STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29519	A. BUILDING: _____ B. WING _____	C 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTON HOUSE OF TIFFANY SPRINGS	5901 NW 88TH STREET KANSAS CITY, MO 64154

(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
A2296	19 CSR 30-86.022(16)(D)(3)(A - E) Locking Devices Requirements Standards for Designated Separated Areas. (D) The facility may provide a designated, separated area where residents, who are mentally incapable of negotiating a pathway to safety, reside and receive services and which is secured by limited access if the following conditions are met: 3. If locking devices are used on exit doors egressing the facility or on doors accessing the designated, separated area, delayed egress magnetic locks shall be used. These delayed egress devices shall comply with the following: A. The lock must unlock when the fire alarm is activated; B. The lock must unlock when the power fails; C. The lock must unlock within thirty (30) seconds after the release device has been pushed for at least three (3) seconds, and an alarm must sound adjacent to the door; D. The lock must be manually reset and cannot automatically reset; and E. A sign shall be posted on the door that reads: PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 30 SECONDS. I/II This regulation is not met as evidenced by: Class II Based on observation and interview, the facility failed to ensure locking devices on egress doors, which led from the secured memory care unit (MCU) to outside, were equipped with delayed egress magnetic locks. The census was 53. 1. Observation on 8/6/25 at 1:30 P.M. of the door that led from the secured memory care unit to outside showed:	A2296		

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A2296	Continued From page 1 -When the push bar was pressed in an attempt to open the door the alarm did not sound and the door did not open; -The door was hard locked and required staff to flip a switch (kill switch) or enter a pass code into a keypad adjacent to the door for the magnetic lock to release. During an interview on 8/6/25 at 1:55 P.M., the maintenance director said: -He/She believed a delayed egress magnetic lock could not be used on a door leading from the MCU to outside. During an interview on 8/6/25 at 2:50 P.M., the facility administrator said: -He/She was not aware that the door leading from the MCU to outside should have a delayed egress magnetic lock. MO257744	A2296		
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 II Based on observation, interview and record review, the facility failed to provide adequate	A4776		

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A4776	Continued From page 2	A4776		

protective oversight for one resident (Resident #1) out of three sampled residents when the resident fell after exiting the facility unattended via an unsecured fire exit leading from the facility's secured memory care unit (MCU) to outside. The facility staff were unaware that the resident had left the building, and the resident was seen by an outside pedestrian who alerted staff to the resident's whereabouts. The facility census was 53.

1. Review of Resident #1's face sheet showed:
-Admit date was 9/1/18;
-Diagnoses included: Alzheimer's Disease.

Review of an incident report dated 8/6/25 showed:
-On 8/4/25 at 9:45 A.M. a pedestrian observed Resident #1 fall on the sidewalk after exiting the facility through an unsecured fire door on the memory care unit;
-The resident was sent to the hospital for evaluation and treatment and returned to the facility later the same day.

During an interview on 8/6/25, at 1:30 P.M., the facility Administrator said:
-On Saturday evening 8/2/25 the fire alarm went off;
-The fire department responded and cleared the building of any fire;
-The maintenance supervisor also responded to the facility and determined the alarm malfunctioned and the alarm was reset;
-She believed that the magnetic lock did not reengage when the fire alarm was reset;
-She did not expect staff to check all doors to verify they were secure after the fire alarm event as the magnetic lock was supposed to reengage automatically;

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A4776	Continued From page 3 -Resident #1's bedroom door is adjacent to the exit door on the MCU; -The resident then walked out of the door undetected on 8/4/25 at around 9:45 A.M.; -The resident walked approximately 50 feet and then fell when he/she attempted to lift his/her four wheeled walker and step down from the curb to street level; -The resident did not have any physical signs of injury; -The resident was sent to the hospital via Emergency Medical Services (EMS) because he/she complained of head pain; -The resident returned to the facility later that day at his/her baseline and did not remember the fall. Observation of Resident #1 on 8/6/25 at 1:40 P.M., showed: -He/She was lying down resting on a couch in a common area on the MCU. During an interview on 8/6/25 at 1:40 P.M., Resident #1 said: -He/She did not remember exiting through the back door; -He/She did not remember falling down; -He/She did not remember going to the hospital. During an interview on 8/6/25 at 2:10 P.M., Certified Medication Technician (CMT) A said: -He/She was the first staff member to get to the resident after his/her fall outside; -He/She took the resident's vital signs which were all normal; -He/She had no physical signs of injury but was complaining of head pain; -The resident did exit seek, and estimated it occurred approximately 2-3 times each week. During an interview on 8/7/25 at 1:05 P.M., CMT	A4776		

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A4776	Continued From page 4 B said: -He/She was the Person In Charge (PIC) on Saturday 8/2/25 when the fire alarm went off; -He/She notified the Administrator and Director of Nursing; -He/She checked all resident rooms; -The fire department responded and cleared the facility of any fire; -He/She did not check the doors to verify the facility was secure after the fire alarm was reset; -The MCU staff were responsible for verifying the MCU was secure; -The maintenance supervisor also responded to the facility and checked the alarm system, but he/she did not know if the maintenance supervisor checked any doors; -He/She went back to passing medications. During an interview on 8/7/25 at 12:50 P.M., Resident Assistant (RA) A said: -He/She was working on the MCU on Saturday, 8/2/25 when the fire alarm malfunctioned; -He/She did not check the door to verify that it was secure after the alarm event; -He/She was not told the doors should be checked to ensure they were secure. During an interview on 8/7/25 at 12:55 P.M., RA B said: -He/She was working on the MCU on Saturday, 8/2/25 when the fire alarm malfunctioned; -He/She did not check the door to verify that it was secure after the alarm was reset; -He/She was not told the doors should be checked to ensure they were secure. During an interview on 8/7/25 at 1:24 P.M., the Maintenance Director said: -He responded to the facility on 8/2/25 when the fire alarm went off;	A4776		

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A4776	Continued From page 5 -He spoke with the fire department staff and checked the alarm panel; -He did not check to ensure all the doors were secure; -The magnetic lock should have reengaged automatically after when the alarm was reset; -Nursing staff was responsible for checking the doors to ensure they were secure. During an interview on 8/8/25 at 11:00 A.M., the Administrator said: -Previous to this incident, she did not expect staff to check the doors to ensure they were secure after a fire alarm event because the magnetic lock was supposed to reengage automatically. MO257744	A4776		

PLAN OF CORRECTION

Provider/Supplier Name:	Benton House of Tiffany Springs
Street Address, City, Zip:	5901 NW 88th Street, Kansas City, MO 64154
Date of Survey:	August 11, 2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

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A2296	19 CSR 30-86.022(16)(D)(3)(A-E) Locking Devices Requirement	
	The doors going to the outside of MCU were not egress doors and were hard locked unless a fire alarm sounded or manually opened.	
	Our third-party contractor was contacted and they are coming out to replace the hard locked doors to egress doors with a sign posted on the door that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 30 SECONDS. ED/MD will monitor the lock changes and going forward will actively test the doors for security.	09/04/2025
A4776	19 CSR 30-86.047 (35) Protective Oversight	
	The outside door is the MCU never reengaged after a fire alarm and Resident #1 went out the door. He went 50 feet and then fell outside with no injuries. Staff did not check all doors to ensure they were secured.	
	Education of the staff is completed and will continue ongoing as new staff are hired. RSD/ED will be conducting the education going forward. After a Fire drill/alarm, staff will complete a head count plus check every door in the community to make sure they are secure to ensure we are giving protective oversight to all of our residents including Resident #1, #2 and #3.	08/11/2025 and ongoing

9/2/25