STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087039	A. BUILDING: _____ B. WING _____	R 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

(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 citations represent the findings of the revisit for correction order 18-192 conducted on 1/8/19 and 1/9/19.	{S 000}		
S3082 SS=D	26-41-201 (d) Functional Capacity Screen Accurate d) Designated facility staff shall ensure that each resident ' s functional capacity at the time of screening is accurately reflected on that resident ' s screening form. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(d) The facility reported a census of 31 residents. The sample included 3 residents and 1 resident for focused review related to falls. Based on interview and record review the operator failed to ensure designated staff accurately reflected resident #489's functional capacity at the time of screening regarding his/her fall risk. Findings included: - Record review for resident #489 revealed an admission date of 7/24/18 with following diagnoses: injury left hip, unsteadiness on feet, lack of coordination, weakness, cognitive communication deficit, paroxysmal atrial fibrillation, hypothyroidism and urge incontinence. The admission nursing note dated 7/24/18 at 11:30 AM indicated the resident admitted from a skilled rehab facility due to a fall at home and required assistance with activities of daily living.	S3082		

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
	N087039	A. BUILDING: _____ B. WING _____	R 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

(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
S3082	Continued From page 1 The annual functional capacity screen (FCS) dated 12/5/18 indicated the resident had deficit with memory recall, needed physical assistance with dressing and bathing. He/she wore glasses, a hearing aid in the left ear and used a walker. The FCS failed to include the resident's fall risk as identified at the time of admission. Nursing notes dated 12/8/18 (no time listed) indicated staff notified the nurse on-call of finding the resident on the floor in his/her apartment in front of his/her closet with multiple skin tears and complaint of hip pain. Staff sent the resident to the hospital by emergency medical services. Licensed nurse B made an entry on 12/10/18 (no time) which indicated the resident was admitted to the hospital and the hip X-rays were negative with plans for the hospital to obtain CT of the pelvis/spine. An entry by licensed nurse B on 12/12/18 (no time) indicated the resident discharged from the hospital and returned to facility. The FCS dated 12/12/18 indicated the resident had memory recall deficit, needed physical assistance with dressing and toileting, wore glasses and a hearing aid. He/she used a wheelchair and a walker. The FCS failed to identify the resident's fall on 12/8/18. Interview on 1/8/19 at 1:20 PM with licensed nurse B confirmed the 12/5/18 and 12/12/18 FCS did not accurately reflect the resident's fall risk. The operator failed to ensure designated staff accurately reflected resident #489's functional capacity at the time of screening regarding his/her fall risk.	S3082		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087039	A. BUILDING: _____ B. WING _____	R 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

(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
{S3085}	Continued From page 2	{S3085}		
{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 31 residents. The sample included 3 residents and 1 resident for focused review related to falls. Based on observation, interview and record review the operator failed to ensure designated staff developed a written negotiated service agreement based upon the functional capacity screen and service needs for 2 of 4 residents (#307 and #489). Findings included: - Record review for resident #307 revealed an	{S3085}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087039	A. BUILDING: _____ B. WING _____	R 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

(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
{S3085}	Continued From page 3	{S3085}		

admission date of 6/20/15 with the following diagnoses: congestive heart failure, atrial fibrillation, confusion, memory loss and osteoarthritis.

The significant change functional capacity screen (FCS) dated 7/10/18 indicated the resident had deficits with short-term memory, memory recall and impaired decision making. He/she required physical assistance with dressing, toileting, transfers and was unable to perform walking/mobility tasks. He/she was a risk for falls or unsteadiness with the use of a wheelchair. The FCS failed to include the use of bed rail/bed assistive device.

The side rail/cane evaluation dated 7/19/18 directed staff the resident's negotiated service agreement and plan of care must indicate the presence and purpose of the side rail/cane. The evaluation indicated the resident needed the side rail/cane for transfers and positioning assistance.

The negotiated service agreement (NSA) dated 7/10/18 indicated the resident required 1 person assist with all personal cares, all aspects of A.M. and P.M. preparation, assistance with all aspects of dressing, 1-2 staff assistance for transfers and wheelchair for mobility. The NSA lacked information related to the resident's memory deficit and impaired decision making, use of a side rail/cane bed assistive device or the residents fall risk/unsteadiness.

Observation on 1/8/19 at 11:00 AM revealed the resident sat in a wheelchair and actively participated in the morning exercise and activities. At 11:23 AM the resident remained in the wheelchair at the dining room table. At 12:55 PM the resident remained in the wheelchair at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087039	A. BUILDING: _____ B. WING _____	R 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

(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
{S3085}	Continued From page 4	{S3085}		

dining room table and observation of his/her room revealed quarter side rails attached to both sides of the resident's bed.

Interview on 1/8/19 at 11:23 AM with certified medication aide A revealed the resident needed assistance with all cares and he/she became wobbly when standing. He/she reported the resident was a fall risk because of the unsteadiness but did not know of any safety interventions to prevent falls. He/she reported the resident would use the side rail/canes when turning in bed.

Interview on 1/8/19 at 1:20 PM with licensed nurse B confirmed the resident used the side rails for bed mobility and the resident was at risk for falls. He/she confirmed the NSA lacked information related to the resident's memory deficit and impaired decision making, his/her identified fall risk or use of the side rail/cane.

Interview on 1/8/19 at 4:00 PM with operator C confirmed the NSA lacked information about the resident's fall risk and used of side rails.

The operator failed to ensure designated staff developed a written negotiated service agreement based upon the functional capacity screen and service needs for this resident.

- Record review for resident #489 revealed an admission dated of 7/24/18 with following diagnoses: injury left hip, unsteadiness on feet, lack of coordination, weakness, cognitive communication deficit, paroxysmal atrial fibrillation, hypothyroidism and urge incontinence.

The admission nursing note date 7/24/18 at 11:30 AM indicated the resident admitted from a skilled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087039	A. BUILDING: _____ B. WING _____	R 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

(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
{S3085}	Continued From page 5	{S3085}		

rehab facility due to a fall at home and required assistance with activities of daily living.

The annual functional capacity screen (FCS) dated 12/5/18 indicated the resident had deficit with memory recall, needed physical assistance with dressing and bathing. He/she wore glasses, a hearing aid in the left ear and used a walker. The FCS failed to include the resident's fall risk as identified at the time of admission.

The negotiated service agreement (NSA) dated 12/5/18 lacked information about the resident's memory recall deficit, lacked specifics for the resident's need for physical assistance with dressing. The NSA indicated the resident ambulated and transferred independently with a walker but failed to identify the resident's fall risk or need for safety interventions.

Nursing notes dated 12/8/18 (no time listed) indicated staff notified the nurse on-call of finding the resident on the floor in his/her apartment in front of his/her closet with multiple skin tears and complaint of hip pain. Staff sent the resident to the hospital by emergency medical services. Licensed nurse B made an entry on 12/10/18 (no time) which indicated the resident was admitted to the hospital and the hip X-rays were negative with plans for the hospital to obtain CT of the pelvis/spine. An entry by licensed nurse B on 12/12/18 (no time) indicated the resident discharged from the hospital and returned to facility.

The FCS dated 12/12/18 indicated the resident had memory recall deficit, needed physical assistance with dressing and toileting, wore glasses and a hearing aid. He/she used a wheelchair and a walker. The FCS failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087039	A. BUILDING: _____ B. WING _____	R 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

(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
{S3085}	Continued From page 6 identify the resident's fall on 12/8/18. The NSA dated 12/12/18 indicated the resident needed assistance with compression hose but did not address if he/she needed assistance with dressing or the compression hose. The NSA identified the resident used a wheelchair to and from meals every day, a walker with stand by assistance, a bed cane to get in/out of bed for increased safety, staff to assist resident with toileting and resident would call for assist. The NSA failed to identify the resident's fall risk or memory recall deficit. Interview with licensed nurse B on 1/8/19 at 1:20 PM confirmed the NSA dated 12/5/18 and 12/12/18 failed to identify the resident's memory recall deficit and fall risk. The operator failed to ensure designated staff developed a written negotiated service agreement based upon the functional capacity screen and service needs for this resident.	{S3085}		
S3155 SS=E	26-41-204 (a) Health Care Services . (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.	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087039	A. BUILDING: _____ B. WING _____	R 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

(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
S3155	Continued From page 7 This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility reported a census of 31 residents. The sample included 3 residents and 1 resident for focused review related to falls. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service to meet the needs for 3 of 4 sampled residents (#307, #318, and #411) and in accordance with the functional capacity screening and the negotiated service agreement regarding falls, assistive devices and dialysis needs. Findings included: - Record review for resident #307 revealed an admission date of 6/20/15 with the following diagnoses: congestive heart failure, atrial fibrillation, confusion, memory loss and osteoarthritis. The significant change functional capacity screen (FCS) dated 7/10/18 indicated the resident had deficits with short-term memory, memory recall and impaired decision making. He/she required physical assistance with dressing, toileting, transfers and was unable to perform walking/mobility tasks. He/she was a risk for falls or unsteadiness with the use of a wheelchair. The FCS failed to include the use of bed rail/bed assistive device. The side rail/cane evaluation dated 7/19/18 directed staff the resident's negotiated service agreement and plan of care must indicate the presence and purpose of the side rail/cane. The	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087039	A. BUILDING: _____ B. WING _____	R 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

(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
S3155	Continued From page 8	S3155		

evaluation indicated the resident needed the side rail/cane for transfers and positioning assistance.

The negotiated service agreement (NSA) dated 7/10/18 indicated the resident required 1 person assist with all personal cares, all aspects of A.M. and P.M. preparation, assistance with all aspects of dressing, 1-2 staff assistance for transfers and wheelchair for mobility. The NSA lacked information related to the resident's memory deficit and impaired decision making, use of a side rail/cane bed assistive device or the residents fall risk/unsteadiness.

The health service plan (HSP) developed on 7/10/18 with subsequent review on 1/2/19 directed staff the resident used a wheelchair for mobility, needed assistance with all aspects of dressing/grooming and toileting. The section for fall prevention directed staff to see fall assessment and lacked any interventions on the HSP. The HSP failed to identify the resident used side rails.

The fall risk assessment and interventions dated 7/19/18 indicated the resident had a score of 28 with scores greater than 7 being at high risk for falls. The only intervention listed was for staff to preform hourly visual checks while in his/her apartment.

Observation on 1/8/19 at 11:00 AM revealed the resident sat in a wheelchair and actively participated in the morning exercise and activities. At 11:23 AM the resident remained in the wheelchair at the dining room table. At 12:55 PM the resident remained in the wheelchair at the dining room table and observation of his/her room revealed quarter side rails attached to both sides of the resident's bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087039	A. BUILDING: _____ B. WING _____	R 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

(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
S3155	Continued From page 9 Interview on 1/8/19 at 11:23 AM with certified medication aide A revealed the resident needed assistance with all cares and he/she became wobbly when standing. He/she reported the resident was a fall risk because of the unsteadiness but did not know of any safety interventions to prevent falls. He/she reported the resident would use the side rail/canes when turning in bed. Interview on 1/8/19 at 2:30 PM with licensed nurse B confirmed the resident used the side rails for bed mobility and the resident was at risk for falls. He/she confirmed the HSP and fall assessment lacked interventions for fall prevention when not in his/her apartment or that he/she used side rails. Interview on 1/8/19 at 4:00 PM with operator C confirmed the HSP lacked intervention to address the resident's fall risk when not in his/her apartment and the use of side rails. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service to meet the needs of this resident and in accordance with the functional capacity screening and the negotiated service agreement regarding fall risks and use of side rail (assistive device). - Record review for resident #318 revealed an admission date of 12/27/18 with the following diagnoses: chronic kidney disease, end stage renal disease, congestive heart failure, diabetes mellitus type 2 insulin dependent, hypertension, chronic obstructive pulmonary disease, coronary artery disease, neuropathy, arthritis, hepatitis C, thrombocytopenia, depression and anxiety.	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087039	A. BUILDING: _____ B. WING _____	R 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

(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
S3155	Continued From page 10 The admission functional capacity screen dated 12/27/18 indicated the resident needed supervision with dressing, bathing and would self-inject insulin. The negotiated service agreement (NSA) dated 12/27/18 indicated the resident was independent with most activities of daily living, would call for assistance as needed and needed assist putting on jeans. The NSA included the resident was a dialysis patient, listed the facility which provided the dialysis and the days of the week for the service. The health service plan dated 12/27/18 identified the resident received dialysis on Tuesdays, Thursdays and Saturdays, listed the location of the dialysis service and the company who provided transportation to dialysis. The HSP lacked identification of the location of the dialysis access site, care of the site, monitoring needs or any precautionary needs for the resident based on dialysis site/services. Interview with licensed nurse B on 1/8/19 at 2:20 PM confirmed the HSP lacked identification of the dialysis access site, care of the site, monitoring or precautions associated with the dialysis site/service. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service to meet the needs of this resident and in accordance with the functional capacity screening and the negotiated service agreement regarding dialysis access site and precautions. - Record review for resident #411 revealed an	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087039	A. BUILDING: _____ B. WING _____	R 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

(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
S3155	Continued From page 11	S3155		

admission date of 6/14/16 with the following diagnoses: hypothyroidism, chronic obstructive pulmonary disease, fatigue, weight loss and hearing loss.

The annual functional capacity screen dated 11/29/18 identified the resident with intact cognition and independent with activities of daily living.

The negotiated service agreement dated 11/29/18 indicated the resident ambulated independently without devices.

The health service plan dated 11/29/18 and without revision indicated the resident ambulated independent without devices, dressed and toileted independently. He/she wore glasses and hearing aids that he/she managed. The HSP did not include the resident as at risk for falls.

Review of the nursing notes revealed an entry on 12/16/18 at 6:30 PM which read resident returned from the hospital per fall earlier today around 1:00 PM. Reported by direct care staff the resident was alert and oriented to person, place and time, had several abrasions on his/her face, nose area and a hematoma on the forehead. The resident could voice his/her needs with a family member at the bedside. Licensed nurse D applied ice to the resident's knee and forehead and noted pupils were PERRLA (pupils, equal, round, reactive to light and accommodation with equal hand grips. The note lacked any information about the location of the fall, causal factors of the fall or interventions implemented to reduce the risk of further falls. The next and last note in the record was dated 12/17/18 at 8:00 PM which indicated the resident remained alert and oriented, pupils equal and reactive to light,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087039	A. BUILDING: _____ B. WING _____	R 01/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VINTAGE PARK AT WATERFRONT LLC	900 N BAYSHORE DR WICHITA, KS 67212

(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
S3155	Continued From page 12 speech clear with bruising to face, nose, forehead, swollen left eye and laceration to left hand. Licensed nurse E applied ice pads to face. Resident up ambulating independently with range of motion in normal limits all extremities. No complaints of headache but had soreness to face and nose. Will continue to monitor closely. Interview on 1/9/18 with licensed nurse B confirmed the facility failed to have an investigation into the cause of the fall, details of the fall as far as location or how staff found the resident. He/she confirmed the HSP lacked a revision to include the fall and any interventions to reduce the risk of further falls. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care service to meet the needs of this resident and in accordance with the functional capacity screening and the negotiated service agreement regarding reducing the risk of further falls.	S3155		