STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265869	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McCrite Plaza at Briarcliff Skilled Facility	1301 Tullison Rd Kansas City, MO 64116

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to respect one resident's rights, when the facility performed Cardiopulmonary Resuscitation on Resident #1, when he/she had a signed Do Not Resuscitate order. This deficient practice affected one of four sampled residents. The facility census was 54. Review of the facility's, undated, Resident Rights Policy showed:- Each resident residing in the facility has the right and will be afforded the right to a dignified existence and self determination;-Each resident will have autonomy and choice to the maximum extent possible;-Resident rights include the right to request, refuse and/or discontinue treatment; -The right to end of life care that respect and follows the resident's stated goals and choices for care and service at the end of the resident's life.Review of Resident #1's admission Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) showed: -Some cognitive loss; -Need for partial assistance with Activities of Daily Living (ADLs: tasks completed in a day to care for oneself). -Diagnoses of atrial fibrillation (Afib: irregular and sometimes rapid heart beat) hypertension, and chronic kidney disease.Review of the resident's comprehensive care plan dated [DATE] showed: Code status of DNR, honor his/her wishes.Review of the resident's physician order sheet for [DATE] showed: Code status: DNR (Do Not Resuscitate).Review of the resident's nurse progress notes showed:-[DATE] at 2:40 P.M. The resident was working with therapy, the resident complained of having no energy or strength. The resident slumped over and did not respond. The resident was placed on the floor and CPR was started. The Director of Nursing (DON) called Emergency Medical Services and the resident's family. DNR paperwork was found, CPR continued until EMS arrived at 3:05 P.M. and called time of death. At 4:56 P.M. an area funeral home was on site to pick up the resident.During an interview on [DATE] at 12:47 P.M. Licensed Practical Nurse (LPN) B said: -DNR paperwork was kept in a book at the nurses station; -DNR direction is also found in the resident's electronic medical record; -A picture of a butterfly or a heart should have been on the back of every resident door; -The butterfly signifies DNR and the heart signifies to perform CPR.During an interview on [DATE] at 1:00 P.M. Registered Nurse B said: -DNR paperwork was kept in a book at the nurses station;-The DNR book should be checked immediately when a resident is nonresponsive; -A picture of a butterfly or a heart could be found on the back of every resident door; -The butterfly signified DNR and the heart signified to perform CPR;During an interview on [DATE] at 1:22 P.M. Registered Nurse (RN) A said: -He/She was the charge nurse for Resident #1 on [DATE]; -About 2:45 P.M. the resident was working with Therapy on toilet transfers and had complained he/she was too weak. RN A went to the room to assist with the transfer; -Resident #1 complained of weakness and right arm weakness; -Resident #1 slumped to the left side, was nonresponsive and his/her color was completely white; the resident was moved to lie on the floor. RN A checked the back of the resident's room door, found no butterfly or heart picture, and started CPR; -He/She told staff to get help; -When help arrived it was the DON, who had the DNR paperwork for the resident; -When EMS arrived they pronounced the resident deceased . During an interview on [DATE] at 1:59 P.M. Resident #1's Nurse Practitioner said: -Staff should not have performed CPR; The resident had a DNR; -The resident did not want CPR and staff should have followed his/her wishes; -He/She would expect staff to follow the resident's wishes for no CPR.During an interview on [DATE] at 10:04 A.M. the Director of Nursing said: -He/She would expect staff to check the electronic medical record first, and the DNR book prior to initiating CPR; -Signs in the residents rooms should not be the only indicator to begin or not begin CPR; -He/She would expect staff to honor the resident's wishes. Incident 1783011