STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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 are the result of a licensure re-survey with attached complaint at the above named assisted living facility on 3/6/17, 3/7/17 and 3/8/17.	S 000		
S3082 SS=E	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 33 residents. The sample included 3 residents. Based on record review, observation and interview for 2 of 3 residents sampled (#306 and #307) the operator failed to ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. Findings included: - Record review for resident #306 recorded admission date of 6/6/15 with diagnoses of: arthritis, hypertension legal blindness and ocular herpes. Functional capacity screen (FCS) dated 6/2/16 recorded resident required physical assistance (2) with bathing, dressing, walk/mobility and management of treatments, supervision (1) with	S3082		

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
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3082	Continued From page 1	S3082		

toileting and transfer, and unable to perform (3) management of medications. Resident communication coded (0) understandable, for expresses information, and (0) understands, for ability to understand others.

Interview on 3/7/17 at 1:45 pm with licensed nurse #A confirmed resident is always a 2:1 transfer assist and staff toilets resident. Confirmed FCS is coded incorrectly as resident requires physical assistance with transfers and toileting.

Interview on 3/6/17 at 1:30pm with resident revealed resident speaks in halting, very broken, slow speech. When asked about his/her last fall resident states he/she " fell out of the car " and points to the wheelchair, stated he/she fell " the day after tomorrow " .

Interview on 3/7/17 at 3:45pm with resident ' s spouse, he/she confirmed resident " has lots of trouble speaking and says no when he/she means yes, it ' s hard for him/her. "

Interview on 3/7/17 at 1:45pm with licensed nurse #A confirmed resident has communication difficulties and FCS is coded incorrectly.

FCS for resident #306 is coded incorrectly for transfer, toileting and communication.

Record review for resident #307 recorded admission date of 12/8/16 with diagnoses of: diabetes mellitus type 2, depression, COPD (chronic obstructive pulmonary disease), hypothyroidism, diabetic neuropathy, edema, heart failure, hypertension, vitamin D deficiency, hypercholesterolemia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3082	Continued From page 2 Functional Capacity Screen (FCS) dated 12/9/16 recorded resident coded independent (0) for bathing and supervision required (1) for management of medications and treatments. FCS/HCSP dated 12/8/16 recorded staff to assist resident with bathing and management of medications and treatments. March 2017 medication record recorded staff administration of medications and treatments daily. Interview on 3/7/17 at 2:00pm with licensed nurse confirmed resident received staff assistance with bathing, medications and treatments and FCS is coded incorrectly. FCS for resident #307 is coded incorrectly for bathing and management of medications and treatments. For residents #306 and #307, the operator failed to ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form.	S3082		
S3085 SS=E	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	S3085		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3085	Continued From page 3	S3085		

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)

The facility census equaled 33 the sample included 3 residents. Based on record review and interview for 2 residents (#307 and #308) the operator failed to ensure the Negotiated Service Agreement (NSA) completed for residents who required health care services, is done in collaboration with the resident or the resident ' s legal representative and contained a description of the services the resident will receive, identify the provider of each service and identify each party responsible for payment if outside resources provide a service.

Findings included:

- Record review for resident #307 recorded admission date of 12/8/16 with diagnoses of: diabetes mellitus type 2, depression, COPD (chronic obstructive pulmonary disease), hypothyroidism, diabetic neuropathy, edema, heart failure, hypertension, vitamin D deficiency, hypercholesterolemia.

Functional Capacity Screen (FCS) dated 12/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3085	Continued From page 4	S3085		

recorded resident required supervision with medications and treatments.

Negotiated Service Agreement (NSA) dated 12/8/16 recorded resident medications and treatments to be administered per doctor ' s order by qualified staff. Outside services: Oxygen: N/A (not applicable)

Observation on 3/6/17 at 1:45pm in resident ' s room revealed resident wearing a nasal CPAP (continuous positive air pressure) machine with oxygen running via the CPAP.

Interview on 3/6/17 at 1:45pm with resident confirmed he/she wears CPAP with 5 LPM of Oxygen.

Interview on 3/7/17 at 2:00pm with licensed nurse #A confirmed NSA lacked entry for use of outside provider for oxygen services.

NSA lacked entry for use of an outside provider for Oxygen services.

Record review for resident #308 recorded admission date of 9/5/15 with diagnoses of: Chronic obstructive pulmonary disease, venous insufficiency, Congestive Heart Failure (CHF), Hypertension (HTN), atrial fibrillation, esophageal reflux and depression.

FCS dated 11/9/16 recorded resident unable to perform management of medications and required physical assistance with management of treatments.

NSA dated 11/9/16 recorded qualified staff to administer medications and treatments per doctor ' s orders. Outside provider services listed for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3085	Continued From page 5 x-ray, lab and podiatry services. Contract skilled nursing services: " [agency name] home health, provider bills. " Entry lacked description of services to be provided and person responsible for payment of the service. Nurse ' s note dated 2/15/17 at 1:15pm recorded order for occupational and physical therapy. Interview on 3/7/17 at 1:40pm with licensed nurse #A confirmed resident receives skilled nursing services for stasis ulcer dressing changes and occupational and physical therapy (OT/PT) services for strengthening. Confirmed NSA lacked entry for name of OT/PT provider, description of services to be provided and person responsible for payment of the services. For residents #307 and #308 the operator failed to ensure the Negotiated Service Agreement (NSA) completed for residents who required health care services, is done in collaboration with the resident or the resident ' s legal representative and contained a description of the services the resident will receive, identify the provider of each service and identify each party responsible for payment if outside resources provide a service.	S3085		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3200	Continued From page 6 of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 33 residents. The sample included 3 residents and one focus review resident. Based on record review and observation for 2 residents (#307and #308) and one focus review resident (#309), the operator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order and professional standards of practice. Findings included: - Record review for resident #307 recorded admission date of 12/8/16 with diagnoses of: diabetes mellitus type 2, depression, COPD (chronic obstructive pulmonary disease),	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3200	Continued From page 7	S3200		

hypothyroidism, diabetic neuropathy, edema, heart failure, hypertension, vitamin D deficiency, hypercholesterolemia.

Functional Capacity Screen (FCS) dated 12/9/16 recorded resident required supervision with medications and treatments.

Negotiated Service Agreement (NSA) dated 12/8/16 recorded resident medications and treatments to be administered per doctor ' s order by qualified staff.

Health Care Service plan (HCSP) dated 12/9/16 recorded medications to be managed by CMA (certified medication aide), LPN (licensed practical nurse or RN (registered nurse). Resident self- injects insulin.

Resident ' s March 2017 medication administration record (MAR) recorded Citalopram (antidepressant) 20mg (milligrams) take ½ tablet to equal 10mg PO (by mouth) at bedtime.

February 2017 Physician order sheet (most recent) lacked order for Citalopram.

Observation on 3/6/17 at 1:45pm in resident ' s room revealed resident wearing a nasal CPAP (continuous positive air pressure) machine with oxygen running via the CPAP.

Interview on 3/6/17 at 1:45pm with resident confirmed he/she wears CPAP with 5 LPM of Oxygen.

February 2017 physician order sheet lacked orders for Oxygen use.

March 2017 MAR lacked entry for resident use of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3200	Continued From page 8 Oxygen. Interview on 3/7/17 at 2:00pm with licensed nurse #A confirmed resident received Citalopram and oxygen, record lacked orders for Citalopram and oxygen and MAR lacked entry for use of oxygen. Record lacked physician ' s orders for medications administered. Record review for resident #308 recorded admission date of 9/5/15 with diagnoses of: Chronic obstructive pulmonary disease, venous insufficiency, Congestive Heart Failure (CHF), Hypertension (HTN), Atrial fibrillation, esophageal reflux and depression. FCS dated 11/9/16 recorded resident unable to perform management of medications and required physical assistance with management of treatments. NSA dated 11/9/16 recorded qualified staff to administer medications and treatments per doctor ' s orders. HCSP dated11/9/16 recorded CMA, LPN, RN to manage medications, resident to self- inject insulin. February 2017 MAR recorded weigh resident Monday-Wednesday-Friday, report weight loss or gain of 3 pounds. Facility weight record recorded the following resident weights: 2/1/17: 235.4 lb (pounds) 2/2/17: 238.8 lb 2/3/17: 238.0 lb	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3200	Continued From page 9 2/4/17: 242.2 lb 2/5/17: 247 lb total gain of 11.6 pounds in 4 days. Physician documentation recorded hospital emergency room summary: arrival date 2/5/17, for shortness of breath, with a 12 pound weight gain in the past week. Intravenous Furosemide administered. Resident admitted to hospital on 2/5/17. Transferred to hospital swing bed unit on February 9, 2017 with acute exacerbation of CHF and acute renal failure. Discharged back to facility on 2/14/17 with orders for Furosemide 40mg daily. Record lacked nurse ' s notes for 2/1/17 to 2/8/17. Hospital discharge orders dated 2/14/17 recorded continue furosemide (diuretic) 40mg by mouth daily. February 2017 MAR recorded Furosemide 20mg one tablet by mouth daily, recorded administered February 15 through February 21st, held February 22nd. Nurse ' s Notes dated 2/22/17 at 4pm recorded resident attended scheduled doctor appointment. Sent to ER (emergency room). Admitted for heart failure. Hospital discharge summary recorded admission date of February 21, 2017 for complaints of difficulty breathing. Received intravenous Lasix (furosemide). Discharged February 22, 2017, (no discharge medication record available). Summary recorded " His/her Lasix was increased from 20mg to 40mg to help keep his/her CHF under better control. "	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3200	Continued From page 10 February 2017 MAR recorded Furosemide 20mg administered February 23 and 24th. February 2017 MAR recorded Furosemide 40mg administered on February 25th through 28th, 2017. Fax from physician regarding a 2/24/17 office visit, recorded Lasix 40mg PO daily. Record lacked nurse ' s notes for 2/24/17 office visit and medication orders. Facility nurses failed to report an 11.6 pound weight gain and failed to administer the correct dose of furosemide as ordered. Interview on 3/7/17 at 12:10pm with licensed nurse #A stated he/she was not aware of the medication errors or resident weight gain. He/she stated he/she confirmed discharge orders via the telephone with the primary physician ' s nurse, but did not record it in the nurse ' s notes. Record review for resident #309 recorded admission date of 6/6/15 with diagnoses of: hypertension, hyperlipidemia, pain and constipation. FCS dated 6/6/16 recorded resident required assistance with management of medications and treatments. NSA dated 6/6/16 recorded staff to manage medications and treatments. HCSP dated 11/25/16 recorded CMA, LPN and RN to manage medications.	S3200		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3200	Continued From page 11 Hospital discharge summary dated 1/3/17 recorded " stop taking these medications " Citalopram (antidepressant) 20mg tablet. Nurse ' s notes dated 1/3/17 recorded to discontinue citalopram 20mg, signed by licensed nurse #A. January 2017 MAR recorded Citalopram 20mg one tablet by mouth at bedtime as administered by staff January 4 to January 31st. Interview on 3/7/17 at 11:58pm with licensed nurse #A confirmed resident medication was discontinued and resident is still receiving the medication. He/she stated discharge orders are confirmed by calling the physician and going over the orders with his/her nurse. He/she confirmed lack of nurse ' s note regarding confirmation of orders. Facility nurse failed to discontinue a medication as ordered by a physician. For 3 residents (#307, #308 and #309) the operator failed to ensure all medications and treatments were administered in accordance with a medical care provider's written order and professional standards of practice resulting in the repeat hospitalization of one resident (#308) for cardiac and renal failure.	S3200		
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	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3261	Continued From page 12 This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 33 residents. The sample included 3 residents. Based on record review and interview for 1 sampled residents (#308), the operator failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action. Findings included: - Record review for resident #308 recorded admission date of 9/5/15 with diagnoses of: Chronic obstructive pulmonary disease, venous insufficiency, Congestive Heart Failure (CHF), Hypertension (HTN), atrial fibrillation, esophageal reflux and depression. Functional Capacity Screen (FCS) dated 11/9/16 recorded resident unable to perform management of medications and required physical assistance with management of treatments. Negotiated Service Agreement (NSA) dated 11/9/16 recorded qualified staff to administer medications and treatments per doctor ' s orders.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3261	Continued From page 13 Health Care Service plan (HCSP) dated 11/9/16 recorded CMA, LPN, RN to manage medications, resident to self- inject insulin. Physician documentation recorded hospital emergency room summary: arrival date 2/5/17 at 8:54pm, for shortness of breath, with a 12 pound weight gain in the past week. Intravenous Furosemide administered. Resident admitted to hospital on 2/5/17. Discharged back to facility on 2/14/17. Nurses notes dated 2/9/17 at 8am recorded resident complaints of shortness of breath and transfer to emergency room. Nurse ' s note dated 2/15/17 at 1:15pm recorded resident returned to the facility. Record lacked nursing documentation for time and resident condition on 2/5/17 transfer to emergency room, hospitalization and time of readmission to facility on 2/14/17. Hospital discharge summary recorded admission on 2/21/17 at 2:15pm following physician ' s office visit on 2/21/17 for congestive heart failure. Discharged 2/22/17. Nurse ' s note dated 2/22/17 at 4pm recorded resident attended scheduled doctor appointment. Sent to ER (emergency room) for heart failure. Transported back to facility. Record lacked nursing documentation on 2/21/17 for time of physician ' s visit, resident condition prior to appointment and subsequent admission to the hospital.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3261	Continued From page 14 Most recent nurse ' s note on 2/24/17 at 10:00 am recorded " resident currently in room. " Fax from physician for 2/24/17 office visit with medication orders for Lasix 40mg po (by mouth) daily. Facility operator confirmed via email fax was from 2/24/17 office visit. Interview on 3/7/17 at 1:15pm with licensed nurse #A confirmed resident was seen in the clinic on the 24th. Record lacked documentation of 2/24/17 office visit with Lasix orders and lacked follow up documentation of resident condition after medication change. For resident #308, the operator failed to ensure documentation of all incidents, and indications of illness or injury including date, time of occurrence, action taken and results of the action.	S3261		
S3280 SS=E	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents;	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3280	Continued From page 15 and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-4-104(d)(3) The census equaled 33 residents; the sample included 3 residents and one focus review resident. Based on interviews and review of records, for all residents, the operator failed to ensure disaster and emergency preparedness when the operator failed to ensure quarterly review of the facility ' s emergency management plan with employees and residents. Findings included: On 3/6/17 at 11:30pm received facility in-service binder on disaster preparedness for 2016 and 2017. Disaster/emergency preparedness in-services with staff were conducted on 3/7/16 and 6/2/16. Interview with facility maintenance staff #B and facility operator stated review of emergency preparedness is only conducted twice a year with	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N043004	A. BUILDING: _____ B. WING _____	C 03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT HOLTON LLC	410 JUNIPER DR HOLTON, KS 66436

(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
S3280	Continued From page 16 staff. Disaster emergency preparedness for residents was conducted as follows: 10/27/15 (37 residents), 1/20/16 (20 residents), 5/20/16 (33 residents), 8/16/17 (7 residents), 10/16 (13 residents). Records lacked resident disaster/emergency preparedness in 2017 and with all residents quarterly. The operator failed to ensure disaster and emergency preparedness when the operator failed to ensure quarterly review of the facility ' s emergency management plan with employees and residents.	S3280		