

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30896</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/28/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CROSS CREEK AT LEE'S SUMMIT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3320 NE WILSHIRE DR LEES SUMMIT, MO 64064</b>
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(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
A4776	<p><b>19 CSR 30-86.047(35) Protective Oversight</b></p> <p>Protective oversight shall be provided twenty-four (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident ' s guardian of the resident ' s departure, of the resident ' s estimated length of absence from the facility, and of the resident ' s whereabouts while on voluntary leave. //I</p> <p>This regulation is not met as evidenced by: Class II</p> <p>Based on observation, interview and record review, the facility failed to ensure side rail assessments were completed for four sampled residents (Residents #1, #2, #4 and #5), failed to ensure physician's orders for two residents with side rails (Residents #1 and #2), failed to ensure staff were appropriately trained on the risk of side rails for four sampled residents (Residents #1, #2, #4 and #5) and failed to ensure staff were trained on the increased risk of entrapment when side rails were used for two sampled residents (Residents #4 and #5) with low air loss mattresses (LALM-a mattress composed of inflatable air cushions that is used to relieve pressure on body parts especially for those being hospitalized for long periods of time who have skin breakdown or to prevent skin breakdown) out of five sampled residents. The facility census was 39 residents.</p> <p>1. Review of Resident #1's Face Sheet showed he/she was admitted on 4/9/22 with diagnosis of: -Dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning). -Parkinson's disease (a condition of the brain that</p>	A4776		

Missouri Department of Health and Senior Services  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Anna Bluetzel*

TITLE

*Executive Director*

(X6) DATE

*1/05/24*

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30996</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/28/2023</b>
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A4776	<p>Continued From page 1</p> <p>causes symptoms including slowed movements, shaking and balance problems that worsen over time).</p> <p>-Stroke. -History of falling.</p> <p>Review of the resident's Individualized Service Plan (ISP) undated showed he/she did not have side rails.</p> <p>Review of the resident's active physician's orders as of 11/28/23 showed no physician's order for side rails.</p> <p>Review of the resident's complete medical record on 11/28/23 showed there was no Risk Assessment for the use of side rails.</p> <p>Observation on 11/28/23 at 9:22 A.M., showed: -The resident was alert and confused and up in his/her wheelchair in his/her room. -There were 1/2 side rails (side rails one half the length of the bed) on both sides of his/her bed. -He/she was unable to answer questions.</p> <p>2. Review of Resident #2's Face Sheet showed he/she was admitted on 10/23/23 with diagnosis of: -Dementia. -Parkinsonism. -Osteoporosis (a bone disease that can cause decreased bone strength that can increase the risk of broken bones).</p> <p>Review of the resident's ISP, undated showed he/she did not have side rails.</p> <p>Review of the resident's active physician's orders as of 11/28/23 showed no physician's order for side rails.</p>	A4776		

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A4776	<p>Continued From page 2</p> <p>Review of the resident's complete medical record on 11/28/23 showed there was no Risk Assessment for the use of side rails.</p> <p>Observation on 11/28/23 at 9:43 A.M., showed: -There were half side rails on both sides of the resident's bed. -He/she was unable to answer questions.</p> <p>3. Review of Resident #4's Face Sheet showed he/she was admitted on 8/30/23 with diagnosis of Dementia.</p> <p>Review of the resident's ISP, undated showed he/she did not have side rails.</p> <p>Review of the resident's active physician's orders as of 11/28/23 showed: -Admit to hospice care (end of life care), dated 8/31/23. -1/2 side rails (side rails that are half the length of the bed) for mobility dated 11/1/23 -LALM for skin protection dated 11/1/23.</p> <p>Review of the resident's complete medical record on 11/28/23 showed there was no Risk Assessment for the use of side rails.</p> <p>Review of the resident's Weights showed his/her weight on 11/3/23 was 133.6 pounds.</p> <p>Observation on 11/28/23 at 9:52 A.M., showed: -There were 1/2 side rails on both sides of his/her bed. -His/her bed had a LALM set at 350 pounds.</p> <p>4. Review of Resident #5's Face Sheet showed he/she was admitted on 7/13/22 with diagnoses of:</p>	A4776		

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A4776	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>-Dementia.</li> <li>-Stroke.</li> </ul> <p>Review of the resident's ISP, undated showed he/she did not have side rails.</p> <p>Review of the resident's active physician's orders as of 11/28/23 showed:</p> <ul style="list-style-type: none"> <li>-Hospice services, dated 10/19/22.</li> <li>-1/2 side rails for mobility, dated 3/9/23.</li> <li>-LALM for skin protection, dated 3/9/22.</li> </ul> <p>Review of the resident's complete medical record on 11/28/23 showed there was no Risk Assessment for the use of side rails.</p> <p>Observation on 11/28/23 at 10:07 A.M., showed:</p> <ul style="list-style-type: none"> <li>-There were ½ side rails on both sides of the resident's bed.</li> <li>-His/her bed had a LALM.</li> </ul> <p>5. During an interview on 11/28/23 at 11:29 A.M. P.M. the Director of Nursing (DON) said:</p> <ul style="list-style-type: none"> <li>-Residents #1, #2, #4 and #5 used the side rails for bed positioning.</li> <li>-There had been no assessments for any of the residents related to use of side rails.</li> <li>-The facility did not have policies for the use of side rails and/or LALMs.</li> <li>-He/she had not provided any staff training for side rails and LALMs since becoming the DON at the facility in the summer of 2023.</li> <li>-For side rail use there should have been assessments, physician's orders, and side rails should have been included in the residents ISPs</li> <li>-He/she would review Resident #1, #2, #4, and #5's electronic medical records for orders regarding side rail use.</li> <li>-For residents on hospice, the hospice orders side rails and the physician's order may be in the</li> </ul>	A4776		

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A4776	<p>Continued From page 4</p> <p>hospice records.</p> <ul style="list-style-type: none"> <li>-He/she would review resident's care plans for side rail use.</li> <li>-For residents with LALMs, the durable medical equipment (DME) company determines the setting for the LALMs.</li> <li>-He/she expected that staff not change the setting on LAMS; if a setting might need adjustment, the DME Company was to be notified to come and check the setting for the LALM.</li> </ul> <p>During an interview on 11/28/23 at 12:24 P.M. Certified Medication Technician (CMT) A said:</p> <ul style="list-style-type: none"> <li>-He/she put Resident #1's side rails up whenever he/she was in bed.</li> <li>-Resident's #2, #4, and #5 normally were not in bed during the day shift when he/she worked.</li> <li>-He/she had worked at the facility for about two and a half years and he/she did not recall ever having had any training at the facility regarding side rails or LALMs.</li> <li>-He/she did not do anything with the settings on LALMs.</li> </ul> <p>During an interview on 11/28/23 at 12:29 P.M. Certified Nursing Assistant (CNA) B said:</p> <ul style="list-style-type: none"> <li>-He/she had worked at the facility for about six years.</li> <li>-He/she did not recall ever having any training at the facility regarding side rails or LALMs.</li> <li>-Some of the residents had side rails to help them turn in bed.</li> <li>-He/she would not change settings on a LALM.</li> </ul> <p>During an interview on 11/28/23 at 12:24 P.M. CMT C said:</p> <ul style="list-style-type: none"> <li>-He/she had worked at the facility for three years.</li> <li>-He/she had not attended any training at the facility regarding side rails or LALMs.</li> <li>-Staff should not change settings on a LALM.</li> </ul>	A4776		

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A4776	<p>Continued From page 5</p> <p>During an interview on 11/28/23 at 12:57 P.M. the DON said: -There were risks to residents with side rails, including that the resident could injured by their head, neck, chest or other body parts getting stuck in the tight spaces around the bed rail. -Use of side rails with a LALMs, especially if the LALM setting was higher than the resident's weight (LALM settings include a setting for the residents weight) may increase the risk of injury for the resident.</p> <p>During an interview on 11/30/23 at 9:32 A.M. the facility Nurse Practitioner (NP - is a nurse who has advanced clinical education and training. NPs share many of the same duties as doctors including performing physical exams, diagnosing and treating diseases and prescribing medication) said: -The facility could enter orders for side rails for the residents as a standing order without contacting them if the resident could benefit from side rails such as to assist the resident's ability to move in bed and to be as independent as possible. -He/she expected the facility would assess residents prior to use of side rails to determine the risks and benefits of side rails. -He/she expected the facility would train the staff regarding side rail use for the residents. -Use of side rails with LALMs would usually be provided by hospice services and in that case the hospice service would manage the order for side rails.</p> <p>During an interview on 11/30/23 at 11:31 A.M. Hospice Registered Nurse(RN) A said: -The hospice service normally orders half side rails for safety and mobility and LALMs for</p>	A4776		

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A4776	Continued From page 6  comfort. -The DME company determines the setting of the LALM, the hospice prefers the facility not change the LALM setting but they are available should the facility have questions regarding the setting.	A4776		

## PLAN OF CORRECTION

<b>Provider Name:</b>	Cross Creek At Lee's Summit	
<b>Street Address, City, Zip:</b>	3320 NE Wilshire Drive Lee's Summit, Mo 64064	
<b>Date of Survey:</b>	11/28/23	
<b>Provider number:</b>	30996	
<b>ID PREFIX TAG</b>	<b>PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</b>	<b>COMPLETION DATE</b>
A4776	<b>Protective Oversight</b>	12/13/23
	For the two residents who did not have physician's orders for side rails, (resident #1, resident #2), physician's orders were obtained by the Director of Nursing on 11/28/23. ISP's were updated to reflect the side rails for resident #1 and resident #2.	11/28/23
	<p>On 12/13/23, an all- staff meeting was held by the Administrator and the Director of Nursing who educated staff on the risks of side rails, including entrapment with low air loss mattresses. Staff were introduced to the new Bed Safety Policy (see attached), and the Proper Use of side Rails/Low Air Loss Mattress Policy (see attached). Staff were also introduced to the new Side Rail/Low Air Loss Utilization Assessment (see attached), which was revised to reflect that side rails will not be used for immobile residents and side rails will not be utilized due to a resident/and or resident surrogate request.</p> <p>The Director of Nursing, or Charge Nurse will complete the Side Rail/Low Air Loss Mattress Utilization Assessment to determine whether side rails and/or a low air loss mattress is appropriate for a particular resident (starting with the least restrictive device). The Director of Nursing will educate families and/or residents on the risks of using side rails and inform them the facility is unable to approve the side rails simply due to the request of a resident and/or resident surrogate. Furthermore, the side rails will only be approved if it is determined they are needed to help manage a medical symptom or condition, or to help the resident reposition. The Side Rail/Low Air Loss Utilization Assessment will be turned in to the Director of Nursing once completed (if completed by the Charge Nurse) and scanned into the resident's chart. The resident's ISP's will be updated to reflect the change at this time. ISP's, along with physician's orders will be reviewed by the Director of Nursing semi-annually to ensure the least restrictive devices are being utilized and all residents with devices have orders and the devices are reflected in the ISP.</p>	1/5/24

