STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265863	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Springs Rehabilitation & Health Care Cente	9191 N Ambassador Drive Kansas City, MO 64154

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46706 Based on interview and record review, the facility failed to perform life saving measures to include Cardio-pulmonary resuscitation (CPR) for one sampled resident (Resident #1) when staff found the full code resident without a pulse or respirations. Additionally, the facility failed to ensure the staff knew safety protocols and emergency procedures when Licensed Practical Nurse (LPN) A did not know where to locate the crash cart (a cart that contains emergency equipment). The facility census was 117. The administrator was notified on [DATE] at 4:51 P.M. of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor on-site verification. Review of the facility's Emergency Procedures/Cardio-Pulmonary Resuscitation Policy, revised, February 2022, showed: -Any unnecessary interruptions in chest compressions decreases the effectiveness of CPR; -If a resident is found unresponsive and not breathing normally, a licensed staff member will verify the code status using the medical record and if the resident is a full code per the medical record a staff member that is certified in CPR will initiate CPR; -Begin CPR if the victim is unresponsive and not breathing normally without assessing the victim's pulse; -Start chest compressions rather than opening the airway and delivering rescue breaths. Review of the facility's undated, Duties of the Licensed Practical Nurse, showed: -The LPN is responsible for ensuring the delivery of efficient and effective nursing care and achieving positive clinical outcomes in accordance with accepted standards of practice; -The LPN is responsible for resident care and direction of nursing care during assigned shift including staff assignments, mentoring and educating nursing personnel; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The principal responsibilities of the LPN are to ensure the physician orders are followed as prescribed, evaluates the effectiveness of care interventions, identifies problems and develops alternative interventions. Review of the facility's undated orientation plan for agency staff showed: -Nurses will be orientated to safety protocols, emergency procedures; -Nurses will be orientated to identification of code status, advanced directives and code status competency. Review of LPN A's Personnel filed showed: -No record of orientation to safety protocols, emergency procedures; -No record of orientation to identification of code status, advanced directives and code status competency. 1. Review of the Resident #1's Significant Change Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated [DATE], showed: -Moderate cognitive impairment; -Dependent on staff for Activities of Daily Living (ADLs); -Occasionally incontinent; -Diagnosis included cancer, high blood pressure, and arthritis. Review of the resident's care plan, dated [DATE], showed: -The resident had an ADL self-care performance deficit; -The resident was dependent on one staff for ADLs; -The resident had an advanced care directive; -The resident was not at or approaching end of life at this time; -The resident was a full code status (a medical directive that indicates if a person's heart stops beating or they stop breathing, life saving measures will be provided); -The resident's wishes will be honored. Review of the resident's medical record showed: -admitted [DATE]; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Full Code (CPR should be started) start date, [DATE]. Review of the resident's progress note, dated [DATE], showed: -The Director of Nursing (DON) said LPN A called him/her at 7:54 P.M., and said the resident had passed unexpectedly. The DON asked LPN A if the resident was a full code. LPN A said he/she thought the resident was on Hospice so she/he was a DNR. The DON told LPN A he/she would be right there. When the DON arrived on the resident's hall, CNA A and CNA B, told the DON the resident was a full code and they needed to start CPR and compressions right away. The DON entered the resident's room to assess him/her. The resident had no response to verbal or tactile stimuli, no respirations, no movement or pulse. The resident had a large amount of vomit covering his/her left side. The DON looked at the resident's medical record and verified he/she was a full code status. The DON told LPN A, CNA A, and CNA B to start compressions and the DON grabbed the crash cart. CNA A and CNA B were doing chest compressions and the DON was preparing the suction machine on the crash cart. The DON gave two breaths with the Ambu Bag (bag valve mask used to provide oxygenation and ventilation to a resident who is not breathing) and started suctioning out the airway of the resident. One milliliter of dark brown liquid matter was suctioned out of the resident's airway. CNA A and CNA B continued compressions while the DON and LPN A used the Ambu bag until EMS arrived and took over. Review of the facility's investigation, dated [DATE], showed: -On [DATE] LPN A entered the resident's room with CNA B and found the resident unresponsive; -LPN A assessed for vitals, but they were absent; -LPN A called the DON and checked the code status at 7:54 P.M.; -LPN A reported the resident was a full code, but had already passed; -The DON was in the facility and immediately came to the resident's hall; -The DON checked the resident who was breathless and pulseless; -The DON checked the code status of the resident while calling the regional nurse; -The DON then called 911 and initiated CPR at 8:00 P.M.; -EMS arrived and took over CPR; -EMS called time of death at 8:30 P.M. During an interview on [DATE] at 11:10 A.M., CNA B said: -He/She works for an agency that contracts with the facility and has been working at the facility for seven months. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On [DATE] he/she was across the hall from the resident's room in the bathroom and he/she heard the resident yelling and he/she went to check on the resident. He/She told LPN A the resident was yelling and might be in pain; -Between 7:45 P.M. and 7:50 P.M. he/she was standing at the back the nurses station and LPN A came out of the resident's room and said, the resident was not looking very good. -He/She and LPN A entered the resident's room; -The resident was in bed and looked pale and did not respond to touch or verbal stimulation; -He/She touched the resident on his/her arm and shoulder and called his/her name and the resident did not answer; -LPN A put the pulse oximeter (small clip-like device use to check a person's oxygen and pulse) on the resident, but LPN A did not have a stethoscope (medical instrument used to check the action of the heart and/or breathing) or any other instruments to take vitals or assess the resident; -The pulse oximeter had numbers on it; -LPN A checked the pulses in both of the resident's wrists; -LPN A left the resident's room and called the DON and asked him/her what the resident's code status was; -LPN A left the resident's room and did not initiate CPR and did not instruct CNA B to start CPR; -CNA A came down the hall to the resident's room; -CNA A told CNA B the resident is a full code and CPR should be started immediately; -CNA B told LPN A while he/she was on the phone with the DON the resident is a full code and CPR should be started; -LPN A told CNA B there was no use to start CPR the resident was already gone; -The DON came down the hall approximately six or seven minutes later and talked to LPN A and LPN A told the DON the resident was a full code; -The DON obtained the crash cart and instructed CNA B and CNA A to start chest compressions; -The DON used the Ambu bag to give rescue breaths; -The DON had to instruct LPN A on how to use the Ambu bag while trying to suction the resident's airway; -EMS arrived and took over life saving measures; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She told LPN A the resident was a full code multiple times and CPR should be started now; -LPN A kept telling the him/her the resident was deceased and it would not do any good; -CPR should be started immediately on a resident who is a full code. During an interview on [DATE], at 11:44 A.M., CNA A said: -Around 7:30 P.M. on [DATE] he/she went into the resident's room because he/she was yelling; -The resident had spit up some dark fluid and he/she told LPN A; -Approximately 25 to 30 minutes later CNA B was upset and told him/her the resident had passed away and he/she told LPN A the resident was a full code and CPR needed to be started and LPN A said it would not do any good, the resident was gone; -He/She questioned LPN A about not doing CPR on a full code resident and LPN A said it would not do any good, the resident was gone; -He/She told LPN A again the resident was a full code and CPR needed to be started and continued until EMS arrives; -LPN A told CNA A the resident had already passed, so it would not do any good; -The DON arrived on the hall and told CNA B and CNA A to start CPR and the DON grabbed the crash cart; -LPN A was the charge nurse and he/she followed LPN A's direction; -CPR should be started immediately on a resident who is a full code. During an interview on [DATE], at 8:38 A.M., LPN A said: -He/She is an agency nurse; -He/She had been at this facility three times; -He/She is CPR certified; -He/She had received no orientation from the facility on CPR or code status; -He/she did not know where the crash cart was located in the facility; -The facility had a problem with how to determine what a resident's code status is; -He/She has had trouble in the past at this facility determining residents' code status. Sometimes the code status in the chart will be for the resident who was previously in that room and not for the current resident; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Around 7:50 P.M., on [DATE] he/she checked on the resident, came out and told CNA B the resident did not look good and he/she needed help to reposition the resident; -LPN A and CNA B entered the resident's room and found the resident with eyes open and fixed, mouth open, and no respirations; -He/She said he/she felt for radial (wrist) pulses and pedal pulses (pulses in the foot) bilaterally and they were absent; -The resident's body was luke warm; -He/She could not remember if he/she checked for an apical (heart) pulse or checked for a carotid (neck) pulse; -He/She could not remember if he/she had a stethoscope with him/her; -He/She said the resident showed no signs of life; -He/She did not start CPR at that time, because he/she did not know the code status of the resident: -He/She went to the nurses desk and looked at the resident's medical record and found the resident was a full code and he/she did not start CPR or instruct CNA A and CNA B to start CPR; -He/She said he/she did not start CPR on the resident immediately after finding no signs of life because he/she was not clear on the code status of the resident; -He/She called the DON and within 7 to 10 minutes the DON arrived on the hall and started CPR. During an interview on [DATE] at 10:32 A.M., the DON said: -He/She was at the facility on [DATE] in his/her office when LPN A called him/her and said there had been an unexpected death at the facility and the resident was deceased ; -He/She arrived on the 100 hall approximately 5 minutes after receiving LPN A's call; -LPN A told him/her the resident was on Hospice and was a DNR code status and then LPN A told him/her the resident was actually a full code; -He/She grabbed the crash cart and instructed CNA A and CNA B to start chest compressions on the resident; -He/She had to show LPN A how to use the Ambu bag during the code; -He/She expected LPN A to know how to use the Ambu bag and how to give life saving measures; -He/She expected LPN A to know how to determine the resident's code status without a delay in care; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-CNA A and CNA B told him/her they were very upset because they told LPN A the resident was a full code and CPR needed to be started immediately and LPN A said repeatedly it won't do any good, the resident is already gone; -The code status is easily accessible in the resident's chart; -LPN A would have easy access to the code status easily at the computer at the nurses station that is next to the resident's room or on a lap top on the medication and treatment carts; -He/She expected LPN A to start CPR immediately or instruct CNA A and CNA B to start it; -He/She expected LPN A to know how to determine the resident's code status without delay in care and take control of the situation and instruct the CNA's to do chest compressions. -CPR should have been started immediately on the resident. Observation and interview on [DATE] at 10:32 A.M., showed: -LPN C said he/she worked for an agency and he/she picks up shifts on this hall; -LPN C said he/she was CPR certified; -LPN C said CPR should be started immediately on a resident who is a full code. During an interview on [DATE] at 10:44 A.M., LPN B said: -He/She is an employee of the facility; -He/She is CPR certified; -CPR should be started immediately a resident who is a full code. During an interview on [DATE] at 11:47 A.M., the Medical Director said: -He/She expects CPR to be started immediately on residents that are a full code; -He/She expects staff to know the code status of the residents; -He/She expects licensed staff to be orientated to safety protocols and emergency procedures of the facility; -He/She expected LPN A to perform CPR in the resident soon as the resident was found not breathing and no pulse. During an interview on [DATE] at 3:12 P.M. the Administrator said: -He/She expects all nursing staff to know where to find the code status of a resident; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She expects CPR to be performed immediately on residents who are a full code status when the resident is found with no signs of life; -He/She expects the nurses to know how to perform CPR and know how to direct staff in the event CPR is administered; -He/She expects licensed staff to be orientated to safety protocols and emergency procedures of the facility; -LPN A should have started CPR first before calling the DON; -He/She expected LPN A to initiate CPR immediately and direct CNA A and CNA B after the resident was found with no signs of life. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. 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 violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). MO# 237591 MO# 237642