and dressing.

Record review of the service plan signature page signed 1/21/2021 revealed licensed nurse J as nurse responsible for the implementation and supervision of the service plan.

Interview on 6/3/2021 with licensed nurse C revealed licensed nurse C is the nurse responsible for the implementation and supervision of the health care service plan.

- Record review on 6/8/2021 for resident #7 revealed an admission date of 9/22/2015, with diagnoses of muscle weakness, malignant neoplasm of unspecified site unspecified female breast and type 2 diabetes.

Record review of the annual functional capacity screening dated 12/17/2020 revealed the resident was independent with bathing, dressing, toileting, transferring, mobility and eating. She self-administered her own medications and was cognitively impaired with short term memory, long term memory, memory recall, and decision making. She was marked with falls/unsteadiness and required a wheelchair for mobility.

Record review of the negotiated service agreement/service plan instructed staff to stand by assist with showers, assist with transfers, and monitor resident for any changes.

Record review of the service plan signature page signed 20/21/2020 revealed licensed nurse F as nurse responsible for supervision and implementation of the healthcare service plan.

Interview on 6/3/2021 with licensed nurse C revealed licensed nurse C is the nurse

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 06/10/2021

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S3165	Continued From page 16	S3165		

responsible for the implementation and supervision of the health care service plan.

- Record review on 6/3/2021 for resident #8 revealed an admission date of 3/15/2019, with diagnoses of other amnesia, hypertension, occlusion and stenosis of right carotid artery, and major depressive disorder.

Record review of the annual functional capacity screening dated 12/15/2020 revealed the resident was independent with bathing, dressing, toileting, transferring, walking and eating. She required physical assistance with her medications. She had impaired short- and long-term memory, memory recall and impaired decision making.

The negotiated service agreement lacked updates for the year 2020, and the next update was 5/7/2021 when the negotiated service agreement was cancelled.

Record review of the service plan signature page signed 1/7/2020 revealed licensed nurse F as nurse responsible for supervision and implementation of the healthcare service plan.

Interview on 6/3/2021 with licensed nurse C and licensed nurse D confirmed licensed nurse C is the nurse responsible for the implementation and supervision of the health care service plans, and the negotiated service agreement and the health care service plans are a combined document.

The administrator failed to ensure the licensed nurse responsible for implementation and supervision of the health service plan was updated on the resident negotiated service agreement for resident's #2, 7 and 8.