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	03/03/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to safely transfer one of two sampled residents (Resident #1) when staff were not aware the resident required transfer with a mechanical lift and a staff member transferred the resident with a gait belt. This affected one resident out of two sampled. The facility census was 47. Review of the facility's undated Safe Lift, Transfer and Repositioning Policy showed:-Manual lifting of any and all residents who are unable to bear weight will be limited to use of mechanical lift;-Residents identified as totally dependent or extensive assistance will be transferred by means of mechanical lift with the aid of a full body sling rather than by manual lift/assist;-The comprehensive Nursing assessment and MDS section G will be the primary nursing assessment tools for determination of each resident's need for assistance and transfer activities;-The care plan will be reviewed and revised on a continual basis;-The administrator is responsible to facilitate and ensure in-services and training is timely and complete with documentation of all training;-Nursing Supervisors are to ensure all residents, including new and those with change of condition, are assessed for appropriate lift and transfer assistance;-Direct staff are responsible to use proper techniques during resident handling tasks;-Notify supervisor of resident change in condition which might necessitate a re-evaluation of the resident and lift use;-If the resident's mobility or ability to assist varies throughout the course of the day or day to day, the varied ability will be noted in their care plan;-The determination of which lift to use will be documented in resident's care plan; The facility's undated Mechanical Lift Transfer Policy showed: residents who are unable to bear any weight will be transferred safely with a mechanical lift (a device used to support the body weight of a resident during transfers). Review of the facility's undated Use of Transfer Belt/Gait Belt policy showed:-Ensure the resident has appropriate footwear and their feet are on the floor prior to transferring;-Stand in front of the resident;-Position one hand on either side of the gait belt with underhand grip and assist resident to move forward until their feet are touching the floor; -For a pivot transfer, place one hand on each side of the buckle;-Assist the resident to a standing position;-When activity complete, return resident to place of their choice and assist them to a comfortable, safe position. Review of Resident #1's Quarterly Minimum Data Set, (MDS, a federally mandated assessment tool completed by facility staff) dated 2/11/26, showed:-Severe cognitive impairment;-Maximum assistance needed with sit to stand task;-Resident non-ambulatory;-Resident received scheduled pain medication;-Diagnoses included Non-Alzheimer's Dementia, traumatic brain injury and heart disease. Review of the resident's care plan dated 2/25/26, showed:-Resident had potential for pressure ulcer development related to immobility;-Resident was a high risk of falls related to deconditioning, gait/balance problems;-Staff to ensure call light within reach and encourage resident to use;-No documented staff interventions on how to transfer resident. Observation of Resident #1 during a transfer on 02/26/2026 at 7:55 P.M., showed:-Certified Nursing Assistant (CNA) D applied gait belt by sliding it down the back of resident's head and along his/her spine. -CNA C looped his/her right arm through resident's right arm and grabbed gait belt with left hand, behind resident's back. CNA D looped his/her left arm through resident's left arm and grabbed gait belt at patients back with right hand. CNA D did a countdown from three, CNA C and CNA D lifted the resident (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and pivoted him/her onto the edge of the bed, during the transfer, CNA D stumbled kicked the wheelchair, propelling it backwards, causing CNA D to set the resident on bed with excessive force; -Resident moaned during transfer;-Resident was not asked to scoot forward, nor was his/her feet on the floor.-The resident was not transferred in a safe manner and not accordingly to the facility's safe lift and transfer policy. During an observation and interview on 02/27/2026 at 2:30P.M., CNA D said:-Transfer statuses of residents are on the 24-hour report sheet and that it should always be correct;-He/She is unaware of who updates the transfer statuses of residents;-He/She believed Resident #1 was a one-person transfer, but for safety reasons, he/she prefers to use two people to transferring Resident #1;-During a transfer, if a resident can bear weight, his/her feet should touch the ground. -CNA D was unaware that mechanical lift was already in the resident's room or that hospice staff had provided the equipment for the resident for staff to utilize. During an interview on 2/27/2026 at 3:10P.M., DON said:-Transfer statuses of all residents are in their EMR and are easily accessible by all nursing staff;-The Interdisciplinary Team updates resident's transfer statuses and changes are documented/updated as needed;-If a resident is unable to bear weight in legs, he/she should be transferred with a mechanical lift;-During a stand pivot transfer, the resident's feet should remain on ground;-Staff should not loop his/her arms into resident's arms and lift at armpit level; During an interview on 03/03/2026 at 8:15A.M., the Administrator said:-A resident that is listed as a two-person transfer should be able to bear weight on his/her feet and his/her feet should touch the ground during transfer;-Staff should not lift residents by the arms;-Residents that are totally dependent on staff to lift them during transfer should be transferred with a mechanical lift;-Transfer and mobility status changes should be updated in the resident's care plan so staff know what type of transfer is needed. Intake 2737751

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to prevent an avoidable medication error which resulted in the hospitalization of one resident (Resident #1) when facility staff administered insulin to a resident who was not a diabetic. The resident was admitted to the hospital with a diagnosis of hypoglycemia (low blood sugar; a direct effect of insulin administration) and received D10 (intravenous fluids with added dextrose). The resident was diagnosed with acute metabolic encephalopathy (a reversible brain dysfunction caused by a metabolic imbalance or toxicity) due to accidental insulin administration. This affected one resident out of two sampled. The facility census was 47. Review of the facility's undated Medication Administration policy showed:-All medication passes will follow accepted practice-Rights of Medication Administration including administering medication to the right person;-Each resident will be free from unnecessary drugs, defined as: without indications for use. 1.Review of Resident #1's Quarterly Minimum Data Set, (MDS, a federally mandated assessment tool completed by facility staff) dated 2/11/26, showed:-Severe cognitive impairment;-Maximum assistance needed with sit to stand task;-Resident was non-ambulatory;-Resident received scheduled pain medication;-Diagnoses included Non-Alzheimer's Dementia, traumatic brain injury, and heart disease. Review of the resident's care plan, dated 2/25/26, showed:-Resident had the potential for pressure ulcer development related to immobility;-Resident was a high risk of falls related to deconditioning, gait/balance problems;-Staff to ensure call light was within reach and encourage resident to use;-No documented staff interventions regarding diabetes management or care. Review of the resident's nursing progress note, dated 02/06/2026 at 8:13P.M., showed:-At 6:47P.M., Licensed Practical Nurse (LPN) A assisted Certified Nurse's Assistant (CNA) L with putting resident to bed;-CNA A was told by CNA B that the resident they were assisting to bed was Resident #2;-CNA B went into resident's room to verify that it was Resident #2 and CNA B confirmed that the resident was Resident #2;-LPN A assessed resident's blood glucose by performing a finger stick procedure with a reading of 142 and administered 20 units of Insulin Glargine, a long-acting insulin;-LPN A then went to verify identity of Resident #1 with Certified Medication Technician (CMT) and it was discovered that the residents had been placed in the wrong beds and LPN administered insulin to the wrong resident;-LPN A notified the residents physician, facility staff, and family per facility protocol and the physician instructed to send the resident to the hospital if blood sugar dropped below 110.-The resident was sent to the hospital at 7:40 P.M. for monitoring of blood sugar levels when blood sugar reading dropped to 104 , IV fluids, and evaluation by physician. Review of the resident's progress note, dated 02/07/2026 at 1:49A.M., showed that the resident was admitted to the hospital with a diagnosis of hypoglycemia (low blood sugar; a direct effect of insulin administration). Review of the hospital physician's history and physical of the resident, dated 02/06/2026, showed:-The resident was placed on D10 IV fluids (intravenous fluids with added dextrose);-The resident was diagnosed with acute metabolic encephalopathy (a reversible brain dysfunction caused by a metabolic imbalance or toxicity) due to accidental insulin administration. Review of facility's undated Medication Error investigation showed:-LPN A verified resident identity with 2 CNAs;-CNA A reported that CNA B confirmed identity of Resident #2 several times;-CNA B was not sure of the identity of the resident he/she confirmed identity of;-LPN A was advised to ask the resident and other staff members to verify resident identity;-LPN A was not allowed to work at facility again. During an interview on 02/27/2026 at 1:45P.M., LPN A stated:-He/She attempted to confirm resident's identity with two staff members as well as the resident;-The resident was unable to identify self;-The resident was identified as Resident #2 by CNA A and CNA B prior to medication administration;-He/She used the CNA's tablet to better visualize the resident's picture in the electronic medical record and compare to the resident in the bed; -No residents on the unit wear identifying arm bands;-After discovery of medication error, all parties were notified and orders followed. During an interview on 2/27/2026 at 3:10 P.M., DON (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	stated:-If resident is not able to confirm own identity, staff are to ask another staff member to verify;-Resident pictures are updated on as needed basis, no policy or procedure regarding updating of resident pictures on EMR (Electronic Medical Record). During an interview on 03/03/2026 at 8:15A.M., the Administrator stated:-There is no facility policy on how often and who is to update resident pictures in electronic charting system;-There are no names on doors unless resident chooses to place their own;-Resident #1 was placed in Resident #2's bed after CNA A confirmed identity of resident with CNA B. Intake 2737751