STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265803	A. Building B. Wing	07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foxwood Springs Living Center	1500 West Foxwood Drive Raymore, MO 64083

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 22727 Based on interview and record review, the facility failed to notify the resident's responsible party to obtain consent prior to starting a new medication for one sampled resident (Resident #2) out of three sampled residents. The facility census was 88 residents. The Director of Nurses (DON) and the Administrator were notified on 7/9/24 of Past Non-Compliance which occurred on 5/10/24. All nursing staff were in-serviced on notification of responsible parties on 6/21/24. The deficiency was corrected on 6/21/24. Review of the facility's policy titled Charting and Documentation dated July 2017 showed: -Any changes in the resident's condition shall be documented in the resident's medical record. -Documentation should include notification of the family. 1. Review of Resident #2's undated admission record showed the resident had a Durable Power of Attorney (DPOA) and had a diagnosis of dementia (a progressive mental disorder characterized by memory problems, impaired reasoning, and personality changes). Review of the resident's care plan dated 2/10/23 showed: -The resident had dementia. -Special instructions the resident's DPOA wanted to be contacted for any medication changes. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 5/3/24 showed the following staff assessment of the resident: -Severely cognitively impaired. -Had a diagnosis of dementia. Review of the resident's psychiatry/medication progress note dated 5/7/24 showed: (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The visit was for follow-up on the resident's behaviors. -The resident had a diagnosis of dementia. -New orders included: --Add Memantine (cognition-enhancing medication used to treat dementia by decreasing abnormal activity in the brain, which can slow down the decline of one's thinking, memory and reasoning) 5 milligrams (mg) every morning for one week, then increase to 5 mg twice a day, then increase to 10 mg every morning and 5 mg at bedtime and then 10 mg twice a day for behaviors related to dementia. Review of the resident's psychiatry/medication progress note dated 5/15/24 showed: -The visit was for follow-up on the resident's behaviors. -New orders included: --Increase Memantine to 5 mg twice a day the next week and weekly thereafter. --Increase Memantine to 10 mg every morning, 5 mg at bedtime and then 10 mg twice a day for behaviors related to dementia. Review of the resident's Medication Administration Record (MAR) dated May 2024 showed the resident received: -Memantine 5 mg at bedtime for dementia 5/10/24-5/15/24. -Memantine 5 mg at bedtime for dementia 5/30/24-5/31/24. -Memantine 5 mg twice a day for dementia 5/16/24-5/29/24. -Memantine 5 mg in the morning for dementia on 5/30/24. -Memantine 10 mg in the morning for dementia on 5/31/24. Review of the resident's MAR dated June 2024 showed the resident received: -Memantine 10 mg in the morning for dementia 6/1/24-6/17/24. -Memantine 5 mg at bedtime for dementia 6/1/24-6/16/24. Review of the resident's communicate note dated 6/17/24 showed: -The resident's DPOA was notified of a new order for Memantine and one other medication. -The resident's DPOA did not approve of the recommended medications. Review of the resident's communication note dated 6/21/24, documented by the DON showed: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A conference call was held with the resident's DPOA. -They discussed the DPOA's grievance filed regarding not being notified when medication changes were made. Review of the facility's in-service education form dated 6/21/24 showed the facility's nurses were educated on notifying families of changes. During an interview on 7/9/24 at 11:19 A.M., Licensed Practical Nurse A said: -The charge nurse should have notified the resident's DPOA when a new physician's order was given for a new medication. -The resident's DPOA usually declined any recommendations for new medications. During an interview on 7/9/24 at 11:50 P.M., the Administrator said (with the DON present): -The resident's DPOA notified him/her that the resident was prescribed and administered a medication without notifying him/her. -The charge nurses were in-serviced on 6/21/24 of their responsibility for notifying DPOAs of recommended medication changes. During an interview on 7/9/24 at 12:23 P.M., the DON said: -The psychiatrists did not enter their orders into the electronic health record but gave verbal orders to the charge nurses. -The charge nurse at the time of the verbal order was responsible for contacting the resident's DPOA. -The ADON in-serviced all the charge nurses on 6/21/24 that they should contact the DPOA regarding any medication changes. -They also developed a form to obtain consent for an evaluation by the psychiatry group and to receive treatment recommendations. During an interview on 7/9/24 at 2:00 P.M., the resident's DPOA said: -The facility did not notify him/her prior to administering Memantine, which was a new medication for the resident. -He/She found out about the new medication when he/she received the resident's pharmacy bill on 6/17/24. -He/She informed facility staff at that time that he/she had not approved the administration of Memantine and wanted it discontinued. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00237772