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 _____	01/29/2026

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 Re-licensure survey with complaint investigations 192191 and 195159 for the above named assisted living facility conducted on 01/28/26 and 01/29/26.	S 000		
S3175 SS=E	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 25 residents (R). The sample included three residents and one closed record review. Based on interview and record review the administrator failed to	S3175		

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

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S3175	Continued From page 1	S3175		

ensure a licensed nurse completed an assessment for self-administration of medications for two (R3 and R5) of three sampled medications prior to self administering medications and annually.

Findings included:

- Review of R3's medical record revealed he moved into the facility on 04/05/21 with diagnosis of Cerebrovascular accident (CVA) (stroke) - (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

R3's "Functional Capacity Screen" (FCS) dated 03/06/25 revealed R3 required physical assistance with all activities of daily living including administration of medications.

R3's "Negotiated Service Agreement" (NSA) dated 03/06/25 revealed facility staff would assist R3 with all activities of daily living and would assist with medication administration per physician orders. It also identified the resident self administered his Flonase.

R3's record included a self-administration assessment dated 01/02/25 for administration of Melatonin at bedtime.

Interview on 01/29/26 at 08:35 AM R3 confirmed he continued to self-administer his Melatonin but no longer took the Flonase.

Interview on 01/29/26 at 11:07 AM Licensed Nurse C reported she did not know how often a

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S3175	Continued From page 2 self-administration of medication assessment was to be completed by a Nurse. The administrator failed to ensure a licensed nurse assessed R3's ability to self-administer his Melatonin annually. - Review of R5's medical record revealed he moved into the facility on 09/13/25 with diagnosis of Type II diabetes mellitus. R5's "Functional Capacity Screen" (FCS) dated 09/15/25 identified he was independent in the management of his medications and medical treatments. R5's "Negotiated Service Agreement" dated 10/09/25 identified R5 was independent with medication administration. Review of R5's medical record lacked evidence that a self-administration assessment was completed by a nurse prior to R5 administering his own medications. Interview on 01/29/26 at 01:06 PM Administrative Nurse B confirmed R5's record did not include a self-administration assessment of his ability to safely and accurately administer his medications prior to self-administering them.	S3175		
S3200 SS=D	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all	S3200		

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S3200	Continued From page 3 medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205 (d) The facility reported a census of 25 residents (R). The sample included three residents and one closed record review. Based on record review and interview one (R4) three sampled residents, the operator failed to ensure staff administered all medications in accordance with a medical care provider's written order. Findings included: - Review of R3's medical record revealed he moved into the facility on 04/05/21 with diagnosis of Cerebrovascular accident (CVA) (stroke) - (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).	S3200		

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S3200	Continued From page 4 R3's "Functional Capacity Screen" (FCS) dated 03/6/25 revealed R3 required physical assistance with all activities of daily living including administration of medications R3's "Negotiated Service Agreement" (NSA) dated 04/06/25 revealed facility staff would assist R3 with all activities of daily living and would assist with medication administration per physician orders. Review of R3's October 2025 Medication Administration Record (MAR) revealed on 10/25/25, 10/26/25, and 10/27/25 R3 dd not receive his Lisinopril (antihypertensive) due to medication not available. Review of R3's nursing notes revealed the following: 10/28/25 - Licensed Nurse C noted she did not administer Lisinopril and reported the pharmacy that it had been ordered on 10/24/25. The pharmacy did not receive the order and will fill the order right away. Licensed Nurse C notified the physician R3 had not received the medication, his blood pressure was 208/114 and did not have any other symptoms. Pharmacy delivered the medication, and it was administered around 10:20 AM. The resident denied headache or other concerns. 10/28/25 at 12:54 PM blood pressure was 165/100 and at 01:26 PM it was 135 over 70, residents baseline. Interview on 01/29/26 at 11:06 Licensed Nurse C reported the medication had been ordered on Friday the 24th but the pharmacy did not get the order. She worked on the Tuesday the 28th and	S3200		

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S3200	Continued From page 5 the medication was not here so she called the pharmacy and notified the physician. License Nurse C confirmed the Certified Medication Aides who worked did not notify the nurse on call or the pharmacy the medication was not available so R3 did not receive his medication as ordered. The administrator failed to ensure R3 received his Lisinopril as ordered by the medical provider.	S3200		
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 25 residents (R). The sample included three residents, one closed record reviews. Based on interview and record review the administrator failed to ensure one (R3) of three sampled residents and one(R6) of one closed record contained documentation of all incidents, symptoms, and other indications of illness or injury, what was done, and the results of action taken. Findings included:	S3261		

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S3261	Continued From page 6 -- Review of R3's medical record revealed he moved into the facility on 04/05/21 with diagnosis of Cerebrovascular accident (CVA) (stroke) - (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R3's "Functional Capacity Screen" (FCS) dated 03/6/25 revealed R3 required physical assistance with all activities of daily living and was at risk for falls. R3's "Negotiated Service Agreement" (NSA) dated 04/06/25 revealed facility staff would assist R3 with all activities of daily living and he used a transfer pole to assist with trasnfers. Review of R3's nursing documentation included: 11/19/25 - Resident continued to have diarrhea and vomiting intermittently over the last few days and received a new order for Zofran. 11/24/25 - new orders for lab work to be drawn, family to cover stat fee 11/25/25 - labs drawn on 11/24/25 awaiting results The record lacked documentation if R3's vomiting and diarrhea had improved or results of the labs drawn because of the vomiting and diarrhea. Interview on 01/29/26 at 11:09 AM Licensed Nurse C reported we should document medical problems, concerns the resident has or needs. Administrative Nurse B added the nurse should be documenting on changes and follow up in 72 hours.	S3261		

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S3261	Continued From page 7 The administrator failed to ensure designated staff documented follow up results of treatment for diarrhea and vomiting including lab results. - R6 moved into the facility on 11/29/24 with diagnosis of malignant neoplasm of bladder. R6's "Functional Capacity Screen" dated 11/22/24 revealed he needed assistance iwth bathing, toileting, mobility and management of medications and medical treatments. Staff also identified R6 as having a risk for falls. R6's "Negotiated Service Agreement dated 11/25/24 identified stff provided assistance with activities of daily living including administration of medications and medical treatments. It identified R6 used a walker in his room and a wheelchair for longer distances. R6's "Fall Investigation Worksheet" dated 11/30/24 identified he had a fall at 08:00 AM trying to get out of bed. Certified care staff completed the worksheet, and it failed to identify if staff notified a Nurse at the time of the fall. The nurse added to the worksheet on 12/02/24 the resident was new and did not use the call light. R6's other "Fall Investigation Worksheet" dated 11/30/24 identified he had a fall at 12:15 PM when he tried to get back into the bed after using the restroom. It noted the resident did use his call light for help and was in his wheelchair. The worksheet did not identify if staff notified the Nurse at the time of the fall. The nurse added to the worksheet on 12/02/24 that the resident did not wait for assistance after pushing the call light.	S3261		

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S3261	Continued From page 8 Review of the Nursing notes lacked documentation a nurse assessed the resident when he fell and included only one fall in the nursing documentation. Interview on 01/28/26 at 02:48 PM Licensed Nurse C reported after someone has a fall the direct care staff call the nurse; she does an assessment over the phone and gives guidance as to what the direct care staff needed to do next. The Nurse is to make a detailed note in the nurses notes about the fall and would put the resident on fall follow-up for 72 hours. Licensed Nurse C reported she would have expected there to be documentation of both falls in the nurses' notes and follow up on how the resident was doing. The administrator failed to ensure designated staff documented R6's falls in his record including follow up post falls.	S3261		