STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N070006	A. BUILDING: _____ B. WING _____	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT OSAGE CITY LLC	1403 LAING OSAGE CITY, KS 66523

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S 000	INITIAL COMMENTS The following represent the findings of a resurvey for the above named Assisted Living facility conducted on 10/27/25 and 10/28/25.	S 000		
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) The facility reported a census of 24 residents with three residents included in the sample. 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	S3085		

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

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S3085	Continued From page 1	S3085		

Capacity Screen" (FCS), service needs, and preferences for Resident (R)101, R102 and R103.

Findings included:

- R101's medical record revealed she moved into the facility on 01/28/25 with a diagnosis of Alzheimer's Dementia.

The 02/06/25 FCS identified R101 was independent with transfers and triggered for hearing impairment.

The 02/06/25 NSA did not identify that R101 used a bed assist device for transfers and did not include what services staff provided R101 concerning her hearing impairment.

On 10/28/25 at 10:000 AM an observation of R101's apartment revealed she had a bed assist device attached to her bed.

On 10/28/25 at 10:29 AM Administrative Nurse B stated R101's NSA did not address the use of a bed assist device and did not address what services staff provided concerning her impaired hearing.

The operator failed to ensure R101's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.

- R102's medical record revealed she moved into the facility on 08/04/25 with a diagnosis of diabetic neuropathy.

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S3085	Continued From page 2	S3085		

The 09/03/25 FCS identified R102 triggered for falls/unsteadiness and inappropriate behaviors.

The 09/03/25 NSA did not address what services staff provided R102 concerning falls and inappropriate behaviors.

On 10/28/25 at 09:46 AM R102 appeared to be alert and oriented, responded appropriately when asked questions, had a four wheeled-walker nearby and had a call pendant hanging around her neck.

On 10/28/25 at 09:42 AM "Certified Medication Aide" (CMA) C stated R102 at times raised her voice towards staff but was easily redirected.

On 10/28/25 at 10:58 AM Administrative Nurse B stated R102's NSA did not address falls/unsteadiness or inappropriate behaviors.

The operator failed to ensure R102's NSA was fully developed to include all items that triggered on the FCS, his service needs, and preferences.

- R103's medical record revealed she moved into the facility on 01/24/25 with diagnoses of diabetes mellitus and dementia.

The 02/19/25 FCS identified R103 was at risk for falls and had impaired hearing.

The 02/19/25 NSA did not address what services staff provided R103 concerning her impaired hearing or falls.

On 10/27/25 at approximately 02:15 PM R103 was observed walking in the facility hallway

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S3085	Continued From page 3 independently using her walker. On 10/28/25 at 11:22 AM Administrative Nurse B confirmed not all items that triggered on R103's FCS were addressed on her NSA. The operator failed to ensure R103's NSA was fully developed to include all items that triggered on the FCS, her service needs, and preferences.	S3085		
S3092 SS=E	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition, as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(d)(4) The facility reported a census of 24 residents. The sample included three residents. Based on interview, and record review the operator failed to ensure the "Negotiated Service Agreement"	S3092		

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S3092	Continued From page 4 (NSA) for resident (R)101, R102 and R103 were revised when requested by the resident, resident's legal representative or facility staff. Findings included: - R101's medical record revealed she moved into the facility on 01/28/25 with a diagnosis of Alzheimer's Dementia. The most current NSA was completed on 02/06/25 and documented R101 received services from a local home health agency. Review of R101's medical records failed to find an addendum completed when she discharged from home health services on 07/01/25. On 10/28/25 at 10:29 AM Administrative Nurse B confirmed an addendum was not completed for the NSA when R101 was discharged from home health services. The operator failed to ensure an addendum to R101's NSA was completed when she discharged from home health services. - R102's medical record revealed she moved into the facility on 08/04/25 with a diagnosis of diabetic neuropathy. The most current NSA was completed on 09/03/25 and documented R102 received services from a local home health agency. Review of R102's medical records failed to find an addendum completed when she discharged	S3092		

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S3092	Continued From page 5 from home health services on 09/15/25. On 10/28/25 at 10:58 AM Administrative Nurse B confirmed no addendum was completed for the NSA when R102 was discharged from home health. The operator failed to ensure an addendum to R102's NSA was completed when she discharged from home health services. - R103's medical record revealed she moved into the facility on 01/24/25 with a diagnosis of diabetes mellitus. The most current NSA was completed on 02/19/25 and documented R103 received services from a local home health agency. Review of R103's medical records failed to find an addendum completed when started to self-inject her insulin on 05/16/25 and when she discharged from home health services on 05/18/25. On 10/28/25 at 11:22 AM Administrative Nurse B stated an addendum to R103's NSA was not completed when she started to self-administer her insulin or when R103 was discharged from home health services. The operator failed to ensure an addendum to R103's NSA was completed when she discharged from home health services and when she started to self-inject her own insulin.	S3092		
S3155 SS=D	26-41-204 (a) Health Care Services	S3155		

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S3155	Continued From page 6 . (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 reported a census of 24 residents. The sample included three residents. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for one of three sampled residents evidenced by the failure to complete and document an assessment for the purpose to use bed rails, ability to use bed rails safely without risk of entrapment, and to confirm the bed rails were not a restraint for resident (R)101. Findings included: - R101's medical record revealed she moved into the facility on 01/28/25 with a diagnosis of Alzheimer's Disease. The 02/26/25 "Functional Capacity Screen" (FCS) documented R101 was independent with	S3155		

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S3155	Continued From page 7 transfers and walking/mobility. The 02/26/25 "Negotiated Service Agreement" (NSA) failed to document R101 used a U-shaped bed assist device. Review of R101's medical records failed to locate a bed rail assessment completed for the use of a U-shaped bed assist device. On 10/28/25 at 10:00 AM an observation of R101's apartment revealed a U-shaped bed assist device attached to her bed. On 10/28/25 at 10:29 AM Administrative Nurse B stated she did not complete a bed rail assessment R101's use of a U-shaped bed assist device. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for R101 regarding the use of a bed assistive device.	S3155		
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	S3211		

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S3211	Continued From page 8 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 24 residents. Based on observation, record review and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full name of the resident on the original package of over the counter (OTC) medications for seven residents. Findings included: - Observation on 10/27/25 at 12:10 PM of the medication cart revealed the following OTC medications not labelled with the full name of the resident: One bottle of Tylenol PM One bottle of Pepto Bismol Ultra One bottle of DG Health Extra Strength Pain Relief One unopened box of Tylenol 8 HR Arthritis Pain Observation on 10/27/25 at 12:14 PM of the medication room overflow cabinet revealed the following OTC medications not labelled with the full name of the resident: One bottle of Spring Valley Iron 65 milligrams On 10/28/25 at 10:25 AM Administrative Nurse B stated it was her expectation that all OTC	S3211		

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S3211	Continued From page 9 medications were labeled with the full name of the resident. The "Medication Services- Kansas" policy dated 04/30/24 documented, "Over-The-Counter Medications...A licensed nurse or pharmacist shall place the resident's full name on the package..." The operator failed to ensure all OTC medications were labeled by a pharmacist or licensed nurse with the resident's full name.	S3211		