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	12/02/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to follow facility policy by not securing one resident's (Resident #1) controlled substance (substances with high probability for physical and/or psychological dependence), resulting in the loss of the controlled substance. The facility census was 44.On 12/2/25, the Administrator was notified of the past noncompliance incident which occurred on 10/27/2025. On 10/28/25, facility administration was notified of the incident, an investigation immediately began and corrective actions were implemented to include: Replacement of the medication and education of all licensed staff regarding signing in and securing delivery of narcotic mediation. The noncompliance was corrected on 11/5/2025.Review of the facility's undated Medication Administration Policy showed all medications will be administered to every resident as ordered by a physician in a safe and sanitary manner. Review of the facility's undated Documenting Administration of Controlled Substance policy showed:-It is the responsibility of the Nurse and/or Certified Medication Technician (CMT) administering a controlled substance to follow the appropriate policy to ensure proper documentation and count of controlled substances;-Check in order to ensure the right resident, right drug, right dose, right route, and right time;-Pull the medication from the card and sign the medication out on the controlled drug record;-Take medication to the resident and administer the medication staying with the resident to ensure the resident takes the medication prior to leaving the room;-Immediately chart the medication was given in the Electronic Medical Record (EMR), chart appropriately, signing out on the controlled substance sheet alone does not meet the procedure of this medication pass;-It must be charted in the EMR to ensure there is proper and appropriate documentation in the EMR;-At the beginning and end of each shift the staff will complete the following: Count each number of medications on each card and liquids by milliliters for accuracy and sign off. Review of the facility's undated Controlled Medication Check In policy showed:-When the pharmacy delivers a controlled medication, the nurse accepting the medication will review delivery sheet for the list of controlled medications and verify quantity of medication on the card;-If medications are present and correct count, check mark next to medication, sign delivery sheet, copy delivery sheet and give one to pharmacy and one to medical records, write the count on the quantity received on the count sheet/date/and sign, put count sheet into the narcotic count binder, put medication directly into the locked box on the nurses med cart;-If the medication is not present, indicate that on the delivery sheet, sign the delivery sheet for other medications, copy delivery sheet and give one to the pharmacy and one to medical records, call pharmacy and inform them it wasn't delivered, note in the resident's chart it wasn't received;-It is the responsibility of the nurse on duty to ensure the procedure is followed, controlled medications are handled appropriately, and medications are accounted for;-If there is a discrepancy, please notify the Director of Nursing (DON) and/or (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator immediately. 1. Review of Resident #1's electronic medical record on 12/2/25 showed:-The resident's diagnoses included: Fracture of right femur, osteoporosis (a medical condition in which the bones become brittle and fragile from loss of tissue, typically as a result of hormonal changes, or deficiency of calcium or vitamin D), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing a significant impairment in daily life), pain, reduced mobility, falls, obesity (abnormal or excessive fat accumulation that presents a risk to health), anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen throughout the body). Review of the resident's admission Minimum Data Set (MDS, a federally mandated assessment completed by staff) dated 10/19/2025, showed:-The resident had adequate hearing, clear speech, makes self understood and understands others;-He/She scored 9 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly residents);-This score indicated moderately impaired cognition;-He/She received scheduled and as needed pain medication;-He/She reported frequent pain. Review of the resident's comprehensive care plan, dated 10/14/25, showed interventions related to high risk for falls, nutrition, pain related to right hip fracture with repair, and need for assistance with activities of daily living (ADLs). Review of the resident's pain care plan dated, 9/4/25 showed: -The resident received pain medication for chronic pain;-The staff were supposed to anticipate the resident's pain needs and respond to any complaints of pain. Review of the facility investigation on 12/2/2025, showed:-On 10/28/25, Registered Nurse (RN) A advised the DON Resident #1 had a missing card and narcotic count sheet for oxycodone (a highly addictive pain medication used to manage severe pain);-RN A attempted to pull and give Resident #1 an as needed dose of medication, but none was available;-RN A called the pharmacy and was advised that a card of 18 tablets of oxycodone 5 Milligrams (MG) was delivered to the facility on [DATE] and signed for by Licensed Practical Nurse (LPN) A;-The pharmacy and the facility administrator were notified of the missing medications;-The physician was notified of the missing medications and provided a new prescription and the facility provided for replacement medications;-Camera footage from the night of 10/27/25 into 10/28/25 was reviewed by facility administration but no information was gathered;-All medication carts and medication lock boxes were searched but the missing medication was not recovered;-LPN A was suspended pending investigation;-All nurses working at the time the medication was noted missing (RN A, LPN A, and LPN B) were drug tested for narcotic medications, and all tested negative;-All nurses and certified medication technicians (CMTs) were in-serviced about signing in and administration of narcotic medication;-LPN A received education and returned to work at the facility on 11/6/2025. Review of the resident's October 2025 physician orders showed an order for oxycodone 5MG, give one tablet by mouth every four hours as needed for pain. Review of the pharmacy delivery sheet dated 10/27/25 showed one card of 18 tablets of oxycodone 5MG was delivered for the resident on 10/27/25 and signed for by LPN A. Review of RN A's statement dated 10/29/25, showed:-The resident asked for a pain pill the afternoon of 10/28/25;-RN A looked in the medication cart and the card of medication was not there;-RN A had worked on ordering some of the oxycodone on 10/27/25 as the resident had taken the last pill in that card;-RN A looked in the medication safe and the medication was not there;-RN A then called the pharmacy, who advised the medication was delivered to the facility the night of 10/27/25 and signed for by the night nurse, LPN A;-RN A searched the nurse medication cart, CMT medication cart and the other's nurses medication cart and the missing card of medication was not located;-RN A reported the missing medication to the DON. Review of LPN B's statement dated 10/29/2025, showed:-LPN B worked the night of 10/27/25 on the opposite hall of LPN A;-When the pharmacy (continued on next page)

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