Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31077	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO LEE'S SUMMIT	3101 SW 3RD STREET LEES SUMMIT, MO 64081

(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
A8030	19 CSR 30-88.010(29) Dignity/Privacy Each resident shall be treated with consideration, respect, and full recognition of his or her dignity and individuality, including privacy in treatment and care of his or her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the department or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment, or care unless consent has been given by the resident. II/III This regulation is not met as evidenced by: Class II* Based on interview and record review, the facility staff failed to ensure dignity and respect during cares when on 1/30/25 Caregiver A raised his/her voice, was upset and clapped his/her hands loudly while providing cares for Resident #1. Caregiver A and B also held down the resident's arms and legs while he/she was visible upset, yelling, kicking, and swinging at staff out of four sampled residents. The facility census of 51 resident. Review of the facility's Aggressive Behavioral Expression with Dementia revised on 1/23/21 showed: -Associates should recognize signals that may trigger aggressive pr combative behaviors in the resident. these could include arguing loudly, unresponsive to redirection. -Associates shall attempt to de-escalate the situation by: --Approaching the resident in a non-threatening manner and establish limits in a calm and appropriate manner. –Assisting the resident to move away from an	A8030		

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A8030	Continued From page 1 irritation focus on using redirection as appropriate. --Acknowledge the resident's feelings of frustration and helplessness. --Maintain a safe distance. --Do not crowd the resident with to many associates. 1. Review of Resident #1 Profile Sheet showed the resident was admitted with diagnosis of osteoarthritis (is a degenerative disease that worsens over time, often resulting in chronic pain) of hip, osteoporosis (causes bones to become weak and brittle). Review of the resident's Service Plan Detail last modified on 10/31/24 showed: -The resident required hand on assistance with care by facility staff. -The resident would feel safe and respected. -The resident was unable to communicate or receive information; the facility staff will anticipate resident need and preserve dignity. -The resident will be groomed appropriately each day to maintain comfort and dignity. Review of the resident's hospice (end of life care) notes showed the resident was admitted to hospice on 11/8/24 with a diagnosis of Dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities). Review of the resident's Administrator Progress Note showed: -The Administrator was notified on 1/30/25 around 12:30 P.M. hospice staff observed that Caregiver A had raised his/her voice around the resident while completing cares. -The resident was noted to be resistive of care and yelling as well.	A8030		

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A8030	Continued From page 2 -He/she and Caregiver A were excused from the room with a change of care providers. -Hospice staff assisted the resident with Activity of Daily Living (ADLs-grooming, hygiene) and then assisted him/her to lunch. -The Nurse Practitioner (NP) was notified of incident and the resident's Durable Power of Attorney (DPOA- a person previously identified to make decisions for an individual in the event of inability to make wishes known) notified. -Caregiver A gave shift change report and left for the remainder of the shift. -The resident family members arrived shortly after the incident. -Family member had voiced no changes in the resident's behavior. -The resident was pleasant and confused. -The family member had no concerns at that time. Review of the witness statement dated 1/30/25 completed by Caregiver B showed: -He/she and Caregiver A were trying to check the resident's brief when the resident started yelling, kicking and was swinging toward Caregiver A. -Caregiver A held the resident's hands as Caregiver B held the resident's legs for few seconds then let go of the resident's hands and legs. -The resident was yelling out loud, so Caregiver A had started clapping his/her hands telling the resident to "calm down and it's ok" and while Caregiver B was trying to check the resident's brief. -The resident started kicking him/her and swinging at Caregiver A, as the Hospice Nurse A and Hospice Nurse B and another entered the resident room and voiced concern, asking if the resident and staff were OK. -Caregiver A tried to explain the resident was	A8030		

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A8030	Continued From page 3 upset. The resident did not want to be in the mechanical lift sling and the resident was kicking and swinging toward and at the care staff. That was why caregiver were holding the resident hands and legs. -Caregiver A was already upset and express that "he/she goes through this every day, it was hard to take care of this resident." -Hospice Nurse B had ask caregivers about the loud noise. Caregiver A had explained it was him/her clapping his/her hands to get the attention of the resident and had to raise his/her voice over the resident screaming. -Hospice staff stated they would take over resident care and try to get the resident up for lunch. Review of the email witness statement dated 1/30/25 Hospice Nurse A showed: -He/she and Hospice Nurse B were in the dining room area next to the TV room. -He/she had heard some yelling and turned to Hospice Nurse B. -Then he/she heard banging on the wall. -As they walked into the resident's room and saw two caregivers in the room with resident arguing with him/her about getting up for lunch. -Caregiver A and Caregiver B were attempting to connect the resident to the mechanical lift (mechanical lifts/hoyer lifts are used to help people move from a sitting position to standing, or from one place to another) and the resident was upset. -Hospice Nurse B had asked Caregiver A "why are you yelling". -Caregiver A said the resident was arguing with him/her, and he/she had to "defend" himself/herself because the resident was getting aggressive. -Caregiver A and Caregiver B were continuing to	A8030		

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A8030	Continued From page 4 hook up the resident lift sling to the mechanical lift. -He/she had noticed the sling pad was incorrectly positioned and Hospice Nurse B was discussing with Caregiver A how he/she should be going to get the nurse if the resident agitated. -He/she observed the resident face was bright red at that time. -The resident was tense and began to cry. -Hospice Nurse A began to take the sling off the Hoyer lift. -Caregiver A had backed away from the resident and said, "you outsider come in here and think you know, but you don't know what we go through." -Caregiver A began to exit the resident room and said, "I had to hold him/her down so I did not get hit." and left the resident's room. -Then Caregiver B left the room. -The resident had asked the Hospice Nurses A "if they were alone" and he/she told the resident it was just them (hospice nurses). -He/she had rolled the resident to place the Hoyer sling correctly under the resident as he/she moaned in pain with movement. -Had notice the resident pant and brief were saturated with urine and bowel movement. Personal care provided and pants were changed with the resident was compliant as long as Hospice staff provide step by step what action/care they were doing. -The resident was transferred to wheelchair with Hoyer lift and taken to dining room for lunch. Review of the email witness statement dated 1/30/25 Hospice Nurse B showed: -At around 12:25 P.M. he/she had his/her back against the dining room wall and was given report to another hospice nurse. -Hospice Nurse A asked if they had speakers in	A8030		

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A8030	Continued From page 5 this resident room because can hear voices and then he/she heard a thump on the wall behind him/her. -He/she immediately stopped and went into the resident room. -As Hospice staff walked into the resident room, two caregivers were above the resident trying to hook the resident sling onto the Hoyer lift. -Caregiver A had his/her voiced raised, and was yelling. -The caregivers were clearly frustrated. -As he/she opened the door, he/she had asked the caregiver "why are you yelling?" -The resident was lying on his/her right side with his/her black pants around his/her upper thigh and not pulled all the way up to his/her waistline. -Caregiver A said "we are trying to get him/her up and he/she was arguing with caregiver and attempting to hit him/her". The caregiver said he/she "had to defend himself/herself. " -He/she informed the caregivers they would get the resident up. -Caregiver A said, "good luck, you outsiders coming in, and you do not know what we are dealing with." -The caregivers left the resident room. -Hospice Nurse A began to comfort the resident. -He/she said, "I will be back, I'm going to grab the resident's nurse". -Caregiver A was already reporting what had happen to the nurse and with a raised voice and not giving anyone else a chance to talk. -When there was a break in the conversation, he/she advised Caregiver A, that when a resident was being difficult, they need to contact their charge nurse to go in there and to simply walk away. -The resident wanted to know who was in the room and would not open his/her eyes. -The hospice nurses calmed the resident down	A8030		

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A8030	Continued From page 6 and had the resident take some deep breaths and finally the resident opened his/her eyes. -The resident's pants and brief were soaked and soiled with urine and bowel movement. Review of the email witness statement dated 1/30/25 Caregiver A showed: -He/she and Caregiver B went to check on the resident and he/she was sitting on the edge of the bed. -The resident looked upset, so he/she had asked the resident if we could help him/her stand to with assistance to check brief. The resident was not able to stand. -The caregivers attempted to lay the resident down. -The resident began screaming and swinging his/her arms to hit the caregivers. -He/she had clapped his/her hands while the resident was screaming, to try to redirect the resident. -With clapping of his/her hands, he/she was trying calm the resident enough to be able to change the resident, or at least calm him/her down enough to be able to step away to get help. -He/she denied yelling at the resident. -He/she had raised his/her voice over the resident yelling, but he/she would never yell at the resident. -Hospice Nurse B came into the room asked what was wrong and he/she had heard banging. -As if he/she and Caregiver B were doing something wrong. -He/she said that's what frustrates him/her, when "you all come from outside, not knowing what's going on" (here at the facility). -He/she was not disrespectful, but he/she was frustrated. -He/she then left the resident's room and went to charge nurse to explain what happen.	A8030		

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A8030	Continued From page 7 During an interview on 1/31/25 with Caregiver B said: -He/she was working at the facility today on the other end of the hallway. -On 1/30/25 at around lunch time, Caregiver A and himself/herself entered the resident's room. -The resident was sitting up on the side of the bed. -Caregiver A ask the resident if wanted to get up for lunch. The resident said yes. -As the caregivers attempted to lay the resident back to check the brief and connect the Hoyer sling, the resident started yelling, swinging and kicking. -He/she held resident's feet (one hand on each ankle area) while Caregiver A held the resident's hands (one hand on each hand) to prevent the resident from swinging and kicking. (to help calm the resident down). -That lasted about couple of seconds, then they released the resident. -The resident was still yelling, screaming, swing hands and kicking legs. -He/she and Caregiver A repeated holding the resident's hands and legs again for a few seconds. -When holding the resident's hands and feet, he/she was still screaming and trying to kick. -When they let go of the resident's feet, the resident was still yelling, screaming and swing arms and legs. -He/she could hear the resident saying no, no and making screaming noises. -The resident continued to yell, kicking, swing toward staff. -Caregiver A started clapping his/her hand to try get the attention of the resident to calm him/her down and redirect the resident. -Hospice Nurse A and Hospice Nurse B had	A8030		

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A8030	Continued From page 8 entered the resident room to see what was going on. -Caregiver A tried to explain what was happening and the bang they heard was the clapping of his/her hands. -Hospice Nurse staff had then taken over the resident care. -Caregiver A and Hospice Nurse B had exchanged words and he/she and Caregiver B left the resident's room and went to talk with charge nurse. -The Caregivers could not walk away to let the resident calm down, because resident was partially hooked to the Hoyer lift. -They were not able to complete care or change the resident brief due to the resident resistant and combative behavior. -He/she had training while worked at hospital related to combative resident and knew how to hold people's legs and hands when they are kicking or swinging toward staff. -He/she was taught to hold the resident's hands and feet down when resident is combative or aggressive toward staff, that way the resident won't hurt themselves or others. -He/she had completed dementia care and behavioral management training on online at the facility. -Caregiver A had raised his/her voice over the resident to calm him/her down. -The resident appeared to have slight redness of his/her face during the care. -When hospice staff came in and touched the resident, he/she continued to yell out. -The resident had been known to have behaviors resistive to care at times. -Normally two staff member to provide care for the resident. -The resident normally would calm down after the caregivers staff calmly explain process of the	A8030		

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A8030	Continued From page 9 resident care. During an interview on 1/31/25 at 12:05 P.M., the Administrator said: -He/she was aware of a potential incident between the resident and Caregiver A. -He/she had started investigation on 1/30/25 related to the potential employee to resident incident. -He/she was notified on 1/30/25 around 1:30 P.M. of the potential inappropriate interaction. -The facility obtained witness statement from both caregivers, hospice nursing staff and Licensed Practical Nurse (LPN) A on 1/30/25. -Caregiver A was suspended until further investigation. -He/she had not read all written witness statements at that time of interview. -He/she had received the complaint/concern from hospice staff, and which was related to interaction with Caregiver A and the resident. -Hospice staff did not mention Caregiver B. -The facility nurse and hospice staff had completed a full assessment of the resident on 1/30/25 with no skin issue found. During an interview on 1/31/25 at 1:35 P.M., Med Tech A and Caregiver C said: -The resident requires the use of a soft voice directions and to explain step by step how they were going care for the resident. -If a resident was agitated or combative need to ensure the resident was safe and then step away. -They would have another care staff member try to provide care for the resident or he/she would come back later. -He/she would have notified the charge nurse of the resident behaviors or changes in condition. -Sometime he/she would comfort the resident by holding the resident's or arm with a soft light	A8030		

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A8030	Continued From page 10 touch to assist in calming the resident. -He/she would never hold down the resident's hands or legs if kicking or swinging at staff. During an interview on 1/31/25 at 2:31 p.m., Caregiver A said: -The resident had a recent change of condition with room changes and care changes. -The resident now required use of Hoyer lift and personal care provided by staff. -The resident like to "fight/resistant with personal cares." -He/she and Caregiver B entered the resident room and asked the resident if he/she was ready to get up for lunch and he/she said, "Yeah I'm ready." -They were explaining to the resident they had check his/her brief and as attempted to lay the resident back in bed, the resident began to yell, screaming, swing arms and kick his/her legs. -He/she had to talk loudly with raised voice over the resident screaming to be able to get the resident attention. -The resident was saying "no, no, no I don't want to" and then made screaming noise sounds. -He/she then tried to make loud noise by clapping his/her hand to get the resident attention to help calm the resident down. -He/she held the resident's hand down so he/she would not hit the wall with his/her hand or arm. -He/she had placed the resident's hand down and then he/she had stepped away from the resident. -He/she was trying to explain to the resident what they were doing and the resident was to upset and would not calm down. -The Hoyer sling was connected with two hooks and so, care staff could not just walk away from the resident. -He/she had completed dementia care and behaviors training online.	A8030		

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A8030	Continued From page 11 -The resident required two staff to assist with all resident cares due to behaviors. -He/she denied that the caregiver staff had held the resident's hands and legs down during cares to get the resident to stop kicking and swing. -Hospice staff came into the resident room and started asking question and caregiver staff exited the resident room while hospice nursing staff completed resident's care. -He/she had gone to inform Licensed Practical Nurse (LPN) A of the incident. During an interview on 1/31/25 at 2:55 P.M., LPN A said: -Caregiver A was explaining what happen as Hospice Nurse B entered the nursing station. -Caregiver A had a raise voice and was talking over the hospice staff. -He/she was not aware Caregiver B was in the room and part of the resident care at that time. -Concern were made that Caregiver A was yelling at the resident as the resident was screaming, as she/she said "you can't hear me when your screaming". -He/she felt the incident that occurred was Caregiver A had an inappropriate interaction with the resident during care and with hospice staff conversation. -Caregiver A reported that he/she had raised voice and was clapping of his/her hands to calm the resident. During an interview on 1/31/25 at 2:55 P.M., Administrator said: -It was the facility administration staff understanding that the hospice nurse complaint was related to Caregiver A alleged inappropriate interaction with resident during cares and with hospice staff. -The complaint was that Caregiver A was yelling	A8030		

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A8030	Continued From page 12	A8030		

at Resident #1 to calm him/her down.
-Hospice staff had discussed with him/her their concerns that Caregiver A was not being kind to the resident.
-He/she would expect care staff to try to redirect the resident, change caregivers and should walk away if resident increase agitation during care.
-When a resident would get overwhelmed, he/she would expect light touch hand holding or arm touch to help calm or redirect the residents. Related to dementia care, each resident may have a different way on how to handle them if they would become overwhelmed and agitated.
-Resident #1's family member was notified and had arrived not long after the incident.
-The resident was fine and was not fearful of staff.
-He/she had no other affects from the incident.
-At that time the facility felt the incident was a customer service/ unprofessional behavior issue with Caregiver A.
-The facility was continuing to investigation the incident at that time.

During an interview on 2/3/25 at 9:19 A.M. the Caregiver A said:
-The resident had been agitated and aggressive that day.
-He/she had raised his/her voice over the resident screaming and yelling to get the resident to hear him/her voice and to be able calm the resident down.
-He/she then had clapped his/her hands loudly to try to redirect the resident and to get the resident attention.
-He/she said to the resident with raised voice "Hey, honey you can't hear me when you are screaming".
-He/she had placed the resident's arm on his/her chest so would not hit the wall or hit toward staff

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	31077	A. BUILDING: _____ B. WING _____	C 02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVERADO LEE'S SUMMIT	3101 SW 3RD STREET LEES SUMMIT, MO 64081

(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
A8030	Continued From page 13 during cares. He/she should use a soft touch while holding the resident's hand or of the arm to redirect the resident. During an interview on 2/3/25 at 1:35 P.M., Director of Nursing (DON) said: -The caregiver staff assignment sheet has a code telling them how to care for the resident and how to meet the resident needs. -He/she would expect caregivers staff to step away and call for assistance if a resident resistant to care or had become agitated and combative toward staff. -He/she would expect caregivers to ensure the resident was safe before leaving the room. -The facility had suspended Caregiver A until further investigation. -He/she would expect caregivers to use a soft touch to redirect the resident like comfort hand holding or touch of arm to attempt to calm a resident. -The facility staff complete online training which does include resident rights and dementia care with behaviors. *"The higher classification merited due to the extent of the violation and the violations effect on the resident(s)." Complaint# MO 00248840	A8030		

PLAN OF CORRECTION

Provider Name:	Silverado Lee's Summit Memory Care
Street Address, City, Zip:	3101 SW 3rd St. Lee's Summit, MO 64081
Date of Survey:	2-3-25
Provider number:	31077

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A8030	1) Abuse & Neglect In-Service for All Staff	2/1/2025
	2) Resident and family interviewed – no safety concerns.	2/1/2025
	3) Abuse & Neglect Policy reviewed upon orientation and annually.	continuing
	4) Caregivers identified in this the SOD were provided education regarding dignity, and	2/11/2025
	5) In-Service for Assessment & Management of Residents with Behavioral Expressions.	3/6/2025
	6) Care Plan scheduled with Myers Family	3/5/2025
	7) Resident referred to NP and Hospice for medical review. Medication change started 2/20/2025.	2/20/2025

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.