STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N003005	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT ATCHISON LLC	1301 N 4TH ATCHISON, KS 66002

(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 and complaint investigation 88456 conducted at the above named assisted living facility on 6-24-15 and 6-25-15.	S 000		
S3155 SS=G	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 39 residents. The sample included 3 residents. Based on observation, record review and interview for 1 (#122) of 3 sampled residents, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of the resident and were in accordance with the functional capacity screening and the negotiated service agreement. Findings included: - Record review for resident #122 revealed admission on 4-23-14 with diagnoses Muscle Weakness, Renal Failure, Pain in Thoracic Spine,	S3155		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N003005	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT ATCHISON LLC	1301 N 4TH ATCHISON, KS 66002

(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
S3155	Continued From page 1 Lumbago, Hypertension, Atrial Fibrillation, Congestive Heart Failure, Hyperlipidemia, Pacemaker, Constipation, Hypotassemia, and Neurogenic Bladder. The functional capacity screen (FCS) dated 4-8-15 recorded resident required physical assistance with bathing and management of medications/treatments; and supervision with dressing, toileting, transfers, walking/mobility and eating. Continent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks included: Falls and impaired vision. The negotiated service agreement/health care service plan (NSA/HCSP) dated 4-8-15 recorded the following services: Qualified staff to provide standby assistance of 1staff three times per week with whirlpool; Qualified staff to stand by assist times 1 with walker to and from meals and activities; Qualified staff to assist with dressing needs as needed. Resident will call for assist. Toileting: Assist on/off toilet as needed, resident will call. Licensed/Certified staff to administer medications and reorder medications. Resident 122 ' s record revealed a history of : - a fall on 9-10-14 with a hip fracture followed by hospitalization, rehabilitation and return to facility on 12-20-14; - a fall from his/her recliner on 3-17-15 with no injury; - hospitalization on from 4-3-15 to 4-7-15 for phlebitis of the right leg, and - a fall on 4-27-15 that resulted in a hospitalization .	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N003005	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT ATCHISON LLC	1301 N 4TH ATCHISON, KS 66002

(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
S3155	Continued From page 2 Hospital record revealed discharge on 4-29-15 with diagnoses C1 cervical fracture; C2 cervical fracture; Chronic Kidney Disease; Fall; Atrial Fibrillation; Kyphosis; Thoracic Compression Fracture. 4-29-15 at 3:00 pm: Resident returned to facility from hospital...presents with cervical collar due to C1 and C2 cervical fractures. Collar ordered to be worn at all times with exception of being changed to soft collar while bathing..." Signed by licensed staff B. The revised functional capacity screen (FCS) revised on 4-29-15 upon return from hospital recorded resident required physical assistance with bathing, dressing, toileting, transfers, walking/mobility and management of medications and treatments; and supervision with eating. Continent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks included: Falls and impaired vision. The revised negotiated service agreement/health care service plan (NSA/HCSP) dated 4-29-15 upon return from hospital included the following services: Standby assistance three times weekly with bathing; Staff assistance with dressing; Stand by assistance of 1 staff for toileting including assist on/off toilet and to/from bathroom; Standby assistance of 1 staff for all transfers; Stand by assistance with ambulation with walker Reminders for activities and staff to check every two hours from 8 pm to 6 am.	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N003005	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT ATCHISON LLC	1301 N 4TH ATCHISON, KS 66002

(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
S3155	Continued From page 3	S3155		

Monitoring Wellness and Medications: Neck brace to be worn at all times and only change into soft brace for bathing..
Cognition: Orient as needed. Resident is forgetful at times - mostly to time and short term memory but remains able to make needs known.

The NSA/HCSP lacked instructions for staff regarding correct application and care/cleaning of the cervical collar or monitoring and reporting any signs of redness or skin breakdown in areas under and around the collar.

Nurses notes lacked documentation of monitoring of the cervical collar placement and assessment of skin in areas under and around the collar.

Nurses note recorded:
6-19-15 at 7:30 pm: "Resident's left cheek is swollen with a foul smell. Resident can't suck from a straw and can barely drink from a cup. I called family member to ask if they would like resident sent to the emergency room. Family member asked how soon should resident see a doctor, I said I felt that resident should go to the emergency room tonight. Family member showed up, removed resident's neck brace to look at cheek. Family member didn't want to put on "dirty" brace he/she took off so I gave him/her resident's bath brace. I called for ambulance to transfer resident to emergency room..." Signed by licensed staff C.

Note: hospital documentation revealed resident admitted to hospital on 6-19-15 with diagnoses Facial Cellulitis and sore from rubbing from neck brace, Cervical Spine Fracture, Weakness, Dehydration, elevated Protime/INR (International Normalized Ratio) and Peripheral Edema.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N003005	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT ATCHISON LLC	1301 N 4TH ATCHISON, KS 66002

(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
S3155	Continued From page 4 6-23-15 at 1:30 pm: "Resident returned from hospital...assisted to room via wheelchair. When asked if he/she was experiencing any pain or discomfort resident states discomfort in neck and legs. Resident states this is ongoing discomfort and denies nurses offer of pain medications...Bandage on left side of face appears clean and intact. Resident toileted with stand by assistance. Call light system review with resident by nurse. Resident voices understanding of care plan that he/she is to call for assist with all transfers and ambulation...New order received to leave neck brace off until cellulitis healed, then use soft neck brace..." Signed by licensed staff B. The NSA/HCSP lacked documentation of interventions to address wound management or precautions to be followed during time neck brace is off. Observations on 6-24-15 revealed resident in wheelchair assisted by two certified staff to stand, pivot and transfer from wheelchair to recliner. Resident has a gauze bandage to left cheek/jawline. Wound located underneath left jawline measures approximately 1.0 x 0.5 centimeters with small amount of yellowish drainage. Area is open with clean borders and a yellow center. Two rigid cervical collars and one soft foam cervical collar on counter in room. Both rigid cervical collars had small to moderate amounts of a dried dark brown substance on them. Note: Culture of wound obtained on 6-19-15 report recorded 4 + MRSA (Methicillin Resistant Staphylococcus Aureus). Interview on 6-24-15 at 1:45 pm with licensed staff B confirmed both rigid cervical collars needed to be cleaned. Further confirmed no	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N003005	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT ATCHISON LLC	1301 N 4TH ATCHISON, KS 66002

(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
S3155	Continued From page 5	S3155		

written instructions were provided to staff regarding application, maintenance and use of the cervical collar or performance and documentation of ongoing skin observations.

Confidential interviews on 6-24-15 with 3 certified staff confirmed no written instructions were provided by facility for care of resident's cervical collar, proper placement of collar and monitoring of resident's skin. One staff stated "there was a man who came from the hospital that showed us how to take care of it" but confirmed no written instructions were given and not all staff were present when the person from the hospital provided instructions."

Interviews on 6-25-15 at 1:00 pm and 1:25 pm with licensed staff B stated they did not receive any manufacturer's recommendations for care of the neck brace, "if any came with it, it was given to the family at the hospital, it wasn't given to us." Confirmed he/she did not request the recommendations for care of the brace. Stated the hospital called and reported resident's wound was positive for MRSA.

Interview on 6-24-15 at 4:10 pm with licensed staff C stated he/she first noticed "a bit of swelling" on 6-18-15, "I felt the area to check for warmth, he/she wasn't running a fever, and denied pain." Stated he/she notified another licensed staff about the swelling; confirmed he/she failed to notify physician or document his/her findings and failed to further assess skin for impairment. Licensed staff C also stated the neck brace came with two sets of padding, certified staff washed the padding in the washer and it fell apart leaving them with only one set of padding. Verbal instructions given were to "switch the old one (padding) ...put new ones on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N003005	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT ATCHISON LLC	1301 N 4TH ATCHISON, KS 66002

(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
S3155	Continued From page 6 and wash the old ones." Interview on 6-24-15 at 3:00 pm with certified staff I stated he/she "didn't notice anything with (resident's) skin" last time he/she assisted resident with bathing. Interview on 6-25-15 at 1:25 pm with licensed staff B confirmed certified staff I assisted resident with bathing on 6-17-15. For resident #122, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services that met the needs of this cognitively impaired resident related to correct application and care/cleaning of the cervical collar and monitoring/reporting any signs of redness or skin breakdown in areas under and around the cervical collar. Resident #122 developed facial cellulitis and a sore from rubbing from neck brace, weakness and dehydration requiring hospitalization.	S3155		
S3246 SS=F	26-41-102 (b) Staff Qualification Awake - Responsive (b) Direct care staff or licensed nursing staff shall be awake and responsive at all times. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(b) The facility reported a census of 39 residents. The sample included 3 residents. Based on observation, record review and interview for all residents, the operator failed to insure direct care	S3246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N003005	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT ATCHISON LLC	1301 N 4TH ATCHISON, KS 66002

(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
S3246	Continued From page 7 staff or licensed staff shall be in attendance and responsive at all times. Findings included: - Interview on 6-24-15 at 11:50 am with administrative staff A stated there was an incident on the 10 pm to 6 am shift in which one staff member went outside to smoke and the other staff member went outside to talk to him/her. The door locked behind the second staff member locking both staff outside. These staff knocked on the window of resident #122 and asked this resident to go to the front and open the door for them. Confirmed there has always been a keypad on the outside of the front door to enter the building if the door is locked, but stated the staff had not been given the code. " We hadn ' t really used it " the maintenance staff " just showed me the code recently. " Observation of smoking area on 6-24-15 revealed area located on front " porch " between kitchen back door and outside door on north end of building. Two resident room windows open onto this porch area, resident #122 ' s room and another resident room. The resident roster identified 38 residents in facility with cognitive impairment. Interview on 6-24-15 at 12:15 with licensed staff B confirmed resident #122 ' s FCS dated 1-13-15 identified the resident as a fall risk. For all residents the operator failed to ensure direct care staff or licensed staff shall be in attendance and responsive at all times when both certified staff were locked outside of the facility during the night shift.	S3246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N003005	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT ATCHISON LLC	1301 N 4TH ATCHISON, KS 66002

(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