STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046037	A. BUILDING: _____ B. WING _____	10/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT LENEXA LLC	8710 CAENEN LAKE RD LENEXA, KS 66215

(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 a resurvey with complaint investigations 121556, 120829 at the above named assisted living facility conducted on 9-27-17, 9-28-17 and 10-2-17.	S 000		
S 170 SS=D	26-39-103 (o) Resident Right Personal Property (o) Personal property. The administrator or operator shall ensure that each resident is afforded the right to retain and use personal possessions, including furnishings and appropriate clothing as space permits, unless doing so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: KAR 26-39-103(o) The facility reported a census of 29 assisted living residents and 1 day care resident. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1 (#927) of 3 sampled residents, the operator failed to ensure that the resident was afforded the right to retain and use personal possessions unless doing so would infringe upon the rights or health and safety of other residents. Findings included: - Record review for Resident #927 revealed admission on 4-9-13 with diagnoses Dementia, Hearing Loss, Depression, Gastroesophageal Reflux Disease and Hypertension.	S 170		

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
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S 170	Continued From page 1 The Functional Capacity Screen dated recorded resident required physical assistance with bathing, dressing, toileting and eating; supervision with transfers and walking/mobility; unable to perform management of medications and treatments. Occasionally incontinent of bladder. Cognition: problems with short term memory and decision-making. Current problems/risks identified included falls/unsteadiness, impaired hearing and impaired decision-making. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 4-12-17 recorded services for staff assistance with bathing, dressing, toileting, meals, medication management and supervision of transfers and ambulation. Nurse's Notes: 9-21-17 10:45 am: "Family has placed a video camera in resident's room over the labor day weekend. Staff and management unaware. (Family member) asked myself and administrator if camera could be placed 8-28-17 when he/she reported (Resident's) briefs and toilet paper were disappearing quickly - we, at that time asked that he/she allow us to investigate. We also informed him/her we thought that a camera is not allowed in facility without staff and management approval. Camera was noted by myself approximately a week ago. Policy does state no spying devices allowed. Camera removed and (family member) notified 9-20-17. Signed by Licensed Staff B. On 9-27-17 at 9:25 am during entrance interview with Operator stated, "...a family put a camera in a room because they thought (another resident) was going in and out and stealing briefs." Stated when he/she found out about the camera, he/she	S 170		

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S 170	Continued From page 2	S 170		

unplugged it and called (home office). (The home office) sent a highlighted residency agreement and copy of the handbook which stated they can't put in cameras.

Observation on 9-27-17 at 3:15 pm of Resident's room revealed private room with separate bedroom and bathroom. There was a combined living room/dining area with a kitchenette. The kitchenette had a sink with cabinets and a small dorm-size refrigerator. Licensed Staff B pointed to top of the upper cabinet and stated this was where the video camera had been located.

Review of Residency Agreement 2.1 stated, "You have selected Residence #____ in which to live. You will have a personal and non-assignable right to live in your Residence, subject to the terms of this Agreement, and the Resident Handbook, as amended from time to time, in Operator's discretion. (See Appendix A for a current copy of the Resident Handbook.)

Resident Handbook stated, "Video/Audio Recording: The Community prohibits the use of any video or audio recording of its campus, property, staff and other residents. The Residents and employees' privacy must be maintained and thereby videotaping and audio recording is a violation of the individual's constitutional rights to privacy. No camera, recorders or other type of spying devices are permitted on these premises. Violators will be subject to eviction for failure to comply with the Community rules and regulations."

For Resident #927, the operator failed to ensure the resident was afforded the right to retain and use personal possessions unless doing so would infringe upon the rights or health and safety of

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S 170	Continued From page 3 other residents.	S 170		
S3028 SS=E	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 by: KAR 26-41-101(f)(3)	S3028		

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S3028	Continued From page 4	S3028		

The facility reported a census of 29 assisted living residents and 1 day care resident. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1 (#927) of 3 sampled residents and 1 (#931) non-sampled resident, the operator failed to ensure each allegation of abuse or neglect shall be reported to the department with 24 hours.

Findings included:

- Record review for Resident #927 revealed admission on 4-9-13 with diagnoses Dementia, Hearing Loss, Depression, Gastroesophageal Reflux Disease and Hypertension.

The Functional Capacity Screen dated recorded resident required physical assistance with bathing, dressing, toileting and eating; supervision with transfers and walking/mobility; unable to perform management of medications and treatments. Occasionally incontinent of bladder. Cognition: problems with short term memory and decision-making. Current problems/risks identified included falls/unsteadiness, impaired hearing and impaired decision-making.

The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 4-12-17 recorded services for staff assistance with bathing, dressing, toileting, meals, medication management and supervision of transfers and ambulation.

Review of Medication Administration Record for September 2017 revealed Ipratropium-Albuterol nebulizer breathing treatments to be administered routinely twice daily for shortness of air and wheezing. The record documented that the

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S3028	Continued From page 5	S3028		

treatments were not administered from 9-4-17 at 8:00 am through 9-15-17 at 8:00 am. Certified Medication Aides documented "machine broken" as reason breathing treatments not administered.

Interviews on 9-27-17 at 2:00 pm and 2:50 pm with Licensed Staff B stated the resident's family member had mentioned resident was not receiving his/her breathing treatments, so he/she investigated and found there was a part on the machine broken so the machine wouldn't create the mist. A new machine was ordered and staff were given written warnings regarding notification of nurse and pharmacy when a medication can not be given. Stated resident's nurse practitioner was notified that the resident failed to receive medication as ordered. Confirmed he/she failed to notify the department of the allegation of neglect.

On 9-27-17 at 11:14 am during interview regarding roster with Licensed Staff B, stated two residents that sit together in the dining room for meals had a resident to resident confrontation in which Resident #931 afterward felt threatened by Resident #929.

Interview on 9-28-17 at 12:43 pm with Resident #931 stated that another resident "threatened my life" and that Administrative Staff A knew about it.

Interview on 9-27-17 at 4:56 pm with Administrative Staff A confirmed he/she had gone to the dining room to talk with both residents to calm them down. Confirmed Resident #931 came to his/her office later to explain his/her version of what had happened. Administrative Staff A told Resident #931, he/she needed to talk to a few other people to better understand what happened. Confirmed the incident was not

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S3028	Continued From page 6 reported to the department. Facility policy for Abuse Neglect and Exploitation stated: 2) The Executive Director (operator) will investigate immediately and document all allegations of resident abuse or neglect and/or exploitation. Each allegation of abuse, neglect, or exploitation will be reported to the operator of the community as soon as staff is aware of the allegation and to KDADS within 24 hours. For Residents #927 and #931, the operator failed to ensure each allegation of neglect and abuse was reported to the department.	S3028		
S3201 SS=E	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered.	S3201		

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S3201	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(3)(D) The facility reported a census of 29 assisted living residents and 1 day care resident. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 2 (#927, #929) of 3 sampled residents, the operator failed to ensure the certified medication aides documented the administration of the resident's medication in the resident's medication administration record immediately following completion of the task. Findings included: - Record review for Resident #927 revealed admission on 4-9-13 with diagnoses Dementia, Hearing Loss, Depression, Hypertension, and Gastroesophageal Reflux Disease (GERD). The Functional Capacity Screen dated 4-12-17 recorded resident unable to perform management of medications/treatments. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 4-12-17 recorded medication management by qualified staff as ordered by physician. Review of the Medication Administration Record (MAR) for September 2017 revealed the following: The MAR lacked documentation of administration of medications on the following dates/times: Pantoprazole (GERD) 40 mg (milligrams) on 9-8-17 at 4:00 pm; Acetaminophen (pain reliever) 325 mg 2 tabs (tablets) on 9-20-17 at 4:00 pm;	S3201		

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S3201	Continued From page 8 Melatonin (for sleep) 3 mg tabs on 9-20-17 at 8:00 pm; Removal of TED hose on 9-21-17; Eucerin Cream to feet at bedtime on 9-20-17 at 8:00 pm; Namenda (dementia) 28 mg capsule on 9-16-17 at 8:00 am; Donepezil (dementia) 10 mg 9-16-17 at 8:00 am; Cranberry Powder 425 mg capsule on 9-16-17 at 8:00 am; Citalopram 20 mg tab on 9-16-17 at 8:00 am; Cetrizine (allergies) 10 mg tab on 9-16-17 at 8:00 am; - Record review for Resident #929 revealed admission on 5-12-17 with diagnoses Insulin Dependent Diabetes Mellitus, Hypertension, Obesity, Anemia, Neuropathy, and Traumatic Brain Injury. The Functional Capacity Screen dated 5-12-17 recorded resident required physical assistance with management of medications and treatments. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 5-12-17 recorded medication management by qualified staff as ordered by physician. Certified Medication Aide/Licensed Practical Nurse to dial insulin pen for resident to self inject. Review of the Medication Administration Record (MAR) for September 2017 revealed the following: The MAR lacked documentation of administration of medications on the following dates/times: Tramadol (pain) 9-2-17 at 2:00 pm, 9-8-17 at 2:00 pm, 9-9-17 at 2:00 pm; Gabapentin 300 mg capsule 9-8-17 at 12:00 pm, 9-9-17 at 12:00 pm, 9-20-17 at 8:00 pm, 9-22-17	S3201		

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S3201	Continued From page 9 at 12:00 pm; Donepezil 10 mg tab 9-20-17 at 5:00 pm; Novolog insulin 22 units per sliding scale on 9-8-17 at 2:00 pm and 9-9-17 at 2:00 pm, 9-9-17 at 8:00 am and 11:30 am, 9-16-17 at 11:30 am, 9-17-17 at 4:30 pm, 9-20-17 at 4:30 pm; Lantus insulin 35 units 9-9-17 at 8:00 am, 9-15-17 at 8:00 am, 9-23-17 at 8:00 am; Cetrizine (allergies) 10 mg on 9-23-17 at 8:00 am, 9-25-17 and 9-26-17 at 8:00 am. Interview on 9-28-17 at 2:09 pm with Administrative Staff A and Licensed Staff B confirmed the MARs lacked documentation of administration of medications on the above dates and times. Stated the staff have been monitored to ensure they are administering medications, the issue has been with initialing the MAR, "they don't understand the importance of documenting." For Residents #927 and #929, the operator failed to ensure the certified medication aides documented the administration of the resident's medication in the resident's medication administration record immediately following completion of the task.	S3201		
S3227 SS=E	26-41-205 (l) (2) Medication Regimen Review Variance Report (l) (2) The licensed pharmacist or licensed nurse shall notify the medical care provider upon discovery of any variance identified in the medication regimen review that requires immediate action by the medical care provider. The licensed pharmacist shall notify a licensed nurse within 48 hours of any variance identified in the resident ' s regimen review that does not require immediate action by the medical care	S3227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3227	Continued From page 10 provider and specify a time within which the licensed nurse must notify the resident ' s medical care provider. The licensed nurse shall seek a response from the medical care provider within five working days of the medical care provider ' s notification of a variance. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(l)(2) The facility reported a census of 29 assisted living residents and 1 day care resident. The sample included 3 residents and 1 focus review resident. Based on record review and interview for 1 (#927) of 3 sampled residents and 1 (#930) of 1 focus review resident, the licensed nurse failed to notify the medical care provider upon discovery of any variance identified in the medication regimen review. Findings included: - Record review for Resident #927 revealed admission on 4-9-13 with diagnoses Dementia, Hearing Loss, Depression, Hypertension, and Gastroesophageal Reflux Disease. The Functional Capacity Screen dated 4-12-17 recorded resident unable to perform management of medications/treatments. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 4-12-17 recorded medication management by qualified staff as ordered by physician. The Medication Regimen Review dated 4-11-17 recommended dose reduction for Citalopram	S3227		

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S3227	Continued From page 11 (antidepressant) from 20 mg (milligrams) to 10 mg. The record lacked documentation this recommendation sent to the physician for a response. Review of current medication administration record revealed current dosage for Citalopram to be 20 mg daily. - Record review for Resident #930 revealed admission on 5-15-17 with diagnoses Insulin Dependent Diabetes Mellitus, Hypertension and Anemia. The Functional Capacity Screen dated 5-15-17 recorded resident unable to perform management of medications and treatments. The Negotiated Service Agreement/Health Care Service Plan (NSA/HCSP) dated 5-15-17 recorded medication management by qualified staff as ordered by physician. Staff to check blood sugars, dial insulin pen for resident to self-inject. The Medication Regimen Review dated 7-6-17 recommended pulse parameters for Carvedilol (beta blocker used to treat hypertension). Review of Medication Administration Record revealed the MAR lacked documentation of pulse parameters for Carvedilol. Interview on 9-27-17 at 4:37 pm with Licensed Staff B stated he/she had not gotten a report form the consulting pharmacist and did not know the medication regimen reviews were left in the chart by the pharmacist. Confirmed the review letters had not been printed and given out to the doctors and the records lacked documentation of notification of physician regarding consulting pharmacist recommendations.	S3227		

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S3227	Continued From page 12 For Residents #927 and #930, the licensed nurse failed to seek a response from the medical care provider upon discovery of a variance identified in the medication regimen review.	S3227		