

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/30/2024
NAME OF PROVIDER OR SUPPLIER MISSION CHATEAU SENIOR LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 8500 MISSION ROAD PRAIRIE VILLAGE, KS 66206		
(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 represents the findings of a resurvey with attached facility report #191381 at the above named assisted living conducted on 10/29/24 and 10/30/24.	S 000		
S3085 SS=D	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 72 residents with six residents included in the sample. Based on interview and record review the administrator failed to ensure the "Negotiated Service Agreement" (NSA) for Residents (R)1 and R2 described the services they received based on their service needs and preferences.	S3085		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3085	Continued From page 1 Findings included: - Record review for R1 revealed an admission date of 05/04/23 with a diagnosis of dementia. The 10/17/23 "Functional Capacity Screen" (FCS) identified R1 had short-term memory, memory/recall, and decision-making cognitive difficulties. The 10/17/23 "NSA" identified facility staff would break tasks into small subtasks for cognitive difficulties. The "NSA" failed to describe services provided for R1's sexual activity and preferences. The 07/25/24 nursing "Health Status Note" documented the night nurse reported R1 was in bed partially clothed with a male resident who appeared to be compliant with the interaction. Staff encouraged R1 to get up, get dressed, and go to her own apartment. The 09/19/24 nursing "Health Status Note" documented staff reported R1 was in a male resident's room while staff were assisting him to get ready for the night. R1 wanted to lay down in the male resident's bed and refused to leave. R1 yelled and became physical with staff. Staff were able to get her to leave the room. The 10/22/24 nursing "Health Status Note" documented R1 was found undressed under the covers with a male resident in his bed. The male resident forced staff out of the room and pushed on the door to prevent staff from entering his room. After an undisclosed amount of time, the male resident opened the door to let R1 out of his room. Nursing assessment provided revealed no injury.	S3085		

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S3085	Continued From page 2 - Record review for R2 revealed an admission date of 03/12/24 with a diagnosis of dementia. The 09/12/24 "FCS" identified R2 had short-term memory, memory/recall, and decision-making cognitive difficulties. The 09/12/24 "NSA" identified facility staff would break tasks into small subtasks for cognitive difficulties. The "NSA" failed to describe services provided for R2's sexual activity and preferences. The 07/25/24 nursing "Health Status Note" documented the night nurse reported R2 was in bed partially clothed with a female resident who appeared to be compliant with the interaction. Staff encouraged R2 to get up and get dressed, and encouraged the female resident to get up, get dressed, and go to her own apartment. The 10/22/24 nursing "Health Status Note" documented R2 was found dressed with a female resident undressed under the covers with him in his bed. He forced staff out of the room and pushed on the door to prevent staff from entering his room. After an undisclosed amount of time, R2 opened the door to let the female resident out of his room. On 10/30/24 at approximately 09:57 AM Administrative Nurse B confirmed R1 and R2's "NSAs" failed to describe services provided based on their service needs and preferences. On 10/30/24 at 01:26 PM an "NSA" policy was requested which the facility failed to provide. The administrator failed to ensure the "NSA" for R1 and R2 described the services they received	S3085		

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S3085	Continued From page 3 based on their service needs and preferences.	S3085		
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 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 72 residents with six residents included in the sample. Based on interview and record review the administrator failed to ensure facility staff administered all medications to Resident (R) 2 in accordance with his medical care provider's orders. Findings included: - Record review for R 2 revealed an admission	S3200		

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S3200	Continued From page 4 date of 03/12/24 with diagnoses of dementia and hallucinations. The 09/12/24 "Functional Capacity Screen" (FCS) identified R2 required physical assistance with management of medications. The 09/12/24 "Negotiated Service Agreement" (NSA) identified facility administered all medications. The 03/13/24 "Physician's Order" documented amiodarone tablet 200 mg. Give one tablet by mouth one time a day for abnormal heart rhythm. Hold for pulse less than 60 beats per minute (bph). Review of R2's "Medication Administration Record" (MAR) for the months of August, September, and October 2024 revealed staff documented administration of amiodarone while pulse rates were less than 60 bpm on the following dates: Eight times in August 2024 on 08/06, 08/09, 08/10, 08/21, 08/25, 08/27, 08/30, and 08/31. Two times in September 2024 on 09/14 and 09/24. And three times in October 2024 on 10/09, 10/19, and 10/20. On 10/30/24 at approximately 12:56 PM Administrative Nurse C confirmed facility staff failed to administer amiodarone in accordance with his medical care providers orders. The undated facility's "Medication Administration Policy for Senior Living" policy documented staff must verify the medication against the order or "MAR" to ensure accuracy.	S3200		

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S3200	Continued From page 5	S3200		
S3211 SS=E	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 72 residents with 33 in the memory care unit. Based on observation and interview the administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of six over-the-counter (OTC) medications in the memory care. Findings included: - Observation on 10/29/24 at 12:48 PM revealed	S3211		

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S3211	Continued From page 6 Certified Medication Aide (CMA) D unlocked and opened the memory care medication cart. The following OTC medications lacked residents' full names: One eight-ounce bottle of Biotene oral rinse One bottle of vitamin D-3 125 micrograms (mcg); 250 softgels One bottle of Aller-Ben diphenhydramine antihistamine 25 milligrams (mg) One bottle of calcium 1200 mg; 125 softgels One bottle of flaxseed oil 1200 mg; 125 softgels One bottle of Women's Advanced multivitamin; 100 tablets On 10/29/24 at approximately 12:48 PM CMA D confirmed six OTC medications in the memory care medication cart lacked residents' full names. The facility's 12/2022 "Over the Counter Medications (OTC)" policy documented a licensed nurse would place the resident's first and last name on the medication container and manufacturer's package of OTC medications. The administrator failed to ensure a licensed pharmacist or licensed nurse placed the full names of residents on the original packages of three OTC medications.	S3211		
S3215 SS=F	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations.	S3215		

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S3215	Continued From page 7 (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The facility reported a census of 72 residents with 39 in the assisted living and 33 in the secured memory care unit. Based on observation and interview, the administrator failed to ensure resident medications were stored in accordance with each manufacturer's recommendations. Findings included:	S3215		

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S3215	Continued From page 8 - Observation on 10/29/24 at 12:36 PM of the assisted living medication room revealed a refrigerator with an opened box with an unsealed vial of tuberculin. The vial lacked a date it was opened. On 10/29/24 at approximately 12:36 PM Administrative Nurse B confirmed the tuberculin vial in the assisted living medication room lacked a date it was opened. Observation on 10/29/24 at 12:48 PM of the memory care medication room revealed a refrigerator with an opened box with an unsealed vial of tuberculin. The vial lacked a date it was opened. On 10/29/24 at approximately 12:48 PM Certification Aide (CMA) D confirmed the tuberculin vial in the memory care medication room lacked a date it was opened. The boxes and product inserts of tuberculin contained instructions that a vial of tuberculin which has been opened and in use for 30 days should be discarded. The 05/2019 facility's "Tuberculosis Testing (Mantoux Test)" policy documented staff must initial and date when they opened a new vial as it was only good for 30 days after opening. The administrator failed to ensure medications were stored in accordance with each manufacturer's recommendations.	S3215		