| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | N030008 | A. BUILDING: _____ B. WING _____ | 03/14/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| VINTAGE PARK AT OTTAWA LLC | 2250 S ELM ST OTTAWA, KS 66067 |

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| S 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a resurvey with a complaint (#122489) at the above named assisted living facility conducted on 3-13,14-2019. | S 000 | | |
| S3085 SS=E | 26-41-202 (a) Negotiated Service Agreement<br><br>(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:<br>(1) A description of the services the resident will receive;<br>(2) identification of the provider of each service; and<br>(3) identification of each party responsible for payment if outside resources provide a service.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-202(a)(1)<br><br>The facility reported a census of 37 residents. The sample included 3 residents and 1 focused record review. Based on observations, interview and record review, the operator failed to ensure designated staff developed a written negotiated service agreement for 3 (#100, #200, #300) of 3 residents which included a description of the | S3085 | | |

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

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| S3085 | Continued From page 1 | S3085 | | |

services the resident would receive related to bed rails and incontinence assistance.

Findings included:

- Review of resident #100's medical record revealed he/she admitted to the facility on 6/1/17 with diagnoses of anxiety, depression, diabetes, and Parkinson.

Review of the functional capacity screen dated 6-1-18 revealed the resident required physical assistance with bathing and dressing and was independent with transfers and used a walker.

Review of the negotiated service agreement dated 6-1-18 failed to identify the resident used a bed rail for assistance with mobility when in bed.

Observation on 3-14-19 at 9:30 AM revealed the bed with head elevated slightly and had 2 1/4 bed rails attached to the bed in the down position.

During an interview on 3-14-19 the resident reported the/she had the bed since his/her heart surgery and used the rails to pull herself up in bed.

- Review of resident #200's medical record revealed he/she admitted to the facility on 6-6-16 with diagnosis of peripheral vascular disease, hypertension and anxiety.

Review of the functional capacity screen dated 9-17-18 revealed the resident required physical assistance with bathing and dressing, used a slide board and motorized wheelchair.

Review of the negotiated service agreement dated 9-9-18 failed to identify the resident used

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|---|---|---|---|---|
| S3085 | Continued From page 2 | S3085 | | |

bilateral quarter side rails on the bed as assistive devices for bed mobility.

Observation on 3-14-19 at 9:32 AM the resident's bed had bilateral quarter side rails on the bed.

At 9:32 AM on 3-14-19 the resident reported he/she used the bed rails to scoot him/herself up in bed and to reposition in the bed.

During an interview on 3-14-19 at 9:55 AM licensed nursing staff A reported he/she thought safety assessments for side rails had been completed but could not find them and also thought the bed rails were written in as assistive devices on the functional capacity screen and were in the health service plan. Reviewed the plan and confirmed the bed rails were not in the care plan or the service agreement.

- Review of resident #300's medical record revealed he/she admitted to the facility on 2-23-19 with diagnosis of hypertension, esophageal reflux and bells palsy.

Review of the functional capacity screen dated 2-23-19 revealed the resident had frequently bladder incontinence and word depends occasionally. Review of the negotiated service agreement dated 2-23-19 lacked services to be provided related to the resident's bladder incontinence.

During an interview on 3-13-19 at 3:45 PM licensed nursing staff A reported the resident managed his/her own incontinence but did not identify that on the negotiated service agreement.

The operator failed to ensure designated staff developed a negotiated service that included bed

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| S3085 | Continued From page 3<br>rail usage for residents #100 and #200 and services related to bladder incontinence for resident #300. | S3085 | | |
| S3155 SS=E | 26-41-204 (a) Health Care Services<br>. (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.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR 26-41-204(a)<br><br>The facility reported a census of 37 residents. The sample included 3 residents and 1 focused record review. Based on observations, interview and record review, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of 2 (#100 and #200) of 3 residents related to safety assessment for the use of bed rails.<br><br>Findings included:<br><br>- Review of resident #100's medical record revealed he/she admitted to the facility on 6/1/17 with diagnoses of anxiety, depression, diabetes, and Parkinson. | S3155 | | |

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| S3155 | Continued From page 4<br><br>Review of the functional capacity screen dated 6-1-18 revealed the resident required physical assistance with bathing and dressing and was independent with transfers and used a walker.<br><br>Review of the negotiated service agreement/ health care service plan dated 6-1-18 failed to identify the resident used a bed rail for assistance with mobility when in bed.<br><br>Observation on 3-14-19 at 9:30 AM revealed the bed with head elevated slightly and had 2 1/4 bed rails attached to the bed in the down position.<br><br>During an interview on 3-14-19 the resident reported the/she had the bed since his/her heart surgery and used the rails to pull herself up in bed.<br><br>- Review of resident #200's medical record revealed he/she admitted to the facility on 6-6-16 with diagnosis of peripheral vascular disease, hypertension and anxiety.<br><br>Review of the functional capacity screen dated 9-17-18 revealed the resident required physical assistance with bathing and dressing, used a slide board and motorized wheelchair.<br><br>Review of the negotiated service agreement/ health care service plan dated 9-9-18 failed to identify the resident used bilateral quarter side rails on the bed as assistive devices for bed mobility.<br><br>Observation on 3-14-19 at 9:32 AM the resident's bed had bilateral quarter side rails on the bed.<br><br>At 9:32 AM on 3-14-19 the resident reported | S3155 | | |

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| S3155 | Continued From page 5<br>he/she used the bed rails to scoot him/herself up in bed and to reposition in the bed.<br><br>During an interview on 3-14-19 at 9:55 AM licensed nursing staff A reported he/she thought safety assessments for side rails had been completed but could not find them.<br><br>The operator failed to ensure a licensed nurse provided or coordinated a safety assessment for the use of side rails for resident # 100 and #200 for safe usage and functionality of the bed rails to ensure necessary health care services met the needs of each resident. | S3155 | | |
| S3175 SS=D | 26-41-205 (a) (1) Self Administration of Medication<br><br>(a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance.<br>(1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually.<br><br>This REQUIREMENT is not met as evidenced | S3175 | | |

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| S3175 | Continued From page 6<br>by:<br>KAR 26-41-205(a)(1)<br><br>The facility reported a census of 37 residents. The sample included 3 residents and 1 focused record review. Based on interview and record review the operator failed to ensure designated staff completed a self -administration of medication assessment annually for 1 (#200) of 3 residents who self administered some of his/her medications.<br><br>Findings included:<br><br>- Review of resident #200's medical record revealed he/she admitted to the facility on 6-6-16 with diagnosis of peripheral vascular disease, hypertension and anxiety.<br><br>Review of the functional capacity screen dated 9-17-18 revealed the resident required assistance with management of medications.<br><br>Review of the negotiated service agreement dated 9-9-18 revealed the facility would manage the residents medications except the resident would manage his/her won symbicort and pepto-bismol.<br><br>Review of the residents record revealed a self-administration medication assessment dated 10-19-17 but did not have one done since.<br><br>During an interview on 3-14-19 at 9:52 AM licensed nursing staff A looked in the chart and did not see an assessment for 2018.<br><br>The operator failed to ensure designated staff completed a self-administration medication assessment annually for resident #200. | S3175 | | |

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| S3299 SS=F | 26-41-206 (e) (1) Facility Food Storage<br><br>(e) Food storage. Facility staff shall store all food under safe and sanitary conditions.<br>(1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving.<br><br>This REQUIREMENT is not met as evidenced by:<br>KAR26-41-206(e)<br><br>The facility reported a census of 37 residents. Based on observations and interviews the operator failed to ensure designated dietary staff stored all food under safe and sanitary conditions related to the thawing of meat and measuring scoop in cornmeal.<br><br>Findings included:<br><br>- During initial tour on 3-13-19 at 8:49 AM the dry storage area contained large containers of rice, flour, sugar and corn starch. In the container of corn starch was a measuring cup and the handle of the cup was down in the corn starch.<br><br>At 8:53 AM observation revealed a chub of hamburger sitting in the dry sink to thaw. The package was thawed on the very edges but still frozen internally.<br><br>During an interview on 3-13-19 at 8:56 AM dietary staff B reported he/she took the hamburger out about an hour ago because they had forge to take it out yesterday to thaw in the refrigerator. | S3299 | | |

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| S3299 | Continued From page 8<br>Staff B then asked staff C to put the hamburger in the refrigerator.<br><br>The operator failed to ensure designated staff stored cornstarch and thawed hamburger in a safe and sanitary manner. | S3299 | | |