STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N075006	A. BUILDING: _____ B. WING _____	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WAMEGO LLC	1607 4TH ST WAMEGO, KS 66547

(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 196897, 192450, and 189088 at the above named assisted living facility conducted on 11/20/25-11/25/25.	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)(2) The facility reported a census of 30 residents with three residents included in the sample and four closed record reviews. Based on interview, observation, and record review the operator	S3085		

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

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S3085	Continued From page 1	S3085		

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, R6, and R7 including a description of the services the resident received and the provider of each service.

Findings included:

- Record review for R1 revealed an admission date of 04/19/25 with diagnoses including atrial fibrillation, pulmonary hypertension, and chronic pain.

The 05/16/25 Functional Capacity Screen (FCS) identified R1 required physical assistance with dressing, transfers, mobility, and management of medications and treatments; required supervision with bathing and toileting; was independent with eating; had no cognitive difficulties; was understandable and understood others during communication, continent of bladder, and at risk of falls.

The 05/16/25 Negotiated Service Agreement (NSA) acknowledged facility staff provided setup assistance with bathing and assistance from staff for dressing, toileting, transferring, mobility, and administration of medications and treatments. The NSA failed to describe services provided for prevention of falls.

The 04/22/25 "Evaluation & Service Plan" (HSP) noted R1 had one to two falls in the past three months without services provided to prevent falls.

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S3085	Continued From page 2	S3085		

Review of nurse note dated 05/12/25 at 06:50 PM documented the resident reported he tripped on the carpet transition strip and fell.

Review of "Fall Investigation Worksheet" dated 05/07/25 revealed R1 fell due to his shoes not put on correctly and staff educated him to make sure they are on properly.

- Record review for R2 revealed an admission date of 08/08/22 with a diagnosis of Alzheimer's.

The 06/08/25 FCS identified R2 required physical assistance with bathing, dressing, toileting, and management of medications and treatments; was independent with mobility and eating; needed supervision with transfers; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; was usually understandable and understood others during communication; and had impaired decision making and was at risk for falls.

The 06/08/25 NSA failed to describe services provided to R2 for cognition or communication difficulties, impaired decision making, or prevention of falls. The NSA failed to identify who completed blood sugar checks for R2.

Review of incident note dated 05/10/25 at 09:27 PM revealed the resident sustained a fall and complained of leg pain.

On 11/25/25 at 10:58 AM R2 entered the family room and Unlicensed Staff C instructed her twice to reach back for the chair before sitting. During their conversation Unlicensed Staff C continued to repeat herself for clarity and understanding.

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S3085	Continued From page 3 On 11/25/25 at 11:30 AM Unlicensed Staff C stated R2 required repetition or sometimes demonstration for communication. On 11/25/25 at 12:17 PM Administrative Nurse B stated R2's blood sugar checks are weekly and the facility's Certified Medication Aides complete them. She confirmed this is not on the NSA. - Record review for R3 revealed an admission date of 10/05/18 with diagnoses including dementia and scoliosis. The 09/22/25 FCS identified R3 required physical assistance with bathing, dressing, toileting, transfers, walking/mobility, management of medications, and management of treatments; was incontinent of urine; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; was usually understandable and understood others during communication; and had impaired decision making and impaired hearing. The 09/22/25 NSA failed to identify what services were provided to R3 for cognition and communication difficulties, impaired hearing, or impaired decision-making. The 09/22/25 HSP instructed staff R3 was hearing impaired, did not wear hearing aids, and had difficulty understanding others without instructing staff how to help R3. The HSP instructed staff to provide R3 with frequent verbal and visual cues. On 11/25/25 at 11:48 AM Administrative Nurse B	S3085		

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S3085	Continued From page 4	S3085		

stated R3 required staff to get to her level and speak loud for communication and hearing.

- Record review for R4 revealed an admission date of 08/19/21 with diagnoses including dementia and Alzheimer's.

The 08/07/23 FCS identified R4 required physical assistance with bathing, dressing, and management of medications and treatments; was independent with toileting, transfers, walking/mobility, and eating; was continent of urine; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; was understandable and understood others during communication; and had impaired decision making.

The 08/07/23 NSA failed to identify what services were provided to R4 for cognition and impaired decision-making.

- Record review for R6 revealed an admission date of 07/29/23 with a diagnosis of cancer.

The 12/09/24 FCS identified R6 required physical assistance with bathing, dressing, toileting, transfers, and management of medications and treatments; required supervision with walking/mobility and eating; was frequently incontinent of urine; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; was sometimes understandable and sometimes understood others during communication; and was at risk of falls, wandered, had socially inappropriate behavior, and had impaired decision making.

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S3085	Continued From page 5 The 12/09/24 NSA failed to identify what services were provided to R6 for cognition and communication. - Record review for R7 revealed an admission date of 04/06/21 with a diagnosis of idiopathic peripheral neuropathy. The 11/08/24 FCS identified R4 required physical assistance with dressing and management of medications and treatments; required supervision with bathing, toileting, transfers, and walking/mobility; was continent of urine; had no cognition or communication difficulties; and was at risk of falls. The 11/08/24 NSA failed to identify what services were provided to R4 for prevention of falls. Review of incident note dated 11/10/24 at 09:24 AM revealed R7 fell while reaching for a towel and staff instructed her to use call light for transfer assistance. On 11/25/25 at 11:50 AM Administrative Nurse B confirmed the NSAs did not include services for cognition, communication, impaired hearing, impaired decision making or prevention of falls for R1, R2, R3, R4, R6, and R7. The operator failed to ensure R1, R2, R3, R4, R6, and R7's NSAs described the services they received, and the provider of the service based on their FCS, service needs, and preferences.	S3085		
S3213 SS=E	26-41-205 (g) (2) Medication Labeling (g) (2) Each prescription medication container	S3213		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S3213	Continued From page 6 shall have a label that was provided by a 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: KAR 26-41-205(g)(2) The facility reported a census of 30 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 of all medications. Findings included: - Observation on 11/20/25 at 10:25 AM of the medication cart revealed the following medications: One 300-unit insulin glargine pen without resident name On 11/20/25 at approximately 10:30 AM Administrative Nurse B confirmed the pen was not labeled with a resident name or pharmacist affixed label. The facility's last revised 04/30/24 "Medication Services - Kansas" policy read prescription medication containers must include provider's name, resident name, medication name and dose, and dispensed date.	S3213		

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S3213	Continued From page 7 The operator failed to ensure each prescription medication container had a label provided by a dispensing pharmacist affixed to the container.	S3213		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication 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	S3215		

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S3215	Continued From page 8 expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The facility reported a census of 30 residents. Based on observation and interview, the operator failed to ensure medications were stored in accordance with each pharmacy or manufacturer's recommendations or those of federal and state laws and regulations. Findings included: - Observation on 11/20/25 at 10:25 AM of the medication cart revealed the following medications: One 300-unit insulin aspart pen without date opened Three 300-unit insulin glargine pen without dates opened One 300-unit insulin lispro pen without date opened One Ozempic insulin pen without date opened One Wixela 250/50 inhaler without date opened and label read use within 30 days One tube clobetasol propionate 0.05% with expired date of 03/23/23 One box ondansetron 4mg disintegrating tablets with expired date of 05/02/25 On 11/20/25 at approximately 10:32 AM Administrative Nurse B confirmed the medications did not have opened dates or were	S3215		

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S3215	Continued From page 9 past the date of use. The facility's last revised 04/30/24 "Medication Services - Kansas" policy read medications were stored according to the instructions on the medication container. The operator failed to ensure medications were stored in accordance with each pharmacy or manufacturer's recommendations or those of federal and state laws and regulations.	S3215		
S3261 SS=E	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 30 residents with three residents included in the sample and four closed record reviews. Based on interview and record review the operator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action when Resident (R) 4 and R5 were discharged and R6 passed away.	S3261		

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S3261	Continued From page 10 Findings included: - Record review for R4 revealed an admission date of 08/19/21 with diagnoses including dementia and Alzheimer's. The 08/07/23 Functional Capacity Screen (FCS) identified R4 required physical assistance with bathing, dressing, and management of medications and treatments; was independent with toileting, transfers, walking/mobility, and eating; was continent of urine; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; was understandable and understood others during communication; and had impaired decision making. The 08/07/23 Negotiated Service Agreement (NSA) failed to identify what services were provided to R4 for cognition and impaired decision-making. Review of "Notes Report" revealed no documentation for R4 when she was discharged including where and why. - Record review for R5 revealed an admission date of 11/05/18 with diagnoses including hypothyroidism, chronic kidney disease, anxiety, and mitral valve disorder. The 06/13/23 FCS identified R5 required physical assistance with bathing, mobility, and management of medications and treatments; required supervision with transferring; was independent with dressing, toileting, and eating; and had no cognition or communication difficulties.	S3261		

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S3261	Continued From page 11 The 06/14/23 NSA identified staff assisted R5 with bathing, administration of medications and treatments, and mobility outside of room. Review of "Notes Report" revealed on 05/03/24 facility nurse reported to R5 provider symptoms of cloudy urine and confusion, a urinalysis was ordered, and an antibiotic was ordered. The next note dated 05/08/25 documented R5 was discharged with no documentation for R5 regarding her death. On 11/25/25 at 12:05 PM Administrative Nurse B stated R5 passed away on 05/07/25 and confirmed she did not document in the notes. - Record review for R6 revealed an admission date of 07/29/23 with a diagnosis of cancer. The 12/09/24 FCS identified R6 required physical assistance with bathing, dressing, toileting, transfers, and management of medications and treatments; required supervision with walking/mobility and eating; was frequently incontinent of urine; had short-term memory, long-term memory, memory/recall, and decision-making difficulties; was sometimes understandable and sometimes understood others during communication; and was at risk of falls, wandered, had socially inappropriate behavior, and had impaired decision making. The 12/09/24 NSA failed to identify what services were provided to R6 for cognition and communication. Review of "Notes Report" revealed on 12/15/24	S3261		

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S3261	Continued From page 12 R6 sustained a fall and was assisted back to his chair. On 12/19/24 R6 was discharged. The notes failed to indicate where R6 was discharged and why. On 11/25/25 at 12:55 PM Administrative Nurse B stated R6 was discharged to another facility due to confusion. She confirmed the notes did not indicate where R6 went and why. The operator failed to ensure licensed staff documented all incidents, symptoms, and other indications of illness or injury including the date and time of occurrence, action taken, and results of the action when Resident (R) 4 and R5 were discharged and R6 passed away.	S3261		
S3320 SS=F	28-39-254 CONSTRUCTION (a) The assisted living facility or residential health care facility shall be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel and the public. (b) All new construction, renovation, remodeling and changes in building use in existing buildings shall comply with building and fire codes, ordinances and regulations enforced by city, county, and state jurisdictions, including the state fire marshal. (c) New construction, modifications and equipment shall conform to the following codes and standards: (1) Title III of the Americans with disabilities act, 42 U.S.C. 12181, effective as of January 26,	S3320		

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S3320	Continued From page 13 1992; and (2) "Food Service Sanitation Manual," health, education, and welfare (HEW) publication no. FDA 78-2081, as in effect on July 1, 1981. This REQUIREMENT is not met as evidenced by: KAR 28-39-254(a) The facility reported a census of 30 residents. Based on observation and interview the operator failed to ensure the facility was maintained to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas. Findings included: - Observation on 11/20/25 at approximately 10:15 AM of the north public bathroom revealed a seven-ounce aerosol can of air freshener with labels that said "Keep out of reach of children." On 11/20/25 at approximately 10:16 AM Administrative Staff A confirmed the chemical was not stored in a locked area. - Observation on 11/20/25 at 10:54 AM of the south public bathroom revealed a maintenance cabinet that contained the following chemicals with labels that said, "Keep out of reach of children." One spray bottle of spic and span antibacterial cleaner One aerosol can of Zip disinfectant	S3320		

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	N075006	A. BUILDING: _____ B. WING _____	11/25/2025

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S3320	Continued From page 14 One container ProSpray disinfectant/cleaner wipes One aersol can of air freshener One gallon metal can of denatured alcohol On 11/20/25 at approximately 10:55 AM Administrative Staff A confirmed chemicals were not stored in a locked area. - Observation on 11/20/25 at 10:56 AM of the south hall revealed an unlocked housekeeping cart that contained the following chemicals with labels that read "Keep out of reach of children." One container of Stix shower tile cleaner One spray bottle of stain and odor remover One spray bottle of bleach One aerosol can of air freshener On 11/20/25 at 10:56 AM Administrative Staff A confirmed cart was not locked. The operator failed to ensure the building was maintained to protect the health and safety of the residents and visitors by ensuring all chemicals were stored within locked areas.	S3320		