STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087088	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD VISTA SENIOR LIVING	402 S MARTINSON STREET WICHITA, KS 67213

(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 an initial certification survey with a complaint #189585 at the above named Assisted Living conducted on 10/22/24 and 10/28/24.	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) The facility reported a census of 31 residents with three residents included in the sample. Based on observation, interview, and record review the operator failed to ensure the "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCSP) was fully developed based on the resident's "Functional Capacity Screen" (FCS),	S3085		

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
	N087088	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD VISTA SENIOR LIVING	402 S MARTINSON STREET WICHITA, KS 67213

(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 1	S3085		

service needs, and preferences for resident (R)101 and R103.

Findings included:

- R101's medical record revealed she moved into the facility on 07/16/24 with a diagnosis of dementia.

The 07/16/24 FCS identified R101 was required physical assistance from staff for the management of medications and treatments.

The 07/16/24 NSA/HCSP did not address what services they provided R101 for management of medications and treatments.

An observation on 10/28/24 at 02:00 PM revealed R101 visited with a family member. She was alert but not oriented and appeared to be pleasantly confused.

On 10/28/24 at 01:14 PM Administrative Nurse B stated R101's NSA/HCSP did not address what services staff provided for medication and treatment management.

The operator failed to ensure R101's NSA/HCSP was fully developed to include all items that triggered on the FCS, her service needs, and preferences.

- R103's medical record revealed she moved into the facility on 06/26/24 with diagnoses of diabetes mellitus and muscle weakness.

The 06/26/24 FCS identified R103 required physical assistance with medical treatment management and triggered for falls and impaired

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087088	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD VISTA SENIOR LIVING	402 S MARTINSON STREET WICHITA, KS 67213

(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 hearing. The 06/26/24 NSA/HCSP did not address what services staff provided R103 concerning management of treatments, her impaired hearing or falls. The NSA did not address the use of bilateral bed assist devices. On 10/28/24 at 12:50 PM R103 rested in bed was alert and oriented but very hard of hearing and could not understand what staff said to her. Staff had to talk very loud and very close to R103 but she was still unable to understand what was being said so staff used a laptop computer to type out communications with R103. There were bilateral bed assist devices properly attached to R103's bed. On 10/28/24 at 12:27 PM Administrative Nurse B stated there was nothing on R103's NSA/HCSP that identified what services staff provided for management of treatments, impaired hearing, falls and did not address the use of bed assist devices. The operator failed to ensure R103's NSA/HCSP was fully developed to include all items that triggered on the FCS, her service needs, and preferences.	S3085		
S3092 SS=D	26-41-202 (d) Negotiated Service Agreement Revisions (d) Each administrator or operator shall ensure the review and, if necessary, revision of each negotiated service agreement according to the following requirements:(1) At least once every 365 days; (2) following any significant change in condition,	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087088	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD VISTA SENIOR LIVING	402 S MARTINSON STREET WICHITA, KS 67213

(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
S3092	Continued From page 3 as defined in K.A.R. 26-39-100; (3) at least quarterly, if the resident receives assistance with eating from a paid nutrition assistant; and (4) if requested by the resident or the resident ' s legal representative, facility staff, the case manager, or, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(d)(4) The facility reported a census of 31 residents. The sample included three residents. Based on interview, observation, and record review the operator failed to ensure designated staff revised a "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCSP) when R103 received services from an outside provider for physical therapy (PT) and occupational therapy (OT). Findings included: - R103's medical record revealed she moved into the facility on 06/26/24 with a diagnosis of muscle weakness. The most current NSA/HCSP available in R103's medical records was dated 06/26/24 with no subsequent addendums to the NSA located in her medical chart. Review of R103's medical record revealed a physician order dated 07/02/24 for PT/OT evaluation. This was noted in the NSA/HCSP but there was not an addendum completed for this	S3092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087088	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD VISTA SENIOR LIVING	402 S MARTINSON STREET WICHITA, KS 67213

(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
S3092	Continued From page 4 service identifying services to be provided, who was going to provide the services and who was responsible for payment of these services. An addendum was not completed when R103 was discharged from these services. Review of R103's medical record revealed an order dated 10/03/24 for PT/OT for transfer and bed mobility. Access for bed mobility device. No addendum R103's NSA/HCSP was completed to show R103 received PT and OT services, who provided these services and who was responsible for payment of these services. On 10/28/24 at 12:27 PM Administrative Nurse B stated there was no addendum to the NSA/HCSP completed for PT/OT services received from an outside provider started 07/24, when she completed these services and again when R103 started PT/OT services ordered 10/24. The operator failed to ensure designated staff revised the NSA/HCSP to identify services provided by an outside provider for PT/OT services.	S3092		
S3155 SS=D	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
	N087088	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD VISTA SENIOR LIVING	402 S MARTINSON STREET WICHITA, KS 67213

(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 5	S3155		

This REQUIREMENT is not met as evidenced by:
3155
KAR 26-41-204(a)

The facility reported a census of 31 residents. The sample included three residents. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for one of three sampled residents evidenced by the failure to complete and document an assessment for the purpose to use bed rails, ability to use bed rails safely without risk of entrapment, and to confirm the bed rails were not a restraint for resident (R)103.

Findings included:

- R103's medical record revealed she moved into the facility on 06/26/24 with a diagnosis of muscle weakness.

The 06/26/24 "Functional Capacity Screen" (FCS) documented R103 required supervision from staff with transfers and was independent with walking/mobility.

The 06/26/24 "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCSP) documented R103 was independent with transfers and walking but did not address the use of bilateral bed assist devices.

Review of R103's medical records failed to locate an assessment for the use of a bed assist device.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087088	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD VISTA SENIOR LIVING	402 S MARTINSON STREET WICHITA, KS 67213

(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 6 An observation on 10/28/24 at 12:50 PM revealed there were bilateral bed assist devices properly attached to R103's bed. On 10/28/24 at 12:27 PM Administrative Nurse B stated there was no assessment completed for R103's use of a bed assist device. The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for R103 regarding the use of a bed assistive device.	S3155		
S3165 SS=F	26-41-204 (d) Health Care Services (d) The negotiated service agreement shall contain a description of the health care services to be provided and the name of the licensed nurse responsible for the implementation and supervision of the plan. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(d) The facility reported a census of 31 residents with three residents included in the sample. Based on interview and record review the operator failed to ensure the "Negotiated Service Agreement/Healthcare Service Plan" (NSA/HCSP) identified the licensed nurse responsible for the implementation and supervision of the health care services plan for resident (R)101 and R103.	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087088	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD VISTA SENIOR LIVING	402 S MARTINSON STREET WICHITA, KS 67213

(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
S3165	Continued From page 7 Findings included: - R101's medical record revealed she moved into the facility on 07/16/24 with a diagnosis of dementia. R101's most recent NSA/HCSP was completed on 07/16/24 and did not identify the nurse responsible for the implementation and supervision of the health care services plan. On 10/28/24 at 01:14 PM Administrative Nurse B acknowledged R101's NSA/HCSP did not identify the nurse responsible for the implementation and supervision of the care plan. The operator failed to ensure R101's NSA/HCSP identified the licensed nurse responsible for the implementation and supervision of the health care services plan. - R103's medical record revealed she moved into the facility on 06/26/24 with diagnoses of diabetes mellitus and muscle weakness. R103's most recent NSA/HCSP was completed on 06/26/24 and listed Licensed Nurse (LN) D as the nurse responsible for the implementation and supervision of the health care services plan. LN D no longer worked at the facility and the NSA/HCSP was not updated to include the current nurse responsible for the implementation and supervision of the health care services plan. On 10/28/24 at 12:27 PM Administrative Nurse B stated R103's NSA/HCSP was not updated to identify that she was the nurse responsible for the implementation and supervision of the care plan.	S3165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087088	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD VISTA SENIOR LIVING	402 S MARTINSON STREET WICHITA, KS 67213

(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
S3165	Continued From page 8 The operator failed to ensure R103's NSA/HCSP identified the licensed nurse responsible for the implementation and supervision of the health care services plan.	S3165		
S3261 SS=D	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 31 residents. The sample included three residents. Based on observation, interview and record review the operator failed to ensure resident (R)101's record contained documentation of all incidents, symptoms, and other indications of illness or injury. Findings included: - R101's medical record revealed she moved into the facility on 07/16/24 with a diagnosis of dementia. The 07/16/24 "Functional Capacity Screen" (FCS) documented R101 was independent with transfers and mobility. The 07/16/24 "Negotiated Service	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087088	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD VISTA SENIOR LIVING	402 S MARTINSON STREET WICHITA, KS 67213

(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
S3261	Continued From page 9 Agreement/Healthcare Service Plan" (NSAHCSP) documented staff monitored R101's location in the community. Review of R101's medical record and progress notes included the following documentation: The 07/25/24 "Communication- with Family/NOK/POA" note documented staff contacted R101's "Durable Power of Attorney" (DPOA) about an elopement incident involving R101. R101's medical record lacked any additional information regarding her having exited the facility, how staff responded or what interventions were put into place as a result of this incident. On 10/28/24 at 02:24 PM Administrative Staff A acknowledged R101's medical records lacked information describing the elopement incident. The operator failed to ensure designated staff included documentation of all incidents including the date, time of occurrence, action taken, and results of the action.	S3261		
S3305 SS=F	26-41-207 (a) (b) Infection Control (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the	S3305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087088	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD VISTA SENIOR LIVING	402 S MARTINSON STREET WICHITA, KS 67213

(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
S3305	Continued From page 10 spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; (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 (7) transferring a resident with an infectious disease to an appropriate health care facility if the administrator or operator is unable to provide the isolation precautions necessary to protect the health of other residents. This REQUIREMENT is not met as evidenced by: 3305 KAR 26-41-207(b)(4) The facility had a census of 31 residents. The memory care unit had 15 residents that ate food served from the same kitchen. The operator failed to ensure sanitary conditions for food service by not ensuring hot water temperature and chemical strengths were documented daily. Findings included:	S3305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087088	A. BUILDING: _____ B. WING _____	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD VISTA SENIOR LIVING	402 S MARTINSON STREET WICHITA, KS 67213

(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
S3305	Continued From page 11 - Observation of the memory care unit kitchen on 10/22/24 at 02:30 PM revealed there was a dishwasher staff used to wash dishes but there was no log that documented hot water or chemical strength for sanitization. On 10/22/24 at approximately 03:30 PM Dining Services Director C stated the memory care unit dishwasher utilized a high heat water temperature dishwashing unit and dietary staff logged the temperatures but he was unable to locate the hot water temperature log for the memory care dishwasher. The "Environmental Standards Cleanliness and Sanitation" policy dated 10/25/23 documented, "To minimize the potential for transmission of food borne illness, team members will be familiar with the food services sanitation program described herein...Sanitary dishwashing procedures and techniques must be followed." The operator failed to ensure sanitary conditions in the kitchen by failing to ensure documentation of hot water and chemical sanitizer strength was logged daily.	S3305		