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	N087088	A. BUILDING: _____ B. WING _____	04/29/2025

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 abbreviated survey for complaints #195079, 195080, 194954, 194362, 194367, 193187 and 192282 of the above named facility conducted on 04/29/25, 04/30/25 and 05/01/25.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-101 (f) (1) (B) The facility reported a census of 44 residents. 20 Residents (R)s resided is a secured specialty unit. Based on observation, interview, and record review the Administrator failed to provide sufficient staffing services to R1, placing her in immediate jeopardy. R1 left a secured unit without staff knowledge when another resident experienced a medical emergency. The one staff member available attended to all 20 residents in the unit at the time and could not provide services to R1 who had a known elopement risk. R1 was away from the facility for approximately	S3026		

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

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83 minutes before being returned to the facility by a local police officer. R1 was found approximately 0.5 miles from the facility and had to cross at least two major city streets that were very heavily trafficked with posted speed limit of 35 miles per hour.

Findings included:

- Record review of the facility provided "Resident Roster" revealed seven out of twenty residents required physical assistance with "Activities of Daily Living" (ADLs) and one resident required two staff for assistance.

Record review for R1 revealed an admission date of 03/07/25 with diagnoses of malignant neoplasm of unspecified breast, asthma, presenile dementia, and Alzheimer's disease.

Review of R1's "Functional Capacity Screen" (FCS) dated 03/07/25 revealed R1 required supervision with bathing, dressing, and walking. She lacked the ability to manage her own medications and had impaired short-term memory, impaired long-term memory, impaired memory recall and impaired decision making. R1 was identified as being at risk for falls and having impaired decision making.

R1's FCS did not identify R1 at risk for wandering.

Review of R1's combined "Negotiated Service Agreement (NSA)/Health Service Plan (HSP)" revealed under the section titled "Safety" under the "Interventions" column it instructed facility staff to provide "Safety Check: Every 2-3 hours".

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S3026	Continued From page 2 Under the section titled "Elopement Risk" under the "Interventions" column it was instructed facility staff to "Observe location in the community. Staff to encourage resident to be in common area". Review of R1's electronic "Medical Record" under the "Forms" tab revealed the facility's "Level of Care" assessment dated 03/07/25. Under the section titled "Safety and Risk" it identified R1 as at risk for elopement. Review of R1's electronic "Medical Record" under the "Forms" tab revealed an "Elopement Risk Screening " dated 03/07/25, that scored "30", and identified the resident as "At risk for elopement". Review of R1's electronic "Medical Record" under the "Forms" tab revealed a "Brief Interview for Mental Status " (BIMS) dated 03/07/25, with a score of 2 indicating the resident had severe cognitive impairment. Record review of R1's electronic "Medical Record" under the "Progress Notes" tab revealed the following entries: On 03/07/25 at 10:26 AM "Move -In Note", R1 arrived at the community accompanied by her "Durable Power of Attorney" (DPOA). R1 was alert to "person but not time". R1 was able to ambulate independently and make her wants and needs known. R1 needed cueing during later parts of the day. R1 was restless, had sundowning, could be exit seeking, and was re-directed.	S3026		

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On 03/22/25 at 09:06 AM an "Order Note", recorded R1 refused her medication .

The record lacked an entry of the nurse being notified R1 refused her medications.

R1's "Nurse's Notes" recorded the following:

On 03/22/25 at 05:00 PM the "Late Entry" note revealed the nurse was leaving the community and observed an open window in the common dining room, with a missing window screen. The nurse instructed staff to close the window while the nurse replaced the screen and left the community. The nurse then received a call stating R1 was not in the community. The nurse instructed staff to check every common room, every resident room, bathroom, and closet. At the same time staff reported another resident was experiencing a medical emergency and the nurse instructed staff to call 911 for emergency medical care for the other resident and the police for R1.

The record lacked documentation regarding actions the facility took when R1 left the community unsupervised and without staff knowledge.

Review of phone messages from R1's family member to "Licensed Nurse" (LN) A, revealed the resident's family questioned the facility about window handles in R1's room and checked to make sure the handles were not accessible to the resident.

The facility's video camera footage (provided in facility investigation documents) revealed the

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following timeline for 03/22/25.

At 09:30 AM Staff administered R1 her medications.
At 10:00 AM R1 sat in a chair in the living room of the secured specialty unit.
At 10:10 AM R1 was observed on camera walking into the private dining room. "(out of view of cameras)"
At 10:17 AM A staff member was observed going into the private dining room.

Additional typed entries made into the video timeline of events included:
At 10:30 AM LN A reported she went into the private dining room and noticed a window that had been cranked open, the screen had been removed, and was lying on the floor. The LN replaced the screen and grabbed the window crank where it was stored and instructed "Certified Medication Aide" (CMA) B to close the window.
At 11:00 AM CMA B realized R1 was not in the secured specialty unit.
At 11:03 AM LN A called Administrator C to report R1 was not in the secured specialty unit.
At 11:15 AM a call was placed to 911.
At 11:40 AM the local Police department called the facility receptionist to inform her that R1 had been found.

Record review of the facility provided document titled "Witness Statement" dated 03/31/25, which was signed by LN A and notarized revealed the following:

LN A stated she was passing medications, assisted R1 with her medication administration at

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09:00 AM, and left the unit to go to the Assisted Living part of the community at approximately 09:30 AM. LN A wrote that she left the community at 10:00 AM and at 10:57 AM she received a call from facility staff stating they could not find R1. LN A instructed facility staff to search the building and instructed the facility receptionist to call the local police station to give a description of R1 and noted that she received a call from the resident's family member. LN A wrote that she started to return to the community and was notified that R1 was found and was being returned to the community.

Record review of the facility provided document titled "Witness Statement" dated 03/31/25, signed by CMA B revealed on 03/22/25 she administered R1 her medication and helped serve her breakfast. At 10:00 AM CMA B wrote that she went to lunch, and when she returned at 10:30 AM she looked for R1 and was unable to find her. CMA B wrote that she notified LN A and was instructed to call 911, and she continued to search for R1.

The "Timeline" submitted to the department by Administrator C stated LN A reported at 10:30 she told staff to close the window in the secured specialty unit. LN A's signed and notarized witness statement stated she left the community at 10:00 AM.

The signed "Witness Statements" for LN A and CMA B identified each one administered R1's medications. The witness statements for LN A and CMA B further did not match the progress note on 03/22/25 at 09:06 AM, which noted R1 refused her medications.

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S3026	Continued From page 6 During an interview on 04/29/25 at approximately 03:08 PM with Administrator C and LN B they confirmed the facility submitted a timeline of the investigation that did not match the signed and notarized witness statements. LN A stated, "I stand by what I wrote". An interview on 04/30/25 at approximately 01:51 PM with CMA B revealed the secured specialty unit had one resident who required two-person assistance for ambulation due to a recent fall and fractured shoulder. CMA B stated due to the resident's gait it was safer to ambulate this resident with a gait belt and two staff. CMA B stated she could not recall if she passed medications on 03/22/25 and when she came back from lunch, she did not see R1 in the common area, so she started looking for her. She stated she called LN A at 10:41 AM 0r 10:42 AM to report to LN A that she was unable to find R1. CMA B revealed that during the process of looking for R1 another resident had a medical emergency, and at this time the family for R1 arrived at the facility to visit R1. CMA B stated she took her lunch break in her car at around 10:00 AM to 10:30 AM, and her car was parked on the curb directly in front of the facility. CMA B stated she did not see R1 exit the front of the facility and further confirmed that when she went on her lunch break that left one staff member in the secured specialty unit for twenty residents. Record review of the facility provided document titled "Timecard Report" revealed CMA B clocked in at 05:50 AM and clocked out at 09:43 AM. CMA B then clocked back in at 10:03 AM to and clocked back out at 02:01 PM .	S3026		

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S3026	Continued From page 7 Record review of the facility provided document titled "March Schedule" revealed on 03/22/24 for the 06:00 AM to the 02:00 PM shift there were two staff scheduled, CMA B and "Certified Nurse Aide" (CNA) D. Interview on 04/29/25 at approximately 05:20 PM with LN A confirmed there was only one person in the secured specialty unit on 03/22/25 when CMA B took her lunch break. LN A further confirmed that of confirmed twenty residents in the secured specialty unit, seven of the twenty listed on the resident roster would walk out the doors to the outside, if the doors were left unsecured . Interview on 04/29/25 at approximately 03:54 PM with "Life Enrichment" Staff E confirmed on 03/22/25 she was going to the secured specialty unit and was notified of a missing resident between 10:30 AM and 11:00 AM Record review of the facility provided report titled "Elopement Risk Screening" dated 04/30/25, revealed sixteen of the twenty residents were "at risk for elopement". On 04/29/25 Administrator C was notified of immediate jeopardy for R1 when LN A neglected to assess the secured specialty unit after finding a window cranked open, and the screen removed in the private dining room. Administrator A further failed to ensure enough staff were present in the secured specialty unit to care for and monitor all residents, when one staff took her scheduled lunch break, leaving one staff member in the unit and unavailable to all residents when one	S3026		

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resident experienced a medical emergency at the approximate time R1 left the facility without staff knowledge and was absent from the facility for approximately 83 minutes, until R1 was returned to the secured specialty unit by local law enforcement after being found approximately 0.5 miles from the facility. R1 had to cross at least two major city streets that have very heavy traffic. The posted speed limit was 35 miles per hour. The intersections were four lanes with a turning lane, the time was approximately 10:00 AM on a Saturday morning with the local temperature at approximately 48 degrees Fahrenheit.

Administrator C and LN A confirmed there had been no elopement training provided to staff after R1 left the building without staff knowledge and was gone unattended from the facility for approximately 83 minutes.

Abatement plan was accepted on 05/01/25 and included:
1. Staff would alter the windows in the secured specialty unit private dining to not open greater than 6 inches on 03/22/25.

2. Education regarding "Resident elopement" was provided to staff on 04/30/25.

3. Education to staff on the facility staffing model and when to take scheduled meal breaks were provided on 04/20/25.

4. To ensure adequate staffing the facility will fill any open shifts created by an absence, by creating an on-call rotation and utilizing agency staffing options.

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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: K.A.R. 26-41-101 (f)(3)(C)	S3028		

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S3028	Continued From page 10 The facility reported a census of 44 residents. The sample included 8 "Residents" (R)'s 1, 2, 3, 4, 5, 6, 7, and 8. Based on interview and record review the Administrator failed to ensure each allegation of abuse or neglect was reported to the Administrator as soon as the facility staff were aware of the allegation and to the department within 24 hours. The Administrator further failed to ensure each allegation was thoroughly investigated within five working days of the initial report and made sure the report was completed and submitted to the department within five working days of the initial report for R2 and R4. Findings included: - Review of the facility provided unsigned "Self Report", with an incident date of 01/25/25, revealed R2 had a laceration to the back of her head of unknown origin that staff found at 06:00 AM. This resulted in requiring R2 going to the local emergency room. R2 received 8 staples to close the laceration to the back of her head, and a "Computed Tomography" (CT) scan to rule out a "Brain Bleed". The "CT" scan was negative for brain a bleed." The "Self Report" lacked a signature of the person completing the document, a date the document was signed, the attachments of the full investigation performed and supporting documentation, nursing notes pertinent to the incident, a copy of R2's "Functional Capacity Screen, Negotiated Service Agreement, Health Service Plan, List of witnesses and notarized witness statements.	S3028		

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S3028	Continued From page 11 Record review for R2 revealed an admission date of 09/17/24 with diagnoses of hypertensive heart disease, acute pain, anemia, and memory deficit following unspecified cerebrovascular disease. Review of R2's "Functional Capacity Screen" (FCS) dated 09/17/24 revealed R2 had impaired short term memory, impaired long term memory, impaired memory recall and impaired decision making. R2 was marked as at risk for falls and impaired decision making. Review of R2's combined "Negotiated Service Agreement (NSA)/Health Service Plan (HSP)" instructed facility staff to provide "Safety Checks" every two to three hours. Review of R2's electronic "Medical Record" revealed the following entries; On 01/23/25 at 02:27 PM and "Incident" note revealed staff alerted the nurse that upon entering R2's room to assist with getting R2 up for the day, staff reported that R2 was lying in bed and when R2 got up staff observed blood on R2's pillow. Staff then determined R2 had blood coming from the back of her head. R2 did not know the cause of the bleeding. The nurse notified R2's family who transported R2 to the local emergency room for treatment. The note lacked documentation of actions taken to protect R2 upon returning from the local emergency room after the treatment of the laceration to the back of her head.	S3028		

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Review of the facility provided "Resident Roster" confirmed R2 resided in the secured specialty unit.

The date reported on the "Self -Report" of the incident on 01/25/25, did not match the date of the incident in R2's progress notes of 01/23/25.

Review of the departments provided "Intake" revealed the report was received on 01/27/25.

- Review of the facility provided unsigned "Self Report" with an incident date of 12/06/24, revealed at approximately 09:30 AM staff alerted the nurse that R4 had bruising noted to the right side of her body. Direct care staff called R4's hospice nurse to come and assess R4. The facility nurse observed bruising that extended from the upper right back of R4 to her lower right calf. Bruising extended to both the posterior and anterior aspect of R4's right side. Bruising was in various shades of blue and purple. R4 was "unaware" of how bruising occurred. R4 was alert to "person and place and this was within normal limits" for R4.

The "Self Report" lacked a signature of the person completing the document, a date the document was signed, the attachments of the full investigation performed and supporting documentation, nursing notes pertinent to the incident, a copy of R2's "Functional Capacity Scree, Negotiated Service Agreement, Health Service Plan, or signed witness statements for the bruising found on 12/06/24.

Record review for R4 revealed an admission

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S3028	Continued From page 13 date of 08/08/24 with diagnoses of Chronic Obstructive Pulmonary Disease, anorexia, repeated falls, critical illness polyneuropathy, hypertension, long term use of anticoagulants, chronic pulmonary edema, and chronic gout. Review of R4's FCS dated 08/28/24 revealed R4 required physical assistance with bathing, and she was cognitively intact. Review of R4's combined NSA/HSP dated 08/28/24 instructed facility staff to provide "Safety Checks" every two to three hours, and under the section titled "Falls", R4 will be encouraged to call for assistance when needed, was "at risk for falls due to falling asleep unknowingly". Review of the facility provided "Resident Roster" confirmed R4 resided in the Assisted Living section of the community. Interview on 04/29/25 at approximately 12:00 PM Operator F and LN A confirmed the facility lacked documents showing a full investigation for their self reported incidents to the department, LN A further confirmed she did not provide the allegations to Administrator C. The Administrator failed to ensure each allegation of abuse or neglect was reported to the Administrator as soon as the facility staff were aware of the allegation and to the department within 24 hours. The Administrator further failed to ensure each allegation was thoroughly investigated within five working days of the initial report and made sure the report was	S3028		

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	N087088	A. BUILDING: _____ B. WING _____	04/29/2025

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S3028	Continued From page 14 completed and submitted to the department within five working days of the initial report for R2 and R4.	S3028		
S3171 SS=F	26-41-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: K.A.R. 26-41-204 (i) The facility reported a census of 44 residents. The sample included 8 "Residents'" (R)'s. Based on record review and interview the administrator failed to ensure the health care services provided to all residents was provided within acceptable standards of practice for the acknowledged training the "Certified Medication Aides" (CMA)'s would receive when they newly hired, and the administrator further failed to ensure the CMA's continued training as was stated in the facility resident hand book. Findings included: - Record review of the facility provided policy titled "On - Boarding and Introductory Employment Period" dated 10/25/23 revealed under the heading titled "Procedure" the following: "(3) Skills checklists and competency demonstration" and (b) Medication Pass.	S3171		

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S3171	Continued From page 15 Review of the facility provided undated "Assisted Living and Memory Care Resident Handbook" revealed on page nine, under the "Pharmacy Services Section" the following would be provided: "In-service training for staff, to minimize the risk of potential errors". Interview on 05/01/25 at 01:50 PM with Administrator C, LN A and Director of Clinical Services G confirmed LN A lacked documentation of initial training of the CMA's upon hire, and she further confirmed there had been no in-services related to medication training provided to the CMA's. The administrator failed to ensure the health care services provided to all residents was provided within acceptable standards of practice for the acknowledged training the "Certified Medication Aides" (CMA)'s would receive when they newly hired, and the administrator further failed to ensure the CMA's continued training as was stated in the facility resident handbook.	S3171		
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 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	S3200		

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S3200	Continued From page 16 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: K.A.R. 26-41-205 (d) The facility reported a census of 44 residents. The sample included 8 "Residents'" (R)'s. Based on record review and interview the administrator failed to ensure the medications managed by the facility were administered to the residents in accordance with a medical care providers written order and professional standards of practice for R5. Findings included: - Record review for R5 revealed an admission date of 06/27/24 with diagnoses of unspecified dementia, major depressive disorder, hypertension, unspecified atrial fibrillation, and anxiety disorder. Review of R5's "Functional Capacity Screen" dated 06/27/24 revealed R5 required physical assistance with bathing and toileting. R5 required supervision with dressing and was independent with transferring, walking, and	S3200		

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S3200	Continued From page 17	S3200		

eating. R5 lacked the ability to manage her own medications and was frequently incontinent. R5 had impaired short term memory, impaired long term memory, impaired memory/recall, and impaired decision making. R5 was able to make herself understood and she understood others. R5 was marked at risk for falls and impaired decision making. R5 used a walker mobility device.

Review of R5's combined "Negotiated Service Agreement (NSA)/Health Service Plan (HSP)" revealed R5 required "Assistance for: medication administration, ordering of medications and communication with the pharmacy".

Review of R5's electronic "Medical Record" under the "Progress Notes" tab revealed the following entry:

On 11/16/24 at 07:35 PM an "Incident Note" of the nurse being notified by the facility staff that R5 was given Xanax 0.25 "milligrams" (mg) instead of Lorazepam 0.5 mg. R5's medical provider was notified and gave the order to hold the lorazepam for one hour and that if R5 was still restless then the Lorazepam could be given as ordered.

Record reviw of the facility policy titled "Medication Administration" dated 05/11/23 revealed the following statement; "of missed medications or medication errors shall be documented on the Medication Error Report and "All incidents given to the Resident Care Director for review."

Interview on 05/01/25 at 01:50 PM with

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S3200	Continued From page 18 Administrator C, LN A and Director of Clinical Services G confirmed R5's electronic record lacked documentation of an investigation into the documented medication administration error. The administrator failed to ensure the medications managed by the facility were administered to the residents in accordance with a medical care providers written order and professional standards of practice.	S3200		
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: K.A.R. 26-41-105 (f) (11) The facility reported a census of 44 residents. The sample included 8 "Residents" (R)'s 1, 2, 3, 4, 5, 6, 7, and 8. Based on interview and record review the Administrator failed to ensure each resident contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time occurrence, action taken and results of the action for R2. Findings included:	S3261		

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S3261	Continued From page 19	S3261		

- Record review for R2 revealed an admission date of 09/17/24 with diagnoses of hypertensive heart disease, acute pain, anemia, and memory deficit following unspecified cerebrovascular disease.

Review of R2's "Functional Capacity Screen" (FCS) dated 09/17/24 revealed R2 had impaired short term memory, impaired long term memory, impaired memory recall and impaired decision making. R2 was marked as at risk for falls and impaired decision making.

Review of R2's combined "Negotiated Service Agreement (NSA)/Health Service Plan (HSP)" instructed facility staff to provide "Safety Checks" every two to three hours.

Review of R2's electronic "Medical Record" revealed the following entries;

On 01/23/25 at 02:27 PM and "Incident" note revealed staff alerted the nurse that upon entering R2's room to assist with getting R2 up for the day, staff reported that R2 was lying in bed and when R2 got up staff observed blood on R2's pillow. Staff then determined R2 had blood coming from the back of her head. R2 did not know the cause of the bleeding. The nurse notified R2's family who transported R2 to the local emergency room for treatment.

The note lacked documentation of actions taken to protect R2 upon returning from the local emergency room after the treatment of the laceration to the back of her head.

Interview on 05/01/25 at approximately 01:50 PM

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S3261	Continued From page 20 with Administrator C, LN A and Director of Clinical Services G confirmed R2's electronic record lacked documentation of results of the actions upon her return from the hospital after receiving staples for a laceration to the back of her head. The Administrator failed to ensure each resident contained documentation of all incidents, symptoms, and other indications of illness or injury including the date, time occurrence, action taken and results of the action for R2.	S3261		