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 _____	01/13/2016

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

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S 000	INITIAL COMMENTS The following citations are the result of a licensure re-survey with complaints, (95896, 95892 and 92110) at the above named assisted living facility in Lenexa, Kansas on 1/11/16, 1/12/16 and 1/13/16. Revised 2567 sent to facility 1/22/16.	S 000		
S3026 SS=G	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101-(f)(1)(A) The facility reported a census of 24 residents. The sample included 4 residents. Based on observation, record review and interview for 1 (#240) of 3 sampled residents, the operator failed to provide services reasonably necessary to ensure this resident's safety and well-being and to avoid harm when a fire alarm sounded at 1:00 pm and staff informed the resident to evacuate his/her apartment with instructions to go to a secure location on the other side of the fire doors and failed to ensure the resident was not subjected to abuse when resident #331operated his/her electric scooter and hit resident #240 ' s legs from behind and rolled up onto the resident '	S3026		

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

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s feet, ankles and legs . Resident #240 fell and experienced fractures in both legs for a total 6 fractures and later died of unknown complications.

Findings included:

- Record review for resident #331 revealed admission on 7-14-15 with diagnoses Hypertension, Hyperlipidemia, Macular Degeneration, Glaucoma, and Parkinson ' s-Like Syndrome.

The Functional Capacity Screen dated 7-14-15 recorded resident was independent with, transfers; required supervision with walking/mobility and unable to perform management of medications and treatments. Cognition: problems with short term memory and memory recall. Current problems included falls and impaired vision.

The Negotiated Service Agreement dated 7-14-15 recorded the following:
Bathing assistance twice a week. Bedside Commode for toileting. Three meals daily. Facility staff to administer medications and treatments as ordered by physician. 12-21-15 amended to add electric wheelchair for distance mobility "
The NSA lacked directions for assistance needed to evacuate.

Nurse ' s Notes:
Written on 12-28-15 at 2:15 pm. " At 11:30 resident ' s roommate called for assist. Resident stated he/she fell. When certified staff G went to the apartment, found resident sitting on the floor facing refrigerator in kitchen, hamper at his/her back and electric scooter was parked near his/her

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right side. Resident stated he/she went to kitchen sink to wash hands and missed the seat on his/her scooter and sat on the floor. Had previously advised resident not to use scooter in apartment when he/she took it in bathroom and damaged roommate ' s trash can and hit his/her dresser when leaving bathroom ... " Signed by licensed staff A.

- Record review for resident #240 revealed admission on 10-30-14 with diagnoses Hypertension, Anemia, Edema, Macular Degeneration, Hypokalemia, Aortic Stenosis, and Anxiety.

The Functional Capacity Screen dated 10-30-15 recorded resident was independent with toileting, walking/mobility, and management of medications; required supervision with dressing and physical assistance with transfers. Cognition: problems with memory/recall. No problems with communication. Uses walker or wheelchair.

The Negotiated Service Agreement/Health Care Plan (NSA/HCP) dated 10-30-15 recorded the following:
Bathing assistance twice a week. Three meals daily. Uses walker for gait instability.

The NSA lacked directions for assistance needed to evacuate.

Nurse ' s Notes:
Written on 1-8-16 at 9:20 am: " On 1-7-16 at 1:00 pm during a fire drill, several residents and 3 visitors and I were in 400 hall near fire doors. The alarm stopped, (maintenance staff member) was holding the south door open, I went to open the north door, (resident #240) was beside me

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with his/her walker and started screaming. I turned to face him/her and he/she was on his/her knees with feet twisted under the foot rest of (resident #331 ' s) electric scooter. (Resident #240) yelled out ' he/she hit my legs! ' and continued screaming. Resident #331 backed his/her scooter out of the way. Certified staff #B and Operator/LPN came and we were able to get resident to a sitting position on the floor. Resident ' s right knee was bent with the lower leg and foot to (resident ' s) right. His/Her left leg was straight out in front of him/her. He/she attempted to move right leg and screamed out in pain. Operator/LPN stayed with resident and I called 911 at 1:05 pm. Emergency Medical staff arrived, stabilized both legs, resident was complaining of pain in left ankle when emergency medical staff was here and left him/her at 1:50 pm taking resident to (hospital). " Signed by licensed staff A.

Hospital Radiology and CT (Computer Tomography) Reports on 1-7-16:
CT Abdomen and Pelvis with contrast: clinically indicated due to " fall, pelvic pain, distal right femur fracture, proximal left tibia fracture and bilateral ankle fractures. No definite acute pelvic fracture identified. Mild age-indeterminate compression deformity superior endplate of T12. "

Bilateral Ankle Series: Right ankle - Acute minimally displaced fracture of the medial malleolus. Acute non-displaced fracture of the distal fibula. Left ankle - Acute comminuted minimally displaced fracture of the medial malleolus

Review of facility policy for "Fire and Emergency Preparedness " stated: " An annual fire drill will be conducted carrying out an emergency drill with

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S3026	Continued From page 4 staff and residents, which will include an evacuation of the designated residents past the closest fire doors to a safe area. Fire: In the event of a fire, the alarm will sound. Residents should begin to make their way to the nearest exit. Staff members will be escorting residents and assisting with evacuation in the building." The policy lacked instructions to staff for ensuring a safe passage to a secure location (example: use of wheelchairs for residents with problems ambulating, ensuring safe following distance for residents using electric scooters/wheelchairs). The facility did not have a policy for motorized scooters that had been implemented. There was a new policy received by the facility on 1-11-16 due to a recent change in ownership, but this policy had not been implemented. Observations: 400 Hall - immediately in front of wooden double doors (fire doors) accompanied by operator/LPN and licensed staff A revealed hallway which measured approximately 6 feet across. Licensed staff A indicated resident #240 had been walking up to the fire doors which had closed when the alarm sounded and was standing slightly to the right of center in the hallway immediately in front of the doors. The door to the resident ' s left had been opened by the maintenance director and licensed staff A was going to move ahead to open the door on the right. There were other " people " standing on either side of resident #240. Manufacturer ' s literature indicated the electric scooter measured 23 inches across (from outsides of front tires); the foot rest extended 15 inches out in front of the chair and the chair travels up to 4 miles per hour. Written statement from licensed staff A on	S3026		

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S3026	Continued From page 5 1-11-16 documented information identical to nurse ' s note written on 1-8-16 at 9:20 am. Confidential Interview stated that the resident while in the emergency room reported that he/she could hear (resident #331) coming and (resident #331) hit him/her and knocked him/her down and (licensed staff A) was saying at the time, ' hurry up, hurry up. ' " Interviews on 1-11-16 at 5:10 pm and 1-12-16 at 2:52 pm with licensed staff A confirmed he/she did not perform an assessment to determine that resident #331 was safe to operate the electric scooter inside the facility. Stated he/she and operator had both spoken to resident about slowing down, taking his/her time and not using the chair in the apartment because the apartment was too small. Further confirmed the facility did not have an active policy for use of electric scooters. Stated resident #331 did not move in with the scooter. He/She had the scooter brought from home in October 2015. Interview on 1-12-16 at 10:45 am with resident #331 stated, " we had a fire drill and I went down in my electric chair ...they kept saying, ' hurry, hurry, hurry. ' " Interview on 1-12-16 at 2:00 pm with certified staff F confirmed resident has problems using the electric scooter and " bumps into things. " Interview on 1-12-16 at 2:50 pm with certified staff B stated resident #331 has problems using the electric scooter. " He/she runs into stuff (walls, tables) ...will say he/she is going backwards and he/she will go forward. " Confirmed management staff " had a talk with him/her."	S3026		

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S3026	Continued From page 6 For resident #240, the operator failed to ensure the resident was not subjected to abuse when a fire alarm sounded at 1:00 pm, staff informed resident to evacuate his/her apartment with instructions to go to a secure location on the other side of the fire doors then failed to provide services reasonably necessary to ensure this resident's safety and well-being and to avoid harm when resident #331operated his/her electric scooter and hit resident #240 ' s legs from behind and rolled up onto the resident ' s feet, ankles and legs. Resident #240 fell and experienced fractures in both legs for a total 6 fractures and later died of unknown complications.	S3026		
S3155 SS=E	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 identified a census of 25 residents. The sample included 4 residents. Based on record review, interview, and observation for 2 (#115, #955) of 4 residents sampled, the administrator failed to ensure a licensed nurse provided and coordinated the provision of	S3155		

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S3155	Continued From page 7	S3155		

necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement.

Findings included:

- Record review for resident #955 revealed an admit date of 7/13/15 with diagnoses of dementia, osteoporosis, secondary hypertension, hearing loss, type 2 diabetes mellitus, polyosteoarthritis and hypothyroidism.
The functional capacity screens (FCS) dated 7/13/15 recorded resident required supervision with toileting, transfer, walking/mobility (walker), eating, bathing, dressing , required physical assistance with bladder incontinence, management of medications and treatments , some difficulties with memory/recall , impaired vision, and hearing, no problems with falls/unsteadiness, communication or decision making, owns a walker.

The negotiated service agreement (NSA)/health care service plan (HCSP) dated 7/13/15 recorded resident #955 to receive assistance with medications/treatments, supervision with shower, clothing selection, toileting, nutrition/hydration and with walker when in sight, uses walker for gait instability.

The amended NSA/HCSP dated 7/23/15 recorded resident to receive assistance with personal hygiene as needed, toileting (am and as needed), to get up and dress in the morning, remind/assist as needed with shower.

Observations on 1/11/16 at 5:05pm and 1/12/16 at 11:22am and 1:30pm revealed resident #955

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sitting in his/her wheelchair.
Interview with resident #955 on 1/12/16 at 1:30pm resident stated he/she did not remember how long he/she had been using w/c, that he/she always uses wheelchair and not walker, and that he/she started using his/her wheelchair instead of the walker because he/she feels safe with wheelchair.

Interview on 1/12/16 at 2:40pm with licensed staff #A, confirms resident uses a wheelchair, that it is not listed on the NSA/HCSP and is unsure how long resident has used it, maybe a month and that he/she just did not want to use walker anymore. Certified staff # F confirms resident has used wheelchair for approximately one month.

For resident #955, the operator failed to ensure a licensed nurse provided and coordinated the provision of necessary health care services to address use of a wheelchair/ change in care needs.

- Record review for resident #115 revealed an admit date of 11/6/15 with diagnosis of type 2 diabetes, peripheral vascular disease, personality disorder, major depressive disorder, constipation, pain, difficulty walking, vitamin D deficiency, generalized muscle weakness.

The FCS dated 11/6/15 recorded the resident independent with bathing, dressing, toileting, transfer, walk/mobility, eating, requires assistance with medications and treatments, and has no cognition or communication problems. Records resident has a walker, crutch and prosthesis for the right lower extremity.

The NSA/HCSP dated 11/6/15 recorded the

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S3155	Continued From page 9 resident uses a wheelchair/walker and has a transfer pole. Medications and treatments to be given by staff, resident injects own insulin after certified medication aide sets up. Medication self- administration assessment records resident is deemed able to safely self-administer insulin. Medication administration record for January 2016 records resident to have blood glucose checks 4 times daily. Blood glucose checks for 11:00am and 4:00pm are circled (as not given). Interview with resident #115 on 1/12/16 at 3:48pm resident states he/she has not taken insulin since arriving at this facility, he/she takes red apple cider vinegar instead and he/she does own blood glucose checks. At 4:27pm resident reports he/she only does blood glucose checks twice a day and learned how to do them by watching staff at previous facility. Interview on 1/12/16 at 4:27pm with certified staff #E confirms resident # 115 does own blood glucose checks and staff records them. Interview on 1/12/16 at 4:50pm with licensed staff #A confirms resident does own blood glucose checks, that he/she does not take insulin,he/she takes vinegar, and he/she was unaware resident was only doing blood glucose checks twice daily. For resident #115, the operator failed to ensure a licensed nurse provided and coordinated the provision of necessary health care services to address the self- administration of blood glucose checks and self-treatment of his/her diabetes.	S3155		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage	S3299		

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S3299	Continued From page 10 (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility reported a census of 25 residents. The sample included 4 residents. Based on observation and interview for all residents living in the facility and receiving meal services, facility staff failed to store food under safe and sanitary conditions. - Findings included: At 2:38 pm. on 1/11/16, during tour of the facility with the operator/licensed nurse observed black mold like substance on seal of ice machine. At 2:40 pm. on 1/11/16, observed the following items in the refrigerator: Two ½ full squeeze bottles of sauce/liquids unlabeled as to contents or date, liquid/sauce dribbled on outside of each container. Three small glasses of red liquid covered with plastic film, unlabeled as to contents or date. Two gallon jugs of liquid one yellow ¼ full, one red ½ full, unlabeled as to contents or date. Several open containers of sauces: 3 mustard, pickle relish, Caesar dressing, horseradish, 2	S3299		

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chocolate syrup, ranch dressing and raspberry vinaigrette dressing, all ¼ to ½ empty. None labeled with open date.

Empty food storage drawers with many spots of food like substance present.

At 2:45 pm. on 1/11/16, observed the following items on the countertops:

Tabletop fryer with dark oil inside, black greasy substance on dial, basket handle, outside of unit and counter surrounding and behind fryer.

Stand mixer and blender with greasy food substance on outside and behind units on counter and wall.

Cabinet doors and drawers with greasy food substance on insides and outsides, food particles inside drawers.

At 2:52pm on 1/11/16, observed in upper cabinet, 12 large open containers of miscellaneous spices, undated. Container labels state: Rosemary best by date: 5/9/15, bay leaf (delivery label) date of 3/11/11.

At 3:00pm on 1/11/16 observed on counter a compact disc player covered with greasy substance and food like particles.

Observed particles on counter behind appliances, compact disc player, and box each of food service film and aluminum foil, open with top of boxes missing.

Observed/felt handles on stainless steel refrigerators and freezers to all be sticky with a food like substance.

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S3299	Continued From page 12 Interview with operator/licensed nurse 1/11/16 at 3:00pm confirmed the above observations. Interview with dietary staff #C 1/11/16 at 2:45pm stated, " I did not know they need dates when opened. " Review of facility policy, (Kitchen Monthly Deep Cleaning Duties) records a list of kitchen areas to be cleaned. Interview with operator/licensed nurse on 1/11/16 at 5:38pm he/she confirms lack of checklist/schedule or oversight for kitchen cleaning duties. Kansas Department of Agriculture publication " Focus on Food Safety " reads as follows: Food must be date marked if it is prepared on-site, or commercially processed, after the original container is opened and held under refrigeration. For all residents living in the facility and receiving meal services, operator failed to ensure facility staff stored food under safe and sanitary conditions	S3299		