STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046069	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT STANLEY LLC	14430 METCALF AVE OVERLAND PARK, KS 66223

(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 represents the findings of a resurvey with attached complaint #176509 at the above named assisted living facility conducted on 05/24/23.	S 000		
S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(b) The facility reported a census of 35 residents with three residents included in the sample. Based on interview and record review the operator failed to ensure Resident (R) 524 and R525's "Negotiated Service Agreements" (NSA) identified who was responsible for the administration and management of select medications. Findings included:	S3186		

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
	N046069	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT STANLEY LLC	14430 METCALF AVE OVERLAND PARK, KS 66223

(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
S3186	Continued From page 1 - Record review for R524 revealed an admission date of 08/01/22 with a diagnosis of depression. The 08/01/22 "Functional Capacity Screen" (FCS) identified R524 required physical assistance with management of medications. The 08/01/22 "NSA" identified facility staff provided R524 administration of medications and he self-administered medications. R524's "NSA" failed to identify who was responsible for the administration of select medications he administered himself and the select medications facility staff administered. On 05/24/23 at 12:14 PM Administrative Nurse B stated R524 self-administrated two medications and facility staff administered all other medications. She confirmed his "NSA" lacked evidence of documentation of select medications. - Record review for R525 revealed an admission date of 07/31/18 with the following diagnoses: type two diabetes and generalized weakness. The 07/25/22 "FCS" identified R525 required supervision with management of medications. The 07/25/22 "NSA" identified facility staff provided R524 administration of medications and she self-administered medications. R525's "NSA" failed to identify who was responsible for the administration of select medications she administered herself and the select medications facility staff administered.	S3186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046069	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT STANLEY LLC	14430 METCALF AVE OVERLAND PARK, KS 66223

(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
S3186	Continued From page 2 On 05/24/23 at 02:07 PM Administrative Nurse B stated R525 self-administrated some medications and facility staff administered all other medications. She confirmed her "NSA" lacked evidence of documentation of select medications. The operator failed to ensure R524 and R525's "NSAs" identified who was responsible for the administration and management of select medications.	S3186		
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 This REQUIREMENT is not met as evidenced by: KAR 26-41-105(f)(11) The facility reported a census of 35 residents with three residents included in the sample. Based on observation, interview, and record review the operator failed to ensure licensed staff documented all symptoms and indications of illness when Resident (R) 525 developed an open sore. Findings included: - Record review for R525 revealed an admission	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046069	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT STANLEY LLC	14430 METCALF AVE OVERLAND PARK, KS 66223

(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 3	S3261		

date of 07/31/12 with the following diagnoses: type two diabetes and generalized weakness.

The 07/25/22 "Functional Capacity Screen" (FCS) identified R525 required physical assistance with dressing; was occasionally incontinent of bladder; and was marked for falls.

The 07/25/22 "Negotiated Service Agreement" (NSA) identified facility staff would provide R525 assistance with shoes and socks for dressing; assistance as needed when requested by R525 for incontinence; and monitoring for safety when in view for falls.

R525's record lacked evidence of documentation of an open sore including wound size (length, width, and depth), odor, tissue characteristics (including drainage) and any signs of infection, action taken and results of the action.

Observation 05/24/23 at 03:02 PM revealed R525 had a wound dressing on her abdomen.

On 05/24/23 at 01:28 PM Licensed Nurse B stated R525 had developed an open sore on her abdomen and confirmed her record lacked evidence of documentation regarding the sore.

The facility's "Skin and Wound Care Management: Assisted Living and Memory Care" policy reviewed on 10/10/22 documented "The Wellness Director or nurse designee will observe all open wounds at least weekly and document the wound healing progress in the resident's record."

The operator failed to ensure licensed staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046069	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT STANLEY LLC	14430 METCALF AVE OVERLAND PARK, KS 66223

(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 4 documented all symptoms and indications of illness when R525 developed an open sore.	S3261		