STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N052008	A. BUILDING: _____ B. WING _____	03/18/2024

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VINTAGE PARK AT TONGANOXIE LLC	120 W 8TH ST TONGANOXIE, KS 66086

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with complaints 180419, 180564, 181072, 182376, 182520, 185903 and 186477 at the above named Assisted Living conducted on 03/13/24, 03/14/24 and 03/18/24.	S 000		
S3026 SS=E	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: 3026 KAR 26-41-101(f)(1)(B)(C) The facility reported a census of 34 residents, with three residents included in the sample and four closed record reviews. Based on interview and record review, the operator failed to protect resident (R)106 from neglect when facility staff deposited R106's morning medications in a sharps container instead of administering these medications to R106. The operator failed to protect another resident, R102, from exploitation when facility staff diverted narcotics from R102's supply of medications.	S3026		

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

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S3026	Continued From page 1 Findings included: - R106's medical record revealed she moved into the facility on 08/05/14. The 07/05/23 "Functional Capacity Screen" (FCS) identified R106 was unable to manage her own medications. The 07/05/23 "Negotiated Service Agreement" (NSA) identified facility staff managed and administered R106's medications. On 03/18/24 at 04:32 PM Administrative Staff A confirmed R106 failed to receive her morning medications on 06/15/23 when CMA C deposited the medication in a sharps container instead. The "Abuse, Neglect and Exploitation Investigation and Reporting" policy dated 05/09/23 provided the following definition, "Neglect: The failure or omission by oneself, caretaker, or another person with a duty to provide goods or services which are reasonably necessary to ensure safety and well-being..." The operator failed to protect R106 from neglect when facility staff deposited R106's medications into a sharps container instead of administering them. - R102's medical record revealed he moved into the facility on 11/21/19. The 11/24/23 FCS identified R102 was unable to manage his own medications.	S3026		

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S3026	Continued From page 2 The 11/24/23 NSA identified facility staff managed and administered R102's medications. Review of R102's medical records revealed a physician's order dated 03/27/22 for Oxycodone/APAP 10-325 milligrams (mg), one tablet by mouth, every four hours as needed for pain. The "Intake Information" form received by KDADS on 02/16/24 reported a card of Oxycodone 10-325 mg for R102 was found to be missing on 02/13/24. Administrative Staff A was in the process of interviewing Licensed Nurse (LN) D for suspected narcotics diversion but was unable to complete the interview. The "Abuse, Neglect and Exploitation Investigation and Reporting" policy dated 05/09/23 documented the following definitions, "Exploitation: Misappropriation of resident property...Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings...without the resident's consent." The operator failed to protect R102 from exploitation when facility staff misappropriated R102's narcotic medication.	S3026		
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	S3028		

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S3028	Continued From page 3 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: 3028 KAR 26-41-101(f)(3) The facility reported a census of 34 residents with three residents included in the sample and four closed record reviews. Based on interview and record review the operator failed to report an allegation of abuse, neglect, or exploitation to the department within 24 hours.	S3028		

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S3028	Continued From page 4 Findings included: - Record review for resident (R)106 revealed she was admitted to the facility on 08/05/14. The 07/05/23 "Functional Capacity Screen" (FCS) identified R106 was unable to manage her own medications. The 07/05/23 "Negotiated Service Agreement" (NSA) identified facility staff administered R106's medications. The 06/15/23 "General Note" documented, "Resident did not receive her am dose of medications today. Doctor notified no new orders at this time..." On 03/20/24 at 01:26 PM Administrative Staff A stated R106's medications were dumped into a sharps container (on 06/15/23) and was reported to the R106's doctor but this incident was not reported to the "Kansas Department for Aging and Disability Services" (KDADS). The "Abuse, Neglect and Exploitation Investigation and Reporting" policy dated 05/09/23 documented, "The Executive Director or designee will ensure that the appropriate procedures are followed, and specified timelines are followed for reporting to appropriate state agency as required by law." The operator failed to report an allegation of abuse, neglect, or exploitation to the department within 24 hours.	S3028		

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S3028	Continued From page 5 - Record review for R102 revealed he was admitted to the facility on 11/29/19. The 11/04/23 FCS identified R102 was unable to manage his own medications. The 11/04/23 NSA identified facility staff administered R102's medications. Review of R102's medical records revealed a physician's order dated 03/27/22 for Oxycodone/APAP 10-325 milligrams (mg), one tablet by mouth, every four hours as needed for pain. On 03/21/24 at 08:37 AM Administrative Staff A stated she made the initial call to report the missing narcotics to the KDADS hotline on 02/15/24. The "Intake Information" form completed by KDADS on 02/16/24 reported a card of Oxycodone 10-325 mg for R102 was found to be missing on 02/13/24. This was not reported to the department within 24 hours of discovery. The "Abuse, Neglect and Exploitation Investigation and Reporting" policy dated 05/09/23 documented, "The Executive Director or designee will ensure that the appropriate procedures are followed, and specified timelines are followed for reporting to appropriate state agency as required by law." The operator failed to report an allegation of abuse, neglect, or exploitation to the department within 24 hours.	S3028		

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S3085 SS=D	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: 3085 KAR 26-41-202(a)(1) The facility reported a census of 34 residents with three residents included in the sample and four closed record reviews. Based on observation, interview, 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)101. Findings included:	S3085		

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S3085	Continued From page 7 - R101's medical record revealed he moved into the facility on 11/07/22. The 11/20/23 FCS identified R101 had short-term and long-term memory impairment. The 11/20/23 NSA did not address what services staff provided concerning his short-term and long-term memory impairment. The 11/20/23 "Evaluation and Service Plan" documented R101 did not demonstrate inappropriate behavior and was generally oriented to person, place and time. On 03/18/24 at 02:55 PM R101 was observed to be alert and oriented and fully capable of communicating in an understandable manner. On 03/14/24 at 12:29 PM Certified Medication Aide B stated R101 was alert and oriented. On 03/18/24 at 05:08 PM Administrative Staff A stated R101's memory was worse in the evenings and confirmed R101's NSA did not address his short-term and long-term memory loss. The operator failed to ensure R101's NSA was fully developed to include all items that triggered on the FCS, his service needs, and preferences.	S3085		
S3213 SS=E	26-41-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container shall have a label that was provided by a	S3213		

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S3213	Continued From page 8 dispensing pharmacist or affixed to the container by a dispensing pharmacist in accordance with K.A.R. 68-7-14. This REQUIREMENT is not met as evidenced by: 3213 KAR 26-41-205 (g)(2) The facility reported a census of 34 residents. Based on observation and interview the operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container. Findings included: - Observation on 03/13/24 at 01:22 PM revealed the facility's upstairs medication cart contained the following prescription medications which were not labeled with a resident's full name: Resident (R)108: One tube of Estradiol Vaginal Cream R109: One inhaler of Trelegy Ellipta 100-62.5-25 milligram (mg) inhaler One inhaler of Albuterol Sulfate One tube of A+D Diaper Rash Ointment R110: One inhaler of Wixela inhalation powder One inhaler of Combivent Respimat	S3213		

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S3213	Continued From page 9 R111: One tube of Nystatin Cream 100,000 units One bottle of Lidocaine Viscous oral topical solution One inhaler of Albuterol Sulfate R101: One bottle of CP Morphine 100mg/5 milliliter Observation of the downstairs medication cart revealed: R112: One inhaler of Wixela inhalation powder R113: One bottle of Latanoprost 0.005 percent eyedrops One bottle of Dorzolamide Hydrochloride and Timolol Maleate Ophthalmic Solution R114: One inhaler of Stiolto AER 2.5-2.5 The operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container.	S3213		
S3280 SS=F	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	S3280		

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S3280	Continued From page 10 admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; 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: 3280 KAR 26-41-104(d)(3) The facility reported a census of 34 residents. Based on record review and interview for all residents and all facility employees, the operator failed to ensure disaster and emergency preparedness by ensuring performance of quarterly review of the facility's emergency management plan with residents. Findings included: - On 03/13/24 review of the quarterly emergency management plan reviews with staff and residents revealed the lack of documentation of quarterly reviews completed with residents for the second and third quarters of 2023. On 03/13/24 at 04:45 PM Administrative Staff A confirmed that she did not have documentation of quarterly reviews of the emergency	S3280		

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S3280	Continued From page 11 management plan completed with residents for the second and third quarters of 2023. The operator failed to ensure disaster and emergency preparedness by failing to perform quarterly reviews of the emergency management plan with residents.	S3280		