STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N061009	A. BUILDING: _____ B. WING _____	11/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT OSAWATOMIE LLC	1520 PARKER AVE OSAWATOMIE, KS 66064

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey conducted at the above named assisted living facility on 11-16-15, 11-17-15 and 11-18-15.	S 000		
S 135 SS=E	26-39-103 (h) Resident Right Notification of Changes (h) Notification of changes. (1) The administrator or operator shall ensure that designated facility staff inform the resident, consult with the resident's physician, and notify the resident's legal representative or designated family member, if known, upon occurrence of any of the following: (A) An accident involving the resident that results in injury and has the potential for requiring a physician's intervention; (B) a significant change in the resident's physical, mental, or psychosocial status; (C) a need to alter treatment significantly; or (D) a decision to transfer or discharge the resident from the adult care home. (2) The administrator or operator shall ensure that a designated staff member informs the resident, the resident's legal representative, or authorized family members whenever the designated staff member learns that the resident will have a change in room or roommate assignment. This STANDARD is not met as evidenced by: KAR 26-39-103(h)(1)(A) The facility reported a census of 31 residents. The sample included 3 residents and 2 focus review residents. Based on record review and	S 135		

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

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S 135	Continued From page 1	S 135		

interview for 2 (#206, #208) of 3 sampled residents, the operator failed to ensure that designated facility staff consulted with the resident's physician and/or notified the resident's legal representative or designated family member upon occurrence of an accident involving the resident that resulted in injury or had the potential for requiring a physician's intervention.

Findings included:

- Record review for resident #206 revealed an admit date of 11-19-06 and diagnoses of Depression, Gastroesophageal Reflux Disorder, Gout, Congestive Heart Failure, Hyperlipidemia and Coronary Heart Failure.

The functional capacity screen dated 8-25-15 recorded resident required supervision with bathing, dressing, toileting, transfer; independent with walking/mobility; and unable to perform management of medications/treatments. Occasionally incontinent of bladder. No problems with cognition or communication. Current problems/risks: falls/unsteadiness, impaired hearing and impaired vision. Uses wheelchair.

The negotiated service agreement/service plan included services for stand by assistance with bathing, and all transfers; assistance with dressing and assistance as needed or requested with toileting; and facility to manage medications.

Review of Interdisciplinary Progress Notes revealed the following incidents:
5-21-15 at 7:50 am: "Resident was overheard in the dining room telling another resident that he/she fell in the shower this morning. This writer went and spoke with the resident and he/she stated 'I didn't fall, I slipped and pulled my

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S 135	Continued From page 2	S 135		

shoulder' pointing to his/her left shoulder. Resident was asked to raise arm and he/she did with some discomfort. Resident was offered pain medication and /or warm packs and refused both. Resident was encouraged to let this writer know if he/she had increased pain or decreased range of motion and he/she agreed." Signed by licensed staff B.
10-31-15 at 2:25 am: "Resident called for assistance, stated that he/she had fallen while toileting. Myself and operator/CNA entered the room to assist. Resident was sitting on bathroom floor with back against the wall. Resident stated that after toileting he/she attempted to seat self in wheelchair and failed to engage brakes. Wheelchair slipped away from resident and he/she ended up on the floor resting on his/her buttocks. Resident stated he/she had no injuries and felt no pain. Was assisted into wheelchair by myself and operator/CNA..." Signed by certified staff C.

The record lacked documentation of notification of the resident's physician and family.

Interviews on 11-17-15 at 10:51 am with licensed staff B and operator/CNA confirmed the incident occurring on 5-21-15 was not reported to the physician or the resident's family, and the incident on 10-31-15 was not reported to the resident's physician.

For resident #206, the operator failed to ensure that designated facility staff consulted with the resident's physician and/or notified the resident's legal representative or designated family member upon occurrence of two falls involving the resident that resulted in injury or had the potential for requiring a physician's intervention.

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S 135	Continued From page 3 - Record review for resident #208 revealed an admit date of 9-22-12 and diagnoses of Osteoarthritis, Hypothyroidism, Overactive Bladder, Gastroesophageal Reflux Disorder, and Urinary Incontinence. The functional capacity screen dated 9-18-15 recorded resident required physical assistance with bathing, dressing, toileting; supervision with transfers and walking/mobility; independent with eating; and unable to perform management of medications and treatments. Frequently incontinent of bladder. Cognition: problems with short term memory, long term memory, memory/recall and decision-making. Current problems/risks included falls, impaired vision, impaired hearing and impaired decision-making. The negotiated service agreement/service plan dated 9-18-15 recorded services for medication/treatment management, food service, assistance with showers twice weekly, and assistance with dressing and toileting. Review of Interdisciplinary Progress Notes revealed the following: 8-13-15 at 7:05 pm: "Staff went into resident's room for a routine check and found resident laying on his/her right side on bathroom floor. Resident stated 'I was looking through my jewelry box and slipped and fell'. Resident had both shoes off and one knee high stocking on and one off. No complaint of pain. Noticed a small skin tear near right elbow..." Signed by licensed staff D. 8-14-15 at 7:00 am: "Resident voices complaint of soreness from fall last evening. Skin tear to right elbow is well approximated and without drainage. Bandage changed. Resident has	S 135		

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S 135	Continued From page 4 minimal bruising noted to right lower side just above hip..." Signed by licensed staff D. The record lacked documentation of notification of the resident's physician. Interview on 11-17-15 at 11:12 am with licensed staff B confirmed the record lacked documentation of consultation with resident's physician regarding resident's fall. For resident #208, the operator failed to ensure that designated facility staff consulted with the resident's physician upon occurrence of a falls involving the resident that resulted in injury or had the potential for requiring a physician's intervention.	S 135		
S3171 SS=E	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(i) The facility reported a census of 31 residents. The sample included 3 residents and 2 focus review residents. Based on record review and interview for 2 (#206, #209) of 2 focus review residents, the operator failed to ensure all health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. Findings included:	S3171		

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S3171	Continued From page 5 - Record review for resident #206 revealed an admit date of 11-19-06 and diagnoses of Depression, Gastroesophageal Reflux Disorder, Gout, Congestive Heart Failure, Hyperlipidemia and Coronary Heart Failure. The functional capacity screen dated 8-25-15 recorded resident required supervision with bathing, dressing, toileting, transfer; independent with walking/mobility; and unable to perform management of medications/treatments. Occasionally incontinent of bladder. No problems with cognition or communication. Current problems/risks: falls/unsteadiness, impaired hearing and impaired vision. Uses wheelchair. The negotiated service agreement/service plan included services for stand by assistance with bathing, and all transfers; assistance with dressing and assistance as needed or requested with toileting; and facility to manage medications. Review of Interdisciplinary Progress Notes revealed the following: 10-31-15 at 2:25 am: "Resident called for assistance, stated that he/she had fallen while toileting. Myself and operator/CNA entered the room to assist. Resident was sitting on bathroom floor with back against the wall. Resident stated that after toileting he/she attempted to seat self in wheelchair and failed to engage brakes. Wheelchair slipped away from resident and he/she ended up on the floor resting on his/her buttocks. Resident stated he/she had no injuries and felt no pain. Was assisted into wheelchair by myself and operator/CNA..." Signed by certified staff C. Review of facility "CMA/CNA (Certified Medication	S3171		

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Aide/Certified Nurse Aide) Protocol for Resident Falls Policy" stated the following guidelines for falls:
"Ask resident if the hurt anywhere.
Look to see if they are bleeding anywhere.
Take their pulse and blood pressure and record it.
Ask if they are able to move the extremities and have them do this for you.
Ask if the resident is having any pain with the movement, look for facial expressions also.
Look for any areas of swelling.
Ask resident and look for any indication that resident hit their head.
Note time of fall, place of fall and what resident tells you.
Call nurse and follow instructions."

Interviews on 11-17-15 at 10:51 am with licensed staff B and operator/CNA confirmed the incident occurring on 10-31-15 was not reported to the resident's physician and operator/CNA stated the resident was not assessed by a licensed nurse before certified staff assisted resident up from the floor on 10-31-15. Confirmed staff failed to follow facility policy to "call the nurse and follow instructions" prior to assisting resident up from the floor.

For resident #206, the operator/CNA failed to ensure all health care services were provided to the resident by qualified staff in accordance with acceptable standards of practice when the resident experienced a fall and certified staff failed to notify a licensed nurse at the time of the fall prior to assisting resident up from the floor.

- Record review for Resident #209 revealed an admit date of 5-29-15 and diagnoses of Diabetes, Insomnia, Hypertension, Anemia, Chronic Kidney

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S3171	Continued From page 7 Disease, Arthropathy and Obesity. Functional Capacity Screening dated 5-29-15 recorded "unable to perform" medication/treatment management. Negotiated Service Agreement dated 5-29-15 recorded facility would manage medications. Review of the Medication Administration Record (MAR) for August, September, October and November 2015 stated Accuchecks (blood glucose monitoring) three times daily before meals for diabetes. The MARs lacked documentation of results of blood glucose monitoring on the following dates/times: At 6:00 am on 8-3, 8-8, 10-10, 10-16, 10-23, 10-24, 10-30, 10-31, 11-1, 11-2, 11-3, 11-4, 11-5, 11-6; 11:00 am on 8-13, 8-14, 9-16, 9-25, 10-16, 10-18, 10-25, 10-30, 11-1, 11-2, 11-4, 11-5, 11-7, 11-12; and 4:00 pm on 8-16, 8-29, 9-12, 9-13, 9-27, 10-17, 11-7, 11-14, and 11-15. Interview on 11-17-15 at 12:30 pm with licensed staff B confirmed the MARs lacked documentation of results of blood glucose monitoring on the above dates and times. Stated licensed nurses and certified medication aides performed blood glucose monitoring. For resident #209, the operator failed to ensure all health care services were provided to the resident by qualified staff in accordance with acceptable standards of practice when staff failed to consistently document blood glucose results.	S3171		
S3201 SS=D	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;	S3201		

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S3201	Continued From page 8 (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. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(3)(D) The facility reported a census of 31 residents. The sample included 3 residents and 2 focus review residents. Based on record review and interview for 1 (#209) of 1 focus review residents, the operator failed to ensure the licensed nurse 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 #209 revealed an admit date of 5-29-15 and diagnoses of Diabetes, Insomnia, Hypertension, Anemia, Chronic Kidney Disease, Arthropathy and Obesity. Functional Capacity Screening dated 5-29-15 recorded "unable to perform" medication/treatment management. Negotiated Service Agreement dated 5-29-15	S3201		

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S3201	Continued From page 9 recorded facility would manage medications. Review of the Medication Administration Record (MAR) for October and November 2015 stated Humulin N 100 units/milliliter, inject 10 units subcutaneously twice daily for diabetes. The MARs lacked documentation of administration of the insulin on the following dates/times: At 7:00 am on 10-27, 10-18, 10-29, 10-30, 10-31. At 7:00 am on 11-1, 11-2, 11-3, 11-4, 11-5, 11-6, 11-7, 11-8, 11-9, and 11-10. At 4:00 pm on 11-1, 11-7 and 11-8. Medication order changed on 11-10-15 to: Humulin N 100 units/ml inject 12 units subcutaneously twice daily. The MAR lacked documentation of administration of the insulin at 7:00 am on 11-11, 11-12, and 11-13. Review of facility policy regarding "Facility Administration of Resident Medications" stated "If the facility is responsible for a resident's medications...the operator shall ensure that...the following are met: ...Document the administration of each resident's medications in the resident's medication administration record immediately before or following completion of the task..." Interview on 11-17-15 at 12:30 pm with licensed staff B confirmed the MARs lacked documentation of administration of the insulin on the above dates and times. Stated only licensed nurses injected the insulin and he/she had administered the insulin on several of the above dates; and confirmed he/she did not initial the medication as given. Further confirmed he/she and other licensed staff had failed to follow the facility policy for documentation of administration of resident's medication. For resident #209, the operator failed to ensure the licensed nurses documented the administration of the resident's medication in the resident's medication administration record immediately following completion of the task.	S3201		