

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265863	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Tiffany Springs Rehabilitation & Health Care Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their Cardiopulmonary Resuscitation (CPR) Policy and failed to follow the documented wishes for Resident #1, when a Licensed Practical Nurse (LPN) performed CPR on the resident when the resident had a documented and physician signed Do Not Resuscitate (DNR) order. The facility census was 111. Review of the facility policy titled, Cardiopulmonary Resuscitation, dated 03/2025 showed if a resident was found unresponsive and no breathing normally, a clinical staff member will verify code status using the clinical record. If the resident is a DNR, per medical record, notify the attending provider. Review of the facility policy titled, Resident Rights, dated 12/2024 showed each resident residing in this community has the right and will be afforded the right to a dignified existence, and self determination. Each resident will have autonomy and choice, about how each resident wishes to live his/her everyday life and receipt of care. Review of Resident #1's face sheet showed:-admission date of [DATE]; -The resident was his/her own responsible party; -Diagnoses included: Chronic Obstructive Pulmonary Disease (COPD: lung disease that restricts airflow, causing coughing/wheezing/breathing difficulty), Congestive Heart Failure (CHF), pain and difficulty walking. Review of the resident's Comprehensive Care Plan dated [DATE] showed the resident was not near his/her end of life, but his/her Advance Directives will be honored. Review of the resident's Electronic Medical Record (EMR) showed an Out of Hospital Do Not Resuscitate Form signed by the resident on [DATE] and signed by the resident's primary care physician on [DATE]. Review of a nurse progress note dated [DATE] at 10:59 A.M. showed: -Upon entering the resident's room at 9:40 A.M., the resident was unresponsive in his/her wheelchair;-A sternal rub (rubbing the knuckles up and down the breast bone to obtain a pain response in an unresponsive person) was done, without any response; -Resident #1 had no pulse and no respirations; -The resident was placed on the floor at 9:42 A.M. by four staff members; -Licensed practical Nurse (LPN) A started CPR at 9:43 A.M.;-Emergency Medical Services arrived at 9:55 A.M., the resident had a heart rate of 83 beats per minute (BPM, normal range 60-100 BPM) and Blood Pressure of 146/60 Normal range 90/60- 120/80); -The resident was transported to an area hospital at 9:58 A.M During an interview on [DATE] at 12:54 P.M. LPN A said:-He/She was CPR certified; -He/She entered the resident's room at 9:40 P.M. on [DATE] to provide a skin treatment;-He/She found the resident sitting in the wheelchair, head bent down and unresponsive, without breath and without a pulse; -He/She yelled for help; -He/She performed a sternal rub without any response from the resident;-He/She checked the resident's wrist and neck for a pulse and did not feel any; -He/She, with assist of other staff, laid the resident on the floor and he/she started chest compressions; -One staff member called 911, one staff member brought the crash cart to the resident's room; -He/She completed 30 chest compressions, checked for pulses, found none and completed another 30 chest compressions where the resident was found to have a pulse; -At 9:55 A.M. the ambulance arrived to the facility and the resident was transported to the hospital at 9:58 A.M.;-He/She had one-on-one education after providing CPR to a resident with a DNR; -He/She should have checked the resident's medical record for code status prior to starting CPR; -He/She panicked and started CPR without checking the (continued on next page)</p>		

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>medical record; -He/She was not trying to harm the resident; -His/Her first instinct was to try to save the resident;-Code status can be found in the electronic medical record or a notebook on the crash cart. During an interview on [DATE] at 12:00 P.M. LPN B said:-Each resident's medical record should be checked to determine if the resident code status was a DNR or full code, prior to starting CPR; -There is a notebook on the crash cart with a list of residents and their code status; -The notebook is updated every night on night shift; -He/She received education from the Director of Nursing on where to find if a resident if a full code or DNR on [DATE]. During an interview on [DATE] at 12:15 P.M. Registered Nurse (RN) A said:-Code status can be found in the resident's electronic record on their name banner, and the book on the crash cart; -The book on the crash cart is updated every night, but the electronic record is the most accurate; -He/She received education on the [DATE] about checking code status before beginning CPR. During an interview on [DATE] at 1:45 P.M. the Director of Nursing said she would expect staff to check a resident's code status prior to starting CPR. Education was provided on [DATE] to check code status prior to starting CPR. During an interview on [DATE] at 11:45 A.M. the Administrator said she expected staff to check code status prior to initiating CPR. LPN A reported he/she did not check the resident's code status, panicked and began CPR.Intake 2984555</p>		