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	10/22/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 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 ensure the physician's order for a narcotic medication was accurately shown on the narcotic sheet and Medication Administration Record (MAR); failed to ensure the nurse accurately documented narcotic medications administered on the MAR; and failed to ensure the policy and procedure for corrections made on the narcotic sheet were followed for one sampled resident (Resident #4) out of 8 sampled residents. The facility census was 92 residents. Review of the facility's Administering Oral Medication policy and procedure dated October 2010, showed the purpose was to provide guidelines for safe administration of oral medications. The policy showed the staff should:-Verify that there is a physician's order for the medication.-Place the MAR within easy viewing distance.-Unlock the medication cart and select the drug from the unit dose drawer.-Check the label on the medication and confirm the medication name and dose with the MAR.-Check the medication dose. Re-check to confirm the proper dose.-For narcotic medication, check the narcotic record for the previous drug count and compare with the supply on hand. Report any discrepancies to the nurse supervisor.-If the medication falls to the floor, discard and document. Repeat the preparation.-Follow the documentation guidelines.-Notify the supervisor if the resident refuses the procedure.-report other information in accordance with policy and procedure and professional standards of practice. Review of the facility's Documentation of medication Administration policy and procedure dated April 2007, showed the facility shall maintain a medication administration record to document all medications administered. the policy showed:-The Staff shall document all medication administered to each resident on the resident's MAR.-Administration of medication must be documented immediately after it is given.-Documentation must include at a minimum; the name and strength of each drug, date and time of administration, reason why the medication was withheld, not administered or refused; signature and title of the person administering the medication and resident response to the medication if applicable (for as needed medication, pain medication). 1. Review of Resident #4's Face Sheet showed the resident was admitted on [DATE] with diagnoses including gout (a complex form of arthritis that can affect anyone. It's characterized by sudden, severe attacks of pain, swelling, redness and tenderness), kidney failure, history of breast cancer and skin cancer, edema (swelling of the tissues, chronic pain, wounds, heart disease with heart failure, osteoarthritis (joint disease that causes the breakdown of cartilage, the smooth tissue that covers the ends of bones), and physical debility. Review of the resident's undated Physician's Orders Sheet showed physician's orders for:-Oxycodone 5 milligrams (mg), two tablets every two hours as needed for chronic pain (started 10/20/25).-Oxycodone 5 mg two tablets every four hours as needed for chronic pain (started 10/19/25). Review of the resident's MAR dated September 2025 showed:-A physician's order for Oxycodone 5 mg two tablets every two hours as needed for chronic pain (1/20/25).-The MAR showed the resident received Oxycodone on 9/13/25, 9/14/25 and 9/29/25. --NOTE: No documentation the medication was removed from the resident's Narcotic Record MAR on these dates. -The MAR did not show Oxycodone was administered on 9/23/25 or on 9/24/25 to the resident (these dates were left blank). The medication showed removed from the resident's Narcotic Record MAR on these dates. Review of the resident's Narcotic Record MAR showed a physician's order for Oxycodone 5 mg one tablet every four hours as needed for 30 days. It showed 30 tablets were delivered by the pharmacy. The date received showed 12/5/24. Amount received showed 30 tablets, but there was a handwritten 20 over the typed 30 tabs. Documentation showed the nurse documented the following administration:-9/23/25 at 2015 showed 2 was scratched through and 1 was documented beside it, leaving 18 tablets on the card. This was not documented on the MAR.-9/24/25 at 0015 showed 1 tablet was administered leaving 17 tablets on the card. This was not documented on the MAR.-9/25/25 at (no time documented) showed 2 tablets were administered, leaving 15 tablets on the card. This was not documented on the MAR. Review of the resident's medical record showed:-The resident's Narcotic Record showed the physician's orders on the Narcotic Record did not match the physician's orders on the resident's POS or MAR dated September 2025 and October 2025.-On the Narcotic Record, the number of tablets the pharmacy showed as delivered (30) was altered to show 20 tablets.-The MAR dated September 2025 did not show the resident was administered oxycodone on 9/23/25 or 9/24/25. Review of the facility Medication Count Sheet (nursing shift sign off sheets) showed nursing staff was instructed to document the name of the resident, name and strength of the medication, number of cards, number of narcotic count sheets, nurse initials (during the shift) and the verifying nurse initial. The inventory