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 _____	05/25/2016

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 a resurvey of the above assisted living facility on 5/23/16, 5/24/16, and 5/25/16.	S 000		
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 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: KAR 26-41-101(f)(3)(A)	S3028		

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

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S3028	Continued From page 1 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 3 (#350, #351, and #352) of 3 residents sampled, the operator failed to report to the department and conduct an investigation in order to rule out abuse and/or neglect when staff found each cognitively impaired resident #350, #351, and #352 on the floor, an injury to resident #350 and #352, and when resident #352 left the facility without staff awareness. Findings included: - Record review for resident #350 revealed an admission date of 11/15/15 and diagnosis of dementia. The functional capacity screen dated 11/2/15 indicated the resident was independent with toileting, transferring, and walking with walker; required physical assistance with bathing and dressing; and experienced impaired short-term memory and decision making. The record contained the following amended negotiated service agreements: 11/20/15 added the service of visual checks two times each shift to ensure walker in reach of resident. 12/28/15 added services of physical and occupational therapy. Therapies discontinued 2/22/16. 3/28/16 added services of one-person assistance with ambulation using walker and toileting. Physical and occupational therapy added.	S3028		

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S3028	Continued From page 2 The nurse's notes contained the following entries: 11/20/15 at 1:00 p.m. a certified medication aide documented activity director found resident on floor in room between recliner and walker with "scrape marks" on left hip. Resident stated was trying to look out window. 1/17/16 5:30 p.m. licensed nurse documented resident complained of pain to left hand. Resident unable to "clasp hand grip of walker. Resident could not recall how injury occurred." 2/20/16 at 3:30 p.m. licensed nurse documented resident found on floor in front of recliner with walker beside resident. 3/14/16 at 5:00 p.m. licensed nurse documented resident found on floor beside bed. Resident stated he/she "was looking for kids." 3/24/16 at 9:30 a.m. licensed nurse documented resident found sitting in laundry basket in closet with walker overturned. Resident stated was looking for clothes. 4/2/16 at 10:00 a.m. certified medication aide documented bruise found on resident's inner left thigh. At 3:30 p.m. on 5/23/16, operator stated the above incidents were not reported to the department. Licensed nurse A stated there were no written investigations of the incidents. Operator failed to report to the department and investigate incidents involving resident #350 in order to rule abuse and/or neglect.	S3028		

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S3028	Continued From page 3 - Record review for resident #351 revealed an admission date of 2/27/09 and a diagnosis of dementia. The functional capacity screen dated 2/21/15 and 9/22/15 indicated the resident required physical assistance with bathing, dressing, toileting, transferring, and mobility with walker, and eating; experienced impaired short-term memory, decision making, and memory recall; and was at risk for falls. The negotiated service agreement/health care service plan dated 11/18/15 documented the services of assistance with ambulation of one person with gait belt and walker and use wheelchair for longer distances; assistance with transfers and ambulation to toilet; and fall interventions of monitor frequently; assist with transfers, ambulation, and toileting; and remind to use call light for assistance. The nurse's notes contained the following entries: 9/3/15 at 9:45 a.m. licensed nurse documented resident called for assistance. Found resident on floor in bathroom with abrasion to middle of back. 1/18/16 at 6:00 p.m. licensed nurse documented resident fell in room. Resident on floor with walker beside resident. Resident complained of pain left foot. X-ray negative for fracture. 1/19/16 at 5:30 p.m. licensed nurse documented resident found on floor in room with 2 centimeter cut above left eyebrow and right thumbnail torn off. At 3:30 p.m. on 5/23/16, operator stated the above incidents were not reported to the	S3028		

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S3028	Continued From page 4	S3028		

department. Licensed nurse A stated there were no written investigations of the incidents.

Operator failed to report to the department and investigate incidents involving resident #351 in order to rule abuse and/or neglect.

- Record review for resident #352 revealed an admission date of 8/14/14 and a diagnosis of dementia.

The functional capacity screen dated 1/21/16 indicated the resident required supervision with transferring and walking with walker; required physical assistance with bathing, dressing, toileting, and eating; experienced impaired short-term memory, decision making, and memory recall; and was at risk for falls.

The negotiated service agreement dated 1/21/16 documented stand-by assistance with ambulation to meals and with toileting. The record contained a health care service plan dated "August 2014" that documented resident required reminders and supervision due to impaired cognition, exhibited a pleasant mood, and had no behaviors. A health care service plan dated 8/4/15 contained the services of stand-by assistance with ambulation with walker to meals and activities; supervise and cue toileting; and fall interventions of offer and assist with toileting, stand-by assistance to and from meals, and resident to use walker when ambulating.

The nurse's notes contained the following entries:

2/21/15 at 7:45 p.m. a licensed nurse documented a visitor of another resident asked if (resident #351) should be outside walking towards the road. Licensed nurse went to find

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S3028	Continued From page 5 resident who stated he/she needed to get a coat and insisted he/she lived across the street. Resident stated he/she needed to see if the parents came to get the kids. The record contained an entry at 6:00 p.m. on 2/19/15 and at 7:45 p.m. 2/20/15 of resident with coat on and wanting to leave facility to go home. 4/27/15 at 6:00 p.m. a licensed nurse documented resident had a 0.5 inch bruise above left eye. Resident did not know cause of the bruise. 5/12/15 at 6:00 a.m. certified medication aide documented another aide found resident on floor in room. Resident unsure how he/she fell. Resident complained of pain in left hip and sent to hospital by ambulance. Admitted to hospital with fractured left hip. During an interview at 3:15 p.m. on 5/23/16, operator stated he/she did not know if the previous operator reported the incidents to the department. Licensed nurse A was unable to locate written investigations of the incidents. Operator failed to report to the department and investigate incidents involving resident #352 in order to rule abuse and/or neglect.	S3028		
S3166 SS=E	26-41-204 (e) Delegation of Duties (e) A licensed nurse may delegate nursing procedures not included in the nurse aide or medication aide curriculums to nurse aides or medication aides, respectively, under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S3166		

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S3166	Continued From page 6 This REQUIREMENT is not met as evidenced by: KAR 26-41-204(e) 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 (#352) sampled resident, 2 (#353 and #354) focus review residents, and 1 (#355) non-sampled resident all requiring blood sugar monitoring with a glucometer and for 4 of 4 certified medication aide employee files reviewed, the licensed nurse failed to delegate glucometer testing of each resident's blood sugar level to certified medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. Findings included: - Review of employee files on 5/23/16 for certified medication aide C, certified medication aide D, certified medication aide E, and certified medication aide F revealed the lack of documentation of licensed nurse delegation of blood sugar testing with a glucometer. At 3:05 p.m. on 5/23/16, licensed nurse A stated he/she had not instructed and observed certified medication aides with use of a glucometer to test resident blood sugar level. At 10:05 a.m. on 5/24/16 certified medication aide B identified 4 residents (#352, #353, #354, and #355) who required glucometer testing of blood sugar. Certified medication aide B stated certified medication aides and licensed nurses performed	S3166		

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S3166	Continued From page 7 the testing. Record reviews for residents revealed resident #352 required glucometer testing 4 times a day, resident #353 required glucometer testing 2 times a day, and resident #354 required glucometer testing 2 times a day. The licensed nurse failed to delegate glucometer testing of each resident's blood sugar level to certified medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S3166		
S3202 SS=D	26-41-205 (d) (4) Delegation of Medication Administration (4) Any licensed nurse may delegate nursing procedures not included in the medication aide curriculum to medication aides under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d)(4) 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 (#353) focus review resident requiring a certified medication aide to prepare and dial an insulin pen, the licensed nurse failed to delegate this nursing procedure to certified medication aide C under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S3202		

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S3202	Continued From page 8 Findings included: - Review of 4 certified medication aide employee files on 5/23/16 revealed the lack of documentation of licensed nurse delegation to certified medication aides to prepare and dial an insulin pen. At 3:10 p.m. on 5/23/16 licensed nurse A stated of the 4 certified medication aide employee files reviewed only certified medication aide C prepared and dialed an insulin pen. Licensed nurse A stated he/she had not instructed and observed certified medication aide C prepare and dial an insulin pen. Record review for resident #353 revealed an admission date of 4/26/11 and a diagnosis of type II diabetes mellitus. The functional capacity screen dated 1/19/16 indicated the resident required physical assistance with medication management and had impaired vision. The negotiated service agreement contained the service of facility management of medications and resident able to self-inject insulin. The record contained medical care provider's orders for resident to receive Humalog insulin 12 units 3 times a day with meals, Humalog insulin extra units 3 times a day based on resident's blood sugar level, and Lantus insulin 50 units at bedtime. At 10:05 a.m. on 5/24/16, certified medication aide B stated resident (#353) required certified medication aide or licensed nurse to prepare and dial insulin pen prior to resident self-injecting insulin. The licensed nurse failed to delegate preparation and dialing of an insulin pen to a certified	S3202		

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S3202	Continued From page 9 medication aide under the Kansas nurse practice act, K.S.A. 65-1124 and amendments thereto.	S3202		
S3248 SS=E	26-41-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following documentation: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult care home; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to have worked as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(d)(4) The facility reported a census of 31 residents.	S3248		

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S3248	Continued From page 10 The sample included 3 residents and 2 focus review residents. Based on record review and interview for 2 of 4 certified employee files reviewed, the operator failed to obtain supporting documentation from the Kansas nurse aide registry that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home prior to the person's employment by the facility. Findings included: - Review of employee files on 5/23/16 revealed certified medication aide C hired 1/30/16 with documentation of nurse aide registry verification on 3/2/16. The file of certified medication aide D hired 3/5/16 contained documentation of nurse aide registry verification on 4/12/16. At 3:15 p.m. on 5/23/16, operator stated he/she did not check the nurse aide registry prior to these two employees providing resident care. The operator failed to obtain supporting documentation from the Kansas nurse aide registry that the individual did not have a finding of having abused, neglected, or exploited a resident in an adult care home prior to the person's employment by the facility.	S3248		
S3420 SS=E	28-39-256 MECHANICAL REQUIREMENTS (c) Mechanical requirements. (1) Heating, air conditioning, and ventilating systems. (A) The system shall be designed to maintain a year-round indoor temperature range	S3420		

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S3420	Continued From page 11 of 70oF or 21oC to 85oF or 26oC. (B) Each apartment or individual living unit shall allow the resident to control the temperature. (2) Plumbing and piping systems. (A) Backflow prevention devices or vacuum breakers shall be installed on fixtures to which hoses or tubing can be attached. (B) Water distribution systems shall be arranged to provide hot water at outlets at all times. The temperature of hot water shall range between 98oF and 120oF at bathing facilities, sinks, and lavatories in resident use areas. (3) Electrical requirements. (A) All spaces occupied by persons or machinery and equipment within the buildings, approaches to buildings, and parking lots shall have adequate lighting. (B) Minimum lighting intensity levels shall be as required in Table 1. (C) Each corridor and stairway shall remain lighted at all times. (D) Each light in resident use areas shall be equipped with shades, globes, grids, or glass panels. This REQUIREMENT is not met as evidenced by: KAR 28-39-256(c)(2)(B)	S3420		

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S3420	Continued From page 12 The facility reported a census of 31 residents. The sample included 3 residents and 2 focus review residents. Based on observation, interview, and record review for the apartment of 1 (#351) of 3 residents sampled, the operator failed to ensure the water distribution system provided hot water to the sink and lavatory in this location at a temperature range of 98 degrees Fahrenheit (F) to 120 degrees F and failed to monitor hot water temperatures throughout the building. Findings included: - At 11:37 a.m. on 5/24/16 with the operator, obtained a hot water temperature reading from the bathroom sink of 126.8 degrees F and 124.8 degrees F from the kitchen sink in the apartment of resident #351. Just prior to checking hot water temperature in apartment of resident #351, obtained hot water temperature readings of 118.2 degrees F from the lavatory and 117.8 degrees F from the kitchen sink in apartment of sampled resident #350 and 114.9 degrees F from the lavatory in the apartment of sampled resident #352. Operator stated he/she would notify maintenance of the above range hot water temperature. At 11:45 a.m. on 5/24/16, operator stated hot water temperatures had not been monitored and recorded since 4/16/15. At 12:05 p.m. on 5/24/16, operator provided the facility policy for maintaining hot water temperatures in resident rooms between 98 degrees F and 120 degrees F with instruction to check hot water temperature in resident rooms at the end of each wing on a rotating basis. The	S3420		

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S3420	Continued From page 13 policy did not specify the frequency to monitor hot water temperatures. The apartment of resident #351 was not located at the end of the hall. At 12:15 p.m. on 5/24/16, maintenance person stated he/she had lowered thermostat on boiler to lower the hot water temperatures to resident use areas. Maintenance person stated he/she had checked hot water temperatures in rooms at the ends of the halls on each of the 2 floors and provided documentation of temperatures between 113.1 degrees F and 120 degrees F. Maintenance person confirmed hot water temperatures were not monitored since 4/16/15. At 12:30 p.m. on 5/24/16 with the maintenance person and the operator, obtained a hot water temperature reading of 109.7 degrees F from the kitchen sink in the apartment of resident #351. The operator failed to ensure the water distribution system provided hot water to the sink and lavatory in all resident use areas at a temperature range of 98 degrees Fahrenheit (F) to 120 degrees F and failed to monitor hot water temperatures throughout the building.	S3420		