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
	30748N	A. BUILDING: _____ B. WING _____	C 02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIFFANY SPRINGS SENIOR CARE COMMUNITY	9101 N AMBASSADOR DRIVE 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
A4777	19 CSR 30-86.047(36) Proper Care Per Individual Service Plan Residents shall receive proper care as defined in the individualized service plan. I/II This regulation is not met as evidenced by: Class II Based on interview and record review, the facility failed to provide proper care for residents, as defined in their individualized service plans (ISP, the planning document prepared by an assisted living facility which outlines a resident's needs and preferences, services to be provided, and the goals expected by the resident or the resident's legal representative in partnership with the facility), for one of four sampled residents (Resident #1) who was not provided with adequate assistance when transferring from his/her wheelchair to his/her bed causing him/her to fall and break his/her leg. The census was 81. Review of the facility Fall Policy last revised on 6/21/21 showed: -A fall was defined as the unintentional coming to rest on the ground, floor, or other lower level and included witnessed and unwitnessed falls with or without an injury; -Residents who were found to be at high risk for falls were placed on the Fall Program and Interventions were implemented to meet individual needs; -If a resident had a fall they were enrolled in the program regardless of prior assessment status; -Following any resident fall, interventions would be implemented and the service plan updated. 1. Review of Resident #1's medical record, showed the following: -Admit date: 10/17/22;	A4777		

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-Diagnoses included: Anemia, hypoglycemia, and repeated falls.

Review of the resident's ISP dated 1/20/25, showed the following:
-He/She used a wheelchair for mobility;
-He/She was at risk for falls due to an unsteady gait;
-He/She required staff assistance with transfers;
-He/She required extensive to total assistance with toileting, bathing, and dressing.

Review of an incident report dated 2/3/25 showed the resident had a fall on 2/2/25 at 9:40 P.M. in his/her room while staff were assisting him/her to bed.

During an interview on 2/10/25 at 11:30 A.M., Resident #1 said :
-Certified Nursing Assistant (CNA) B was assisting him/her to bed when he/she fell;
-CNA B did not use a gait belt;
-CNA B's hand was under his/her armpit;
-He/She tried to use a walker to pull himself/herself to a standing position;
-His/Her right leg gave out and he/she fell;
-He/She went to the hospital due to severe leg pain where he/she learned he/she fractured his/her leg and needed surgery;
-He/She would have to do rehab for several weeks before she could go back to her assisted living apartment;
-He/She had experienced quite a bit of pain since his/her fall;
-He/She had several falls in the past.

Review of a nurse's note dated 2/3/25 at 1:26 A.M. showed:
- Staff were assisting the resident to bed when the resident's leg "gave out" and the resident's leg

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A4777	Continued From page 2	A4777		

twisted with his/her knee underneath him/her;
-The resident was transferred to the hospital due to right knee/leg pain;
-X-ray showed the resident had a fractured femur (large bone of the upper leg) which required surgery.

During an interview on 2/7/25 at 1:42 P.M., Certified Nursing Assistant (CNA) B said:
-He/She attempted to assist Resident #1 to bed on 2/2/25 when the resident fell;
-He/She attempted to assist the resident to a standing position when the resident lost his/her balance and quickly fell to the floor;
-He/She did not use a gait belt;
-He/She had his/her right hand under Resident #1's arm, close to the resident's armpit;
-He/She knew the resident's care plan said he/she required assistance with transfers but the resident stood independently in the past.
-He/she hollered out to CNA A for assistance;
-He/she stayed with the resident while CNA A went and got additional staff to assist.

During an interview on 2/7/25 at 1:35 P.M., CNA A said:
-He/She had just finished answering another resident's call light when CNA B called to her for help;
-He/She went to Resident #1's room where he/she observed the resident on the floor;
-CNA B told him/her the resident fell while transferring from the wheelchair to the bed;
-CNA B stayed with the resident while he/she went to get additional staff to help assist the resident off of the floor.

During an interview on 2/7/25 at 1:15 P.M., Certified Medication Technician (CMT) A said:
-He/She just finished passing medications when

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A4777	Continued From page 3 CNA A came to him/her and said Resident #1 had fallen and was on the floor; -He/She went to the resident's room where he/she observed the resident on the floor; -Resident #1 complained of right leg pain; -CNA A, CNA B, CNA C and himself/herself used a mechanical lift to assist the resident off of the floor and into bed; -He/She then went and told Licensed Practical Nurse (LPN) A that Resident #1 had fallen and the four of them had assisted the resident off of the floor and into bed. During an interview on 2/7/25 at 1:20 P.M., LPN A said -He/She evaluated Resident #1 after the fall on 2/3/25; -When he/she arrived in the resident's room, the resident was laying in his/her bed; -Resident #1 was complaining of sever right knee/leg pain; -The resident was sent to the emergency room for evaluation where they discovered he/she had a fractured femur. During an interview on 2/7/25 at 2:30 P.M., the facility Administrator said: -He expected staff to assist Resident #1 with transfers according to his/her ISP; -A gait belt should have been used; -Placing one hand under the resident's arm was not considered adequate assistance. MO249065	A4777		

PLAN OF CORRECTION

Provider/Supplier Name:	Tifany Springs Senior Living
Street Address, City, Zip:	9101 N Ambassador Drive, Kansas City MO 64154
Date of Survey:	2-10-2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

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A4777	19CSR 30-86.014(36) Proper Care Per Individual Service Plan	
	Immediate actions taken for the resident found to have been affected include: Abuse prevention and prohibition policy reviews with all clinical staff All clinical staff have been educated on utilizing gait belt with transfers Clinical staff were educated on proper transfer techniques in accordance with each resident's individualized service plan. Clinical staff educated on locating and reviewing resident's individual service plans located at the nursing station. **Identification of other residents having the potential to be affected was accomplished by:** A full review of all residents requiring assistance with transfers is being conducted to identify those at risk of similar incidents. The Electronic Health Record and care plans are being audited to ensure that transfer requirements, including gait belt usage, were clearly documented. Staff conducted observational rounds to verify proper transfer techniques were being used with residents requiring assistance. **Actions taken/systems put into place to reduce the risk of future occurrence include:** Random audits will be conducted by the Director of Nursing (DON) or designee weekly for four weeks, then monthly for three months to observe staff during transfers and ensure compliance.	3/10/2025

	Any non-compliance will result in immediate re-education and corrective action. Extra gait belts placed at the nurse station **How the corrective actions will be monitored to ensure the practice will not recur:** The QAPI committee will review this plan of correction until such time consistent substantial compliance has been met as determined by the committee. Audit findings will be discussed by the QA committee and monitoring will be adjusted as determined by the QA committee.	

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.