

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N105018	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/20/2024
NAME OF PROVIDER OR SUPPLIER THE PIPER ALF		STREET ADDRESS, CITY, STATE, ZIP CODE 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 #191881, 190301, and 190201 of the above named facility conducted on 11/18/24, 11/19/24 and 11/20/24.	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: K.A.R. 26-41-101 (f) (3) (A) The facility reported a census of 112 residents. The sample included 1 "Resident" (R) 1. Based on interview and record review the Administrator failed to report to the department an allegation of abuse, neglect or exploitation within 24 hours of being made aware of a traumatic skin tear of unknown origin to R1's left hand. Findings included: - Record review for R1 revealed an admission date of 11/28/22 with diagnoses of acute kidney failure, chronic kidney disease stage 3B, other low back pain, primary generalized arthritis, major depressive disorder recurrent, adult failure to thrive, unspecified dementia unspecified with agitation, repeated falls and essential hypertension. Review of R1's "Functional Capacity Screen" (FCS) dated 11/28/23 revealed R1 required physical assistance with bathing and toileting, and supervision with walking. She was independent with dressing, transferring, and eating. R1 lacked the ability to manage her own medications/medical treatments and she was incontinent. R1 had impaired short-term memory, memory recall, and decision making. She was able to make herself understood and she understood others. She was marked at risk for falls and used a walker mobility device. Review of R1's combined "Negotiated Service Agreement" (NSA)/ "Health Service Plan" (HSP) dated 12/01/23 instructed facility staff to provide the following health services: provide assistance	S3028		

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S3028	Continued From page 2 with transferring in/out of shower, cueing to wash and dry herself, check R1's skin and report any reddened or open areas to the nurse, manage R1's medications and medical treatments, provide incontinence care needs, and provide supervision with mobility. Review of R1's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries: On 10/08/24 at 01:20 PM R1 had two skin tears on the left hand, daughter notified. The nurse practitioner was called for an X-ray order. The nurse cleaned and applied steri strips to the wounds and notified R1's hospice nurse. On 10/08/24 at 02:13 PM the left hand was cleaned and steri strips in place. X-ray ordered for left hand to rule out fracture. Review of the facility provided investigation revealed a plan piece of paper with the following handwritten "Investigation Concluded" Upon investigation we determined staff member did not cause skin tear intentionally. She was educated on notification chain of command" and signed by "Licensed Nurse" (LN) A. Interview on 11/19/24 at approximately 10:50 AM with LN A confirmed she could not remember who reported the skin tear to her on the morning of 10/08/24. She stated when she spoke to R1 and R1 could not tell her what happened. She continued to state that she called staff to come in and provide statements about R1's hand. LN A concluded that based on the information discovered when interviewing staff, that the wounds were accidental and that the case was closed, she further confirmed the incident was not	S3028		

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S3028	Continued From page 3 reported to the department. Interview on 11/20/24 at approximately 01:05 PM with Administrator B confirmed based on the results of his investigation, he did not report within 24 hours to the department ruling out neglect when he was made aware of the skin tear of unknown origin to R1's left hand when she could not verbalize how the skin tear happened. The Administrator failed to report to the department an allegation of abuse, neglect or exploitation within 24 hours of being made aware of a traumatic skin tear of unknown origin to R1's left hand.	S3028		
S3213 SS=D	26-41-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-205 (g) (2) The facility reported a census of 112 residents. Based on interview and observation the Administrator failed to ensure each prescription medication container contained the label provided by the dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14.	S3213		

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S3213	Continued From page 4 Findings included: - Observation on 11/18/24 at approximately 02:35 PM "Licensed Nurse" (LN) A unlocked the medication room on the Rosedale Unit, and in the center cabinets on the east wall were 22 Ondansetron 4 milligram tablets packaged from the manufacturer. The tablets were not in a container. The tablets lacked a label affixed to the packaging from the dispensing pharmacist. Interview on 11/18/24 at approximately 02:35 PM LN A stated the cabinet was for medications to be destroyed. LN A confirmed she did not know who the Ondansetron tablets belonged to, and she further confirmed the Ondansetron tablets were not in the container from the dispensing pharmacist. Review of the undated facility provided policy titled "Medication Management" revealed the following: "7. b. Each prescription container shall have a label that was provided by a dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14". Review of the undated facility provided policy titled "Medication Standard-Discontinued Medications" revealed the following: "2. When a medication is discontinued draw a line through the medication name on the container and on the printout. Write the date discontinued and initial. The Administrator failed to ensure each prescription medication container contained the label provided by the dispensing pharmacist or affixed to the container by a dispensing	S3213		

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S3213	Continued From page 5 pharmacist in accordance with K.A.R. 68-7-14.	S3213		
S3261 SS=D	26-41-105 (f) (11) Resident Record Documentation of Incidents (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-105 (f) (11) The facility reported a census of 112 residents. The sample included 1 "Resident" (R) 1. Based on interview and record review the Administrator failed to ensure R1's record contained documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions. Findings included: - Record review for R1 revealed an admission date of 11/28/22 with diagnoses of acute kidney failure, chronic kidney disease stage 3B, other low back pain, primary generalized arthritis, major depressive disorder recurrent, adult failure to thrive, unspecified dementia unspecified with agitation, repeated falls and essential hypertension. Review of R1's "Functional Capacity Screen"	S3261		

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S3261	Continued From page 6 (FCS) dated 11/28/23 revealed R1 required physical assistance with bathing and toileting, and supervision with walking. She was independent with dressing, transferring, and eating. R1 lacked the ability to manage her own medications/medical treatments and she was incontinent. R1 had impaired short-term memory, memory recall, and decision making. She was able to make herself understood and she understood others. She was marked at risk for falls and used a walker mobility device. Review of R1's combined "Negotiated Service Agreement" (NSA)/ "Health Service Plan" (HSP) dated 12/01/23 instructed facility staff to provide the following health services: provide assistance with transferring in/out of shower, cueing to wash and dry herself, check R1's skin and report any reddened or open areas to the nurse, manage R1's medications and medical treatments, provide incontinence care needs, and provide supervision with mobility. Review of R1's electronic "Medical Record" under the "Progress Notes" tab revealed the following entry: On 10/01/24 R1 was observed lying on her back on the floor of her apartment in front of her recliner. R1 was not able to verbalize how she got on the floor. Resident denied pain and further denied hitting her head. The note lacked actions taken to ensure R1's safety after an unwitnessed event which resulted in R1 being found on the floor of her apartment. Interview on 11/20/24 at approximately 01:05 PM Licensed Nurse C confirmed the electronic "Progress Notes" lacked actions taken and the	S3261		

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S3261	Continued From page 7 results of actions taken for R1. The Administrator failed to ensure R1's record contained documentation of all incidents, symptoms and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions.	S3261		