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 _____	07/01/2025

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 represents the findings of a resurvey with attached complaints 196157, 194875, 193863, 193337, 190770, 187870, and 187152 at the above named assisted living facility conducted on 06/30/25 and 07/01/25.	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 31 residents with three included in the sample, one focused record review, and two closed record reviews. Based on observation, interview, and record review the operator failed to ensure designated facility staff documented the residents' functional capacity accurately on the functional capacity screening form for Resident (R) 1, R3 and R4. Findings included: - Record review for R1 revealed an admission date of 07/01/19 with diagnoses of brain atrophy, multiple meningioma, and cognitive impairment. The 06/26/25 Functional Capacity Screen (FCS) identified R1 was independent with bathing, toileting, transferring, walking, and eating;	S3082		

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

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S3082	Continued From page 1	S3082		

required physical assistance with management of medications and treatments; had no cognitive deficit; and had no communication difficulties. R1 had impaired hearing. The FCS failed to address impaired vision.

The 06/27/25 Negotiated Service Agreement (NSA) identified facility staff would order and dispense medications. The NSA failed to document services provided to R1 for impaired vision or cognition difficulties.

The 06/26/25 "Evaluation & Service Plan" is the facility's Healthcare Service Plan (HSP) which documented R1 requires prompting and reminding to complete tasks like bathing, dressing, and hygiene. R1 frequently lost glasses and asked staff to find them. She required frequent clarification of day and night.

The 01/30/25 local provider's "Progress Notes" documented R1 was blind in the left eye for "some time now" and on review of systems stated, "positive for vision loss in left eye." Within the assessment and plan section the note documented R1 had cognitive impairment as an effect from irradiation of brain. The note stated her neurological status was alert with very poor short-term memory as she repeated multiple questions during the visit.

Observation on 07/01/25 at 11:37 AM revealed R1 sat outside in courtyard attempting to light a cigarette. She held cigarette and lighter to right side of face to light. Her left eyelid was closed. She was wearing glasses which were unclean.

On 07/01/25 at 11:58 AM Certified Medication

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S3082	Continued From page 2 Aide C stated R1 cannot remember when her medications are due but sometimes remembers she had received them after they were taken. On 07/01/25 at approximately 11:42 AM R1 stated she had difficulty with seeing even with glasses. She did not remember what she ate this morning or yesterday. She repeated multiple times the same comment about a food she liked. She stated, "I have short-term memory loss." On 07/01/25 at approximately 01:28 PM Administrative Nurse B confirmed R1's FCS failed to accurately document her cognition level and vision impairment. - Record review for R3 revealed an admission date of 11/30/23 with a diagnosis of deaf. The 11/28/24 FCS identified R3 was independent with bathing, dressing, toileting, transfers, walking/mobility, and eating; was continent of urine; was usually understood by others and was able to understand when communicating; had impaired hearing; and no cognitive difficulties. The 11/28/24 NSA identified R3 could read lips and write communication. The NSA failed to list services the facility provided and the provider of the service for impaired hearing. On 07/01/25 at 11:12 AM R3 was sitting in recliner using a video translation device for communication. During the interview, a notebook was used to ask and answer questions. R3 wrote sometimes he is not able to understand others without writing.	S3082		

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S3082	Continued From page 3 The 11/28/24 HSP documented R1 has difficulty understanding others. The FCS failed to accurately document R3's difficulty understanding others. - Record review for R4 revealed an admission date of 08/01/24 with diagnoses of mild dementia and traumatic subdural hemorrhage. The 08/01/24 FCS identified R4 required physical assistance with bathing, dressing, toileting, transferring, and management of medications and treatments; was independent with eating, and required supervision with walking; was continent of bladder; was at risk for falls; and had no cognition or communication difficulties. The FCS failed to identify R4's accurate cognition level and impaired decision-making. The 08/01/24 NSA identified staff would assist R4 with bathing, dressing, toileting, transfers, management of medications, and management of treatments. The NSA documented R4 was provided with prompting and reminders for hygiene and was encouraged to attend activities. The NSA failed to document services provided to R4 to prevent from falling. The 06/26/25 HSP documented R4 requires prompting and reminding to begin or stay on task for hygiene. He needed assistance with choosing clothes. The HSP documented staff would check on resident at night for safety. The 02/19/25 "General Note" documented R4 had a sling improperly placed on his arm with no	S3082		

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S3082	Continued From page 4 order, complaint of pain, or reason to wear except his friend gave it to him and he put it on. The 03/01/25 "General Note" documented R4 chose to yell in a common area because the person he was talking to decided to play cards. The 03/13/25 "General Note" documented R4 had "been refusing his medication" related to paranoia. The local providers note dated 06/12/25 documented R4 did not allow staff to provide cares and intermittently refused medications. He was difficult to redirect and did not have the mental capacity to make safe medical or financial decisions. On 07/01/25 at approximately 12:02 PM Certified Medication Aide C stated R4 made inappropriate decisions all the time. Staff had to educate and explain his medications to prevent him from refusing to take them. On 07/01/25 at approximately 01:29 PM Administrative Nurse B confirmed R4's FCS failed to identify his cognitive difficulty of decision making. On 07/01/25 at 01:21 PM a policy regarding Functional Capacity Screens was requested which Administrative Staff A confirmed the facility did not have. The operator failed to ensure designated facility staff documented the residents' functional capacity accurately on the functional capacity screening form for Resident (R) 1, R3, and R4.	S3082		

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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 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)(1)(2) The facility reported a census of 31 residents with three residents included in the sample, one focused record review, and two closed record reviews. Based on interview, observation, and record review the operator failed to ensure the Negotiated Service Agreement (NSA) was fully developed based on the resident's Functional Capacity Screen (FCS), service needs, and preferences for resident (R)1, R2, R3, R4 and R6 including a description of the services the resident received and the provider of each service.	S3085		

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S3085	Continued From page 6	S3085		

Findings included:

- Record review for R1 revealed an admission date of 07/01/19 with diagnoses of brain atrophy, multiple meningioma, and cognitive impairment.

The 06/26/25 Functional Capacity Screen (FCS) identified R1 was independent with bathing, toileting, transferring, walking, and eating; required physical assistance with management of medications and treatments; had no cognitive deficit; and had no communication difficulties. R1 had impaired hearing. The FCS failed to address impaired vision.

The 06/27/25 Negotiated Service Agreement (NSA) identified facility staff would order and dispense medications. The NSA failed to document services provided to R1 for impaired hearing, impaired vision, or cognition difficulties.

The 06/26/25 "Evaluation & Service Plan" is the facility's Healthcare Service Plan (HSP) which documented R1 requires prompting and reminding to complete tasks like bathing, dressing, and hygiene. R1 frequently lost glasses and needed staff to find them. She required frequent clarification of day and night.

The 01/30/25 local provider's "Progress Notes" documented R1 was blind in the left eye for "some time now" and on review of systems stated, "positive for vision loss in left eye." Within the assessment and plan section the note documented R1 had cognitive impairment as an effect from irradiation of brain. The note stated her neurological status was alert with very poor

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S3085	Continued From page 7	S3085		

short-term memory as she repeated multiple questions during the visit.

Observation on 07/01/25 at 11:37 AM revealed R1 sat outside in courtyard attempting to light a cigarette. She held cigarette and lighter to right side of face to light. Her left eyelid was closed. She was wearing unclean glasses.

On 07/01/25 at 11:58 AM Certified Medication Aide (CMA) C stated R1 cannot remember when her medications are due but sometimes remembers she had received them after staff administered them to her. CMA C stated staff speaks loudly or repeats what was said for R1 to hear.

On 07/01/25 at approximately 11:42 AM R1 stated she had difficulty with seeing even with glasses. She did not remember what she ate this morning or yesterday. She repeated multiple times the same comment about a food she liked. She stated, "I have short-term memory loss."

On 07/01/25 at approximately 01:26 PM Administrative Nurse B confirmed R1's NSA failed to describe the services provided for impaired hearing, impaired vision, or cognition difficulties.

- Record review for R2 revealed an admission date of 04/01/24 with a diagnosis of cognitive communication deficit, aphasia, cerebrovascular accident, and hemiparesis.

The 04/01/25 FCS identified R2 required assistance with bathing and dressing; was independent with toileting, transferring, mobility,

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and eating; was unable to perform management of medications and treatments; had short-term memory, memory/recall, and decision-making difficulties; and was identified as having impaired vision and decision-making.

The 04/01/25 NSA identified R2 received setup assistance with bathing and physical assist with dressing. Facility staff provided management of medications. The NSA failed to describe services provided for impaired vision, cognition difficulties, and impaired decision-making.

The 04/01/25 HSP documented R2 required repetitive reminders to wake up and reminders to attend meals and activities. R2 was to be supervised by staff when leaving the facility.

Review of local providers note dated 01/08/24 revealed R2's vision was affected by a stroke years ago. She had missed part of a word while reading.

Review of nurse note dated 06/15/25 at 12:22 PM revealed R2 sustained an unwitnessed fall and could not tell staff how it happened.

On 07/01/25 at 11:58 AM CMA C stated R2 requires multiple reminders of time of day and next task to complete. CMA C confirmed R2 has vision issues.

On 07/01/25 at approximately 01:26 PM Administrative Nurse B confirmed R2's NSA failed to describe the services provided for impaired vision, cognition difficulties, and impaired decision-making.

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S3085	Continued From page 9 - Record review for R3 revealed an admission date of 11/30/23 with a diagnosis of deaf. The 11/28/24 FCS identified R3 was independent with bathing, dressing, toileting, transfers, walking/mobility, and eating; was continent of urine; was usually understood when communicating; had impaired hearing; and no cognitive difficulties. The 11/28/24 NSA identified R3 could read lips and write communication. The NSA failed to list services the facility provided and the provider of the service for impaired hearing. On 07/01/25 at 11:12 AM R3 was sitting in recliner using a video translation device for communication. During the interview, a notebook was used to ask and answer questions. R3 wrote sometimes he is not able to use the video for communication due to internet issues. He had provided the notebook for communication with staff. - Record review for R4 revealed an admission date of 08/01/24 with diagnoses of mild dementia, traumatic subdural hemorrhage, and repeated falls. The 08/01/24 FCS identified R4 required physical assistance with bathing, dressing, toileting, transferring, and management of medications and treatments; was independent with eating, and required supervision with walking; was continent of bladder; was at risk for falls; and had no cognition or communication difficulties.	S3085		

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S3085	Continued From page 10	S3085		

The 08/01/24 NSA identified staff would assist R4 with bathing, dressing, toileting, transfers, management of medications, and management of treatments. The NSA documented R4 was provided with prompting and reminders for hygiene and was encouraged to attend activities. The NSA failed to document services provided to R4 to prevent from falling.

The 08/01/24 HSP instructed facility staff to provide safety checks at night and R4 would call for assistance to transfer.

Review of "General Note" dated 03/06/25 at 03:29 PM revealed R4 was found on the floor by his bed. He was unable to explain how he got there.

Review of "General Note" dated 04/17/25 at 02:32 PM revealed R4 reported to staff he had fallen by sliding off edge of bed, got self up, and propelled self to nurse desk.

On 07/01/25 at approximately 12:02 PM CMA C stated R4 was supervised by staff with transfers and helped as needed. R4 was encouraged by staff to use his call light for assistance including transfers.

On 07/01/25 at approximately 01:29 PM Administrative Nurse B confirmed R4's NSA failed to identify services provided to prevent falls.

- Record review for R6 revealed an admission date of 12/21/23 with diagnosis of Alzheimer's disease.

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S3085	Continued From page 11 The 01/31/25 FCS identified R6 required physical assistance with bathing and management of medications and treatments; was independent with dressing, toileting, transferring, mobility, and eating; was occasionally incontinent of bladder; had no communication difficulties; had short-term memory and memory/recall difficulties and inappropriate behavior. The 01/31/25 NSA identified staff would assist R6 with bathing, management of medications, and management of treatments. The NSA failed to document services provided for cognition difficulties or inappropriate behavior. The 01/31/25 HSP instructed staff to provide interventions and activities to redirect and overcome challenging behaviors. The HSP failed to explain how staff assisted R6 with short term memory and memory/recall difficulties. On 07/01/25 at approximately 12:03 PM CMA C stated R6 was impulsive and had to be redirected away from activities if she did not win or the dining room when she threw a fit with her food. She had difficulty with short term memory and had to be reminded of recent events. On 06/30/25 at 02:00 PM Administrative Nurse B stated R1 had mood swings and would change her opinion or desires from minute to minute. She confirmed the NSA did not include services or provider of service for cognition difficulties or inappropriate behavior. The operator failed to ensure the NSA was fully developed based on the resident's FCS, service	S3085		

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S3085	Continued From page 12 needs, and preferences for R1, R2, R3, R4 and R6 including a description of the services the residents received and the provider of each service.	S3085		
S3211 SS=E	26-41-205 (g) (3) OVER THE COUNTER DRUGS (3) A licensed nurse or medication aide may accept over-the-counter medication only in its original, unbroken manufacturer ' s package. A licensed pharmacist or licensed nurse shall place the full name of the resident on the package. If the original manufacturer ' s package of an over-the-counter medication contains a medication in a container, bottle, or tube that can be removed from the original package, the licensed pharmacist or a licensed nurse shall place the full name of the resident on both the original manufacturer ' s medication package and the medication container. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(g)(3) The facility reported a census of 31 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of six over-the-counter (OTC) medications in the medication carts. Findings included: - Observation on 06/30/25 at 12:18 PM of the	S3211		

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S3211	Continued From page 13 medication room revealed the following medications without residents' full names: One box Refresh tears with two bottles each 0.5 fluid ounces Two bottles melatonin 5mg gummies, 120 count In the treatment cart were in two bottles chlorhexidine solution, four fluid ounces each. On 06/30/25 at approximately 12:22 PM Administrative Nurse B confirmed the medications failed to be labeled with resident's full names. - Observation on 06/30/25 at 12:42 PM revealed the hall one and two medication cart contained one bottle acetaminophen 500 milligrams, 200 caplets, was not labeled with resident's full name. On 06/30/25 at approximately 12:45 PM Administrative Nurse B confirmed the OTC medication was not labeled with a resident's full name. The facility's "Medication Services - Kansas" policy last revised 04/30/2024 stated a licensed nurse or pharmacist will place the resident's "FULL NAME" on the medication package. The operator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of six OTC medications.	S3211		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication	S3215		

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S3215	Continued From page 14 aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h)	S3215		

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 _____	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3215	Continued From page 15	S3215		

The facility reported a census of 31 residents. Based on observation and interview the operator failed to ensure medications were stored in accordance with each manufacturer or pharmacy recommendation or those of federal and state laws and regulations.

Findings included:

- Observation on 06/30/25 at 12:18 PM of the treatment cart in the medication room revealed two bottles chlorhexidine solution, four fluid ounces each, were expired with dates per manufacturer's label of 03/2025 and 04/2024.

On 06/30/25 at approximately 11:22 PM Administrative Nurse B confirmed the medications were expired.

- Observation on 06/30/25 at 12:42 PM of the halls one and two cart revealed a zippered bag with the following medications inside:

One three milliliter (ml) insulin glargine 100 units per one ml pen and manufacturer's instructions to use within 28 days with attached label that read opened 05/15/25, expired 06/15/25.
One three ml insulin lispro 100 units per one ml pen with attached label that read opened 05/12/25, expired 06/12/25.

On 12/18/24 at approximately 12:45 PM Administrative Nurse B confirmed the medications were expired.

The facility's "Medication Services - Kansas" policy last revised 04/30/2024 stated all expired non-controlled medication would be destroyed in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S3215	Continued From page 16 a timely manner. The operator failed to ensure medications were stored in accordance with each manufacturer or pharmacy recommendation or those of federal and state laws and regulations.	S3215		