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A4776	19 CSR 30-86.047(35) Protective Oversight 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/II This regulation is not met as evidenced by: Class I* Based on interview and record review, the facility failed to provide protective oversight for one resident (Resident #1) when he/she was left unattended sitting upright in his/her Broda chair (a specialized positioning wheelchair with advanced features like infinite tilt and recline, pressure-relieving seating, and supportive components designed for long-term comfort, safety, and mobility) and experienced a fall resulting in a lump/bump and small abrasion to the resident's forehead. Facility staff on duty did not have the skills necessary to assess the resident for injuries and staff assisted the resident off the floor prior to being fully assessed. The facility did not follow their policy and procedure related to falls with head injury. In addition, staff failed to intervene and manage the resident's pain after the fall when the resident groaned and grimaced in pain. Additionally, facility staff failed to properly transfer Resident #1 to and from his/her Broda chair to his/her bed on three occasions within hours after the fall. The resident was found to have a fractured hip and passed away eight days after the fall on 08/30/25. The facility census was 67. The facility did not provide a policy regarding	A4776		

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following ISPs, pain management, or proper transfers.

Review of the facility's Fall Prevention and Management policy, dated 10/25/23, showed:
-If a resident was found on the floor after an unwitnessed fall, the Resident Care Director (RCD) or designee was to observe the resident's mobility and range of motion prior to assisting the resident off the floor;
-If the resident had a head injury (which included bleeding or bruising) the RCD or designee was to call 911 for a transfer to the hospital for evaluation.

Review of the Broda chair's undated manufacturer's Operating Manual showed:
-After transferring a resident into the chair, the chair seat was recommended to be tilted sufficiently to prevent the resident from falling forward or sliding out of the chair;
-The chair's brakes were to be applied when not in use, during transfers, and when not being moved by the caregiver;
-If locks are applied on the chair the caregiver should not leave the resident unattended;
-Failure to follow the instructions could lead to serious falls.

1. Review of Resident #1's record showed diagnoses included Alzheimer's (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline).

Review of the resident's hospice plan of care, dated 07/18/23, showed:
-He/She received hospice care for his/her Alzheimer's disease since 04/24/23;
-He/She used a Broda chair;
-Safety measures included 24-hour supervision,

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locking wheelchair with transfers, fall precautions, and support during transfer and ambulation.

Review of the resident's ISP, dated 07/31/25, showed:
-The resident had a scheduled Hydrocodone (medication used for pain) at bedtime for generalized pain;
-Staff were to report any new complaints of pain;
-The resident was to be in the Broda chair for safety;
-Staff were to transfer the resident using two staff for all transfers;
-When the resident was sitting at the table, the wheelchair was to be pushed under the table and the wheels locked.

Review of the resident's August 2025 Physician's Orders Sheet (POS) showed:
-12/26/24 Hydrocodone 5-325 milligram (mg), once daily at 8:00 P.M., to treat severe pain;
-09/12/24 Acetaminophen (medication used for pain) 500 mg every 4 hours as needed for pain;
-11/15/24 Morphine Sulfate (medication used for severe pain) 0.25 milliliters (5 mg) every 3 hours as needed for pain.

Review of a progress note for the resident, dated 08/22/25, entered by Certified Nursing Assistant (CNA) A showed:
-On 08/22/25 the resident was found on the floor next to his/her Broda chair;
-The resident was assisted back into his/her Broda chair by CMA A and Caregiver A;
-CNA A completed range of motion and vital signs were taken once the resident was back in his/her Broda chair;
-No pain noted;
-Hospice, physician, RCD, and family notified.

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Review of the facility's investigation of Resident #1's fall on 08/22/25 showed:
-At 4:30 P.M. Certified Medication Aide (CMA) A placed Resident #1 at the bar to get ready for dinner;
-He/She raised the chair's seat to a flat position, the footrest was extended out flat, and the back was brought to a more upright position, with only a slight recline;
-He/She left the resident's Broda chair in this position when he/she walked away from the resident to address another resident's family;
-At 5:00 P.M. resident was observed on the floor next to his/her Broda chair on his/her left side;
-CMA A and Caregiver A did range of motion and checked over Resident #1 for obvious injuries before picking the resident up and placing him/her back in the Broda chair;
-CMA A noticed a goose egg and small abrasion to the resident's forehead, but the resident did not appear to be in any pain;
-CMA A called CNA A over to complete vital signs and do range of motion after placing the resident back in the Broda chair;
-Staff contacted RCD, Assistant Resident Care Director (ARCD), family, and hospice;
-Hospice arrived to assess the resident after the fall between 7:00 P.M. and 8:00 P.M.;
-While CMA A put the resident to bed around 10:00 P.M. on 08/22/25 transferring the resident from the Broda chair to bed by himself/herself, noticed the resident groaned a little, but this was baseline;
-Licensed Practical Nurse (LPN) A arrived to the facility around 11:00 P.M. on 08/22/25 and completed an assessment of Resident #1 and looked at the skin tear on his/her forehead;
-During CMA A's last checks around 5:00 A.M. on 08/23/25, he/she brought LPN A in to check on the resident's head and help roll the resident to

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change him/her. Both CMA A and LPN A noticed the resident groaned and had facial grimacing while moving the resident which stopped when they finished moving the resident, no pain medication was given;
-At 6:34 A.M. on 08/23/25, facility staff asked hospice to return to see the resident due to now being in pain from the fall;
-Around 9:00 A.M. on 08/23/25 Caregiver B got Resident #1 up and dressed for the day during which he/she noticed Resident #1 moaning while being turned, but did not report this to medication staff or a nurse immediately;
-At 11:00 A.M. on 08/23/25 the ARCD arrived and found the resident with discoloration and a skin tear to his/her left forehead, at which time Caregiver B informed him/her the resident seemed to be in pain;
-ARCD completed a range of motion assessment and noticed the resident to be in pain based on facial grimacing;
-Hospice returned to the facility to further assess and ordered a mobile X-ray of the resident's left hip.

During an interview on 09/24/25 at 9:30 A.M., CMA A said:
-On 08/22/25 he/she placed Resident #1 at the bar to get ready for dinner around 4:30 P.M.;
-He/She sat the resident's chair back in a more upright position, the seat was moved up to a flat position, the chair's legs were straight out, and the brakes were locked;
-He/She left Resident #1 in this position when he/she walked away to the back tables where the resident would have been out of his/her sight for five to seven minutes which was when the fall would have occurred;
-He/She was advised the resident was on the floor, and upon returning to the resident found the

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resident on his/her bottom on the floor to the left of the Broda chair;
-He/She should not have left the resident unattended with the chair in that upright position;
-He/She knew the resident was to be reclined back when unattended and could only be in the upright position when someone was with him/her;
-He/She noticed a bump and abrasion to the resident's left forehead, but no other obvious injuries;
-He/she and Caregiver A picked the resident off the floor and placed the resident in the Broda chair;
-He/She did range of motion on the resident prior to moving the resident as expected to do, but he/she would not know how to identify an internal injury if there was one;
-They only called CNA A over who was the person in charge that shift and CNA A called the RCD.
-The resident did not show signs of pain until he/she put the resident down for bed that evening by himself/herself at which time the resident groaned a little;
-He/She did not immediately report the groaning to medication staff, or a nurse until LPN A arrived at the facility;
-He/She did not have much training on identifying nonverbal cues of pain;
-He/She knew the resident was supposed to be transferred by two staff, but everyone transferred the resident by him/herself because the resident was small and they could do it by him/herself;
-He/She was trained how to transfer a resident with two staff, how to use a gait belt, and a forward facing transfer method, but was not trained on the "cradle" method (one arm under the residents shoulders and neck, and one arm under the residents knees) which he/she often used to transfer Resident #1 by himself/herself

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A4776	Continued From page 6 During an interview on 09/24/25 at 3:33 P.M., CNA A said: -When staff came and advised him/her of Resident #1's fall the evening of 08/22/25, the resident was already back in the Broda chair before he/she completed any assessment; -He/She had concerns about the "goose egg" on the resident's forehead and reported it to the RCD when he/she called to notify him/her about the resident's fall shortly after the fall occurred; -He/She followed the facility's protocol and the RCD's direction in calling hospice to come assess, instead of sending to the hospital immediately; -He/She and all staff were expected to keep the resident reclined in his/her Broda chair when left unattended, for safety measures; -The resident was supposed to be transferred by two staff which he/she tried to do every time, but knew other staff did not follow this and would transfer the resident on their own; -If a resident had orders for pain medication it was expected to be used if there were complaints or signs of pain, but the resident was not showing any signs of pain at the time of his/her assessment. Review of a hospice visit note, dated 08/22/25 at 7:00 P.M., showed: -The hospice nurse evaluated the resident and indicated the resident was nonverbal, but did not show any signs of pain (labored breathing, groaning, facial grimacing, or clenched extremities); -Current pain control was adequate; -The resident had a large hematoma with a one centimeter (cm) by two cm abrasion to his/her left forehead; -New order for triple antibiotic ointment for abrasion on forehead.	A4776		

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A4776	Continued From page 7 Review of the resident's August 2024 Medication Administration Record (MAR) showed the resident received his/her scheduled Hydrocodone on 08/22/25 at 8:00 P.M. During an interview on 09/25/25 at 9:05 A.M., LPN A said: -He/She arrived to the facility around 10:00 P.M. on 08/22/25; -He/She assessed the resident around 10:30 or 11:00 P.M. when he/she went in to assist in changing the resident; -While changing the resident he/she saw a bruise on the resident knee and was already aware the resident hit his/her head; -He/She noticed the resident making facial grimacing, but associated this with the bruise on the knee; -He/She did not perform range of motion on the resident, because he/she did not want to hurt the resident anymore; -He/She did not recommend any pain medication, because the resident's facial grimacing stopped when they stopped moving the resident around; -He/She expected staff to call hospice and not 911 if a resident was on hospice, even when there was a head injury; -He/She would not expect staff to perform neuro checks after an injury to the head, as the facility did not perform neurological assessments on residents after head injuries; -The resident was always to be transferred by two staff. Review of the resident's post fall assessment, dated 08/23/25 at 1:37 A.M., showed: -The resident had an unwitnessed fall; -The resident hit his/her head with a raised area and abrasion to his/her left forehead;	A4776		

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-The resident was showing signs (unspecified) of a little more than normal pain.

Review of video monitoring, dated 08/23/25 at 8:54 A.M., showed:
-The resident grimacing in pain, tapping Caregiver B's side frantically, and then grasping Caregiver B's shirt in pain, when Caregiver B rolled the resident onto his/her left side to change his/her undergarments;
-Caregiver B picked the resident up from his/her bed, in the "cradle" technique and placed the resident in his/her Broda chair.

During an interview on 09/24/25 at 9:51 A.M., Caregiver B said:
-He/She came into work at the facility on 08/23/25 at 6:00 A.M.;
-He/She was aware of the resident's fall the night of 08/22/25;
-He/She went to get the resident up and ready for the day by himself/herself around 9:00 A.M. and noticed an abrasion to the resident's left knee, at which time he/she asked other staff if it was okay to proceed with getting the resident up and ready for the day;
-He/She rolled the resident to his/her left side to change his/her undergarments and put his/her pants on and noticed the resident groaned louder than normal;
-He/She told the ARCD once he/she got to the facility, who directed to contact hospice and ask about pain medications;
-He/She did not know how Resident #1 was supposed to be transferred;
-He/She was not trained on the "cradle" method, this was just how he/she figured out how to transfer the resident on his/her own.

During an interview on 09/24/25 at 11:32 A.M.,

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the ARCD said:
-He/She was not aware of the resident's fall on 08/22/25 until he/she came in to work on 08/23/25 around 11:00 A.M. and found the resident with his/her entire forehead bruised and an abrasion to the left side of his/her forehead;
-When he/she arrived to the facility the ARCD was unaware if staff notified the RCD, until he/she confirmed with the RCD by phone that they (RCD) were notified of the fall on 08/22/25;
-He/She completed a full assessment including range of motion and upon moving the resident's legs to check the resident's hips, the resident grimaced in pain;
-The resident had not been properly assessed by a nurse until he/she had completed his/her assessment;
-He/She was unsure if the resident had orders for as needed pain medications;
-The resident was expected to be in a reclined position at all times unless staff were with the resident;
-The resident's fall could have been prevented if he/she was not left unattended in the upright position;
-All transfers for Resident #1 were to be completed with two staff.

Further review of the resident's August 2024 Medication Administration Record (MAR) showed the resident did not receive any Tylenol or Morphine until he/she received Morphine on 08/23/25 at 1:13 P.M.

Review of the resident Physician's Fax Request for Orders, dated 08/23/25 at 2:30 P.M., showed:
-A new order for Hydrocodone 5-325 mg four times daily was requested by the resident's hospice nurse;
-An order for an X-ray of the resident's left hip for

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pain and possible fracture.

Review of the resident X-ray results, dated 08/23/25 and electronically signed by the medical doctor at 5:37 P.M., showed the resident was positive for an acute left displaced intertrochanteric (part of the upper thigh bone) fracture.

Review of video monitoring, dated 08/23/25 at 4:23 P.M., showed:
-Caregiver B, wheeled the resident into his/her room, did not lock the brakes, and picked the resident up from the Broda chair, by himself/herself, in a cradle-like position, and placed the resident in his/her bed;
-Another staff member was present in the room, but did not assist in the transfer until realizing Caregiver B needed assistance turning the resident in the right direction to ensure his/her head was on the pillow instead of his/her feet;
-The resident could be heard groaning while the two staff members covered the resident in blankets, put the bed in it's lowest position and left the room;
-The resident continued groaning loudly after the staff left the room.
-Staff did not acknowledge the resident's pain.

Review of the local medical examiner's office report of death for the resident showed:
-He/She passed away on 08/30/25;
-He/She had a recent unwitnessed fall on 08/22/25 that could be attributed to the cause of death.

During an interview on 09/24/25 at 11:48 A.M., the resident's family member said:
-He/She was contacted on 08/22/25 about the resident's fall and advised about the "goose egg"

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on his/her forehead;
-Staff indicated the resident did not appear to be in any pain at that time;
-He/She called the facility the next morning to check in on the resident at which time, he/she was advised the resident got out of bed around 9:00 A.M., but there was no mention of pain;
-He/She arrived to the facility around 11:30 A.M. on 08/23/25 to find the resident in an "awkward position" (the resident was leaning to his/her right, with the right leg mostly straight out. The resident's left leg was bent and turned in, to where the inside of his/her left knee was laying flat to the chair near the right knee, and his/her left foot was up under his/her left thigh and buttocks) in his/her Broda chair;
-The resident let out a groan and had facial grimacing he/she had never heard or seen before;
-He/She insisted staff do something as the resident was clearly in pain, and he/she did not know how long the resident had been in pain;
-He/She was furious the resident had not received any pain medication until after he/she demanded the staff do something;
-The resident had orders for pain medication as needed and should have been used at any sign of pain;
-The resident was supposed to be a two person transfer with all transfers.

During an interview on 09/18/25 at 1:55 P.M., the Hospice Registered Nurse (RN) said:
-Resident #1 should not have been left unattended with the Broda chair in an upright position;
-The resident had pain medications on hand prior to the fall that should have been administered if he/she was showing signs of pain;
-He/She expected staff to properly transfer the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30758	A. BUILDING: _____ B. WING _____	C 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OXFORD GRAND AT SHOAL CREEK	8280 N TULLIS AVE KANSAS CITY, MO 64158

(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	Continued From page 12	A4776		

resident;
-He/She believed only licensed nursing staff could have and should have fully assessed the resident prior to assisting the resident from the floor.

During an interview on 09/24/25 at 9:40 A.M., the resident's Physician said:
-The resident should have been in a reclined position in his/her Broda chair unless there was a staff member with him/her;
-He/She expected staff to do a general assessment for pain prior to moving a resident from the floor after a fall, but a full assessment could only be conducted by a licensed nurse;
-He/She expected staff to call hospice first before 911 for all unwitnessed falls, including those with head injuries, to allow hospice staff to assess and speak with family about sending the resident to the hospital for further evaluation;
-The resident had pain medication on hand that should have been used for any signs of pain;
-He/She expected staff to properly transfer the resident at all times and in accordance with the facility's plan of care for the resident.

During an interview on 09/24/25 at 12:50 P.M., the RCD said:
-The facility did not perform neurological assessments to monitor head injuries;
-With the information that he/she was given about Resident #1's fall on 08/22/25 (no signs of pain, a goose egg and small abrasion to the resident's forehead), he/she directed staff to call hospice for further evaluation;
-LIMAs are not taught how to assess and would therefore not be qualified to assess;
-There was nothing wrong with the resident being left unattended in the Broda chair;
-Resident #1 was supposed to be transferred with two staff for all transfers;

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OXFORD GRAND AT SHOAL CREEK	8280 N TULLIS AVE KANSAS CITY, MO 64158

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A4776	Continued From page 13	A4776		

-He/She expected staff to provide cares in accordance to residents' ISPs;
-He/She would have expected care staff to notify medication staff if a resident was showing signs of pain, in case there was an as needed (PRN) medication to give for the pain;
-He/She expected all residents' pain to be managed properly.

During an interview on 09/10/25 at 3:12 P.M., the Regional Director of Clinical Services (RDCS) said:
-Qualifications of the RCD position was an LPN or Registered Nurse license;
-When the RCD was not at the facility the next in charge to be delegated to complete an assessment was a CNA or CMT;
-Resident #1 was supposed to be transferred with two staff for all transfers;
-There was nothing wrong with the resident being left unattended in the Broda chair;
-He/She expected staff to contact hospice first if a resident on hospice had fallen, even if there was head injury;
-Pain medications should have been given to manage pain if there were current orders for them and there were signs of pain.

During an interview on 09/25/25 at 9:22 A.M., the previous Administrator at the time of the incident said:
-The resident should not have been left in the upright position unattended and the fall could have been prevented;
-It should have been a nurse assessing a resident after a fall before moving the resident, but if there was no nurse available a CMT was able to do it before moving the resident;
-For residents on hospice, head injuries were to be reported to hospice for hospice to make the

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A4776	Continued From page 14 determination to send to the hospital or not; -Pain should have been managed with pain medication if there was orders for it; -The resident was supposed to be transferred with two staff for all transfers; -No reeducation of staff had been completed after the fall occurred. *The higher classification merited due to extent of violation and the violation's effect on the resident. NOTE: At the time of the complaint investigation, the violation was determined to be at an imminent danger Class I level. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the deficiency. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the deficiency was lowered to a Class II. MO258093	A4776		

PLAN OF CORRECTION

Provider/Supplier Name:	Oxford Grand at Shoal Creek
Street Address, City, Zip:	8280 N Tullis, Kansas City, MO 64158
Date of Survey:	9/29/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A4776	**19CSR30-86.047 (35) Protective Oversight** **All residents have the potential to be affected.** **Actions taken/systems put into place to reduce the risk of future occurrence include:** RCD and DCS completed Immediate in-servicing/training on 9/16/25 and continued through 9/26/25, covering topics such as Range of Motion, Falls, identifying significant injuries, Fall policy, PRN Pain Management, Broda chair safety, and Individual Service Plans with direct care staff. RCD completed additional Broda chair training direct care staff on 9/29/25. Policy reviewed and revised 9/25/25: Fall Prevention and Management policy was reviewed and revised by Director of Clinical Services and Chief Operating Officer/Administrator. Revisions include Guidelines #2 notify Resident Care Director or on-call nurse of a fall, #6 monitoring resident expressing pain after a fall #7 licensed nurse to be called about fall and relay observations of resident condition for further direction if already called 911, #9 if resident free of injury, transfer resident according to lSP, #10 resident indicates pain, check to see if resident has a pain medication and if not request pain med from their provider #11 document fall in resident record, #12 for all head injuries call 911 even if resident has home health or hospice,	11/9/25

	#13 any significant injury other than a head injury call 911 even if resident has home health or hospice. Training and return demonstration for proper transfers was completed on 10/13/25 and 10/15/25 by Luke Hamann, Licensed PT with Specialized Home Health and RCD. 9/26/25 Communication book implemented by RCD to notify direct care staff of changes in Individual Service Plans. RCD or designee will train new Direct Care staff on processes and procedures upon orientation using Skills checklist. **How the corrective actions will be monitored to ensure the practice will not recur:** Resident Safety Rounding Audits (which includes fall prevention, resident positioning, potential pain indicators, broda chair safety) completed by ED/RCD or designee will be done daily x 2 weeks, the 3 x week for 2 weeks then weekly x 2 weeks. **Completion date 11/9/2025.** 10/15/2025 the RCD started conducting observations of transfer procedures to ensure proper technique, using randomly selected residents and direct care staff 3 x week for 2 weeks, then weekly x 2 weeks. **Completion date 11/5/2025** RCD is conducting random ISP verifications verbally with random staff to knowledge check communication book information. **Completed 10/31/25** Knowledge checks will be ongoing during monthly inservices with direct care staff. ED or designee will collect new hire skills checklist at end of orientation and verify completion. The RCD or designee will review all falls to ensure that the Licensed Nurse or Nurse on Call was notified, that EMS was contacted if the resident hit their head or sustained an obvious injury, and that the resident was appropriately evaluated daily x 3 weeks then twice weekly for 2 weeks then weekly thereafter to ensure policy is being followed. **Completion date: 11/8/25**	

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.

Administrator 11/08/25