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 _____	01/05/2023

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

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with attached complaints #170953, #170557, #165345, #161604, and #161601 at the above named assisted living conducted on 01/04/23 and 01/05/23.	S 000		
S3175 SS=D	26-41-205 (a) (1) Self Administration of Medication (a) Self-administration of medication. Any resident may self-administer and manage medications independently or by using a medication container or syringe prefilled by a licensed nurse or pharmacist or by a family member or friend providing this service gratuitously, if a licensed nurse has performed an assessment and determined that the resident can perform this function safely and accurately without staff assistance. (1) An assessment shall be completed before the resident initially begins self-administration of medication, if the resident experiences a significant change of condition, and annually. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(a)(1) The facility reported a census of 35 residents with three included in the sample. Based on interview and record review the administrator failed to ensure an assessment was completed to	S3175		

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

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S3175	Continued From page 1	S3175		

determine that R105 could self-administer medications safely and accurately before she began self-administration of insulin.

Findings included:

- Record review for R105 revealed an admission date of 11/02/20 with a diagnosis of diabetes.

The 11/02/22 "Functional Capacity Screen" (FCS) identified R105 required physical assistance with management of medications.

The 11/02/22 "Negotiated Service Agreement" (NSA) directed facility staff to administer medications as ordered by her primary care physician (PCP).

R105's record lacked documentation of an assessment to determine that she could safely and accurately self-administer insulin.

The "Resident Roster" provided by the facility on 01/04/23 revealed R105 administered her own medications and was on insulin.

On 01/05/23 at approximately 03:13 PM Administrative Nurse B confirmed R105 self administered insulin and her record lacked a self-administration of medications assessment.

On 01/05/23 at 03:59 PM R105 stated she administered her own insulin after facility staff got it ready for her.

The operator failed to ensure an assessment was completed to determine that R105 could safely and accurately self-administer insulin.

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S3186 SS=D	26-41-205 (b) Administration of Selected Medications (b) Administration of select medications. Any resident who self-administers medication may select some medications to be administered by a licensed nurse or medication aide. The negotiated service agreement shall reflect this service and identify who is responsible for the administration and management of selected medications. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(b) The facility reported a census of 35 residents with three residents included in the sample and two closed record reviews. Based on interview and record review the operator failed to ensure Resident (R) 104 and 106's "Negotiated Service Agreement" (NSA) identified who was responsible for the administration and management of select medications. Findings included: - Record review for R104 revealed an admission date of 02/01/22 with the following diagnoses: bipolar, depression, and chronic kidney disease. The 02/01/22 "Functional Capacity Screen" identified R104 required physical assistance with management of medications.	S3186		

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S3186	Continued From page 3 The 02/01/22 "NSA" directed facility staff to administer medications as ordered by her primary care provider (PCP). medications. R104's "NSA" failed to identify who was responsible for the administration and management of melatonin. The "Resident Roster" provided by the facility on 01/04/23 revealed R104 administered her own medications. On 01/05/22 at 03:13 PM Administrative Nurse B confirmed R104 had melatonin in her room that she self-administered at night as needed and facility staff managed all her other medications. - Record review for R106 revealed an admission date of 03/10/22 with the following diagnoses: atrial fibrillation and fibromyalgia. The 03/08/22 "FCS" identified R106 was unable to perform management of medications. The 03/10/22 "NSA" directed facility staff to administer medications as ordered by her PCP. R106's "NSA" failed to identify who was responsible for the administration and management of azelastine nasal spray and Breo inhaler. The "Resident Roster" provided by the facility on 01/04/23 revealed R106 administered her own medications. On 01/05/22 at approximately 03:13 PM	S3186		

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S3186	Continued From page 4 Administrative Nurse B confirmed R106 had nasal spray and an inhaler in her room that she self-administered. The operator failed to ensure R104 and 106's NSA identified who was responsible for the administration and management of select medications.	S3186		
S3211 SS=F	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 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 35 residents. Based on observation and interview the operator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original package of eight over-the-counter (OTC) medications.	S3211		

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S3211	Continued From page 5 Findings included: - Observation on 01/04/23 at 03:42 PM revealed Administrative Nurse B unlocked and opened the medication cart for floor one which contained medications for the residents. The following OTC medications were not labeled with residents' full names: 1 bottle of Vitamin D3 1 bottle of Vitamin C 1 bottle of L-Carnitine Observation on 01/04/23 at 03:47 PM revealed Administrative Nurse B unlocked and opened the medication care for floor two which contained medications for the residents. The following OTC medications were not labeled with resident's full names: 2 bottles of Vitamin C 1000 milligrams (mg) 1 bottle of B-Complex 1 bottle of melatonin gummies 10 mg 1 bottle of Citracal Vitamin D3/Calcium 12.5/400 mg On 01/04/23 at approximately 03:42 PM Administrative Nurse B confirmed three medications in the cart for floor one were not labeled with residents' full names. On 01/04/23 at approximately 03:47 AM Administrative Nurse B confirmed five medications in the cart for floor two were not labeled with residents' full names. The operator failed to ensure all OTC	S3211		

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S3211	Continued From page 6 medications were labeled with the residents' full names.	S3211		
S3310 SS=F	26-41-207 (b) (5-6) (c) Infection Control Policies (b) (5) prohibiting any employee with a communicable disease or any infected skin lesions from coming in direct contact with any resident, any resident ' s food, or resident care equipment until the condition is no longer infectious; (6) providing orientation to new employees and employee in-service education at least annually on the control of infections in a health care setting; and (c) Each administrator or operator shall ensure the facility ' s compliance with the department ' s tuberculosis guidelines for adult care homes adopted by reference in K.A.R. 26-39-105 This REQUIREMENT is not met as evidenced by: KAR 26-41-207(c) The facility reported a census of 35 residents. Based on interview and record review the operator failed to ensure the facility remained in compliance with one out of three residents and three out of five staff sampled with the department's tuberculosis (TB) guidelines for adult care homes adopted by reference in KAR 26-39-105. Findings included:	S3310		

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S3310	Continued From page 7 - Record review for Resident (R) 105 revealed an admission date of 11/02/20 with the following diagnoses: diabetes and hypertension. R105's record lacked yearly symptom screening questionnaires since 11/02/20 which was 793 days before the start of the survey. - Record review for three staff revealed the following: Licensed Nurse B's employee record revealed a hire date of 11/22/21. She had a TB the first step of the two-step TB test administered on 11/22/21. Her record lacked evidence of the first-step test results and two-step test administration and results. Certified Medication Aide (CMA) D's employee record revealed a hire date of 03/29/22. She had the first step of the TB skin test administered on 04/21/22 which was 23 days after hire. Her record lacked evidence of the first-step test results and two-step test administration and results. CMA E's employee record revealed a hire date of 11/12/22. She had a PPD TB test on 03/23/22 which was 50 days passed the six months required to remain in compliance with the department's TB guidelines. Her record also lacked evidence of a symptom screening questionnaire completed within seven days of hire. On 01/05/23 at 03:13 PM Administrative Nurse B confirmed R105's record lacked evidence of yearly TB symptom screen questionnaire.	S3310		

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S3310	Continued From page 8 On 01/05/22 at approximately 10:59 AM Administrative Staff A confirmed Licensed Nurse B and CMA D's employee record lacked evidence of results of the first step of the TB test and the second step test was not administered; that CMA D's first step was administered late; and that CMA E's employee record lacked evidence of a symptom screen questionnaire and TB test completed upon hire. The operator failed to ensure the facility remained in compliance with the department's tuberculosis guidelines for adult care homes adopted by reference in KAR 26-39-105.	S3310		