| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265803 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Foxwood Springs Living Center | 1500 West Foxwood Drive<br>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 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give the resident's representative the ability to exercise the resident's rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42991<br><br>Based on interviews and record review, the facility failed to ensure a resident, who was not determined by a physician to lack the ability to make informed healthcare decisions, was provided with opportunities to make decisions in their best interest for the Care Plan process. This was evidenced by one (1) of three (3) residents sampled for participation in the Care Plan process (Resident #64).<br><br>Findings include:<br><br>Review of the facility's Advance Directives policy with a revision date of December 2016 revealed:<br><br>Policy Statement - Advance directives will be respected in accordance with state law and facility policy. Policy Interpretation and Implementation . 3. If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. 4. If the resident becomes able to receive and understand this information later, he or she will be provided with the same written materials as described above, even if his or her legal representative has already been given the information.<br><br>Review of Resident #64's Durable Power of Attorney (DPOA) for Health Care Decisions document revealed, I appoint the person named below to be my agent to make health care decisions for me when and only when I cannot make decisions or communicate what I want done.<br><br>Review of Resident #64's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated moderate cognitive impairment.<br><br>In an interview on 1/10/25 at 4:25 p.m., Social Worker #1 stated that Resident #64 was determined by his/her physician to lack the capacity to make informed healthcare decisions. Social Worker #1 stated that they did not document a decline in the resident's decision-making capacity, nor could they provide the physician's documentation about such a change.<br><br>(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 |
|---|---|---|---|
| | 265803 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Foxwood Springs Living Center | 1500 West Foxwood Drive<br>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 0551<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 1/10/25 at 4:30 p.m., Social Worker #2 stated that Resident #64 had a Durable Power of Attorney (DPOA) representative who was notified of healthcare concerns and asked to acknowledge changes in care and services. The surveyor asked Social Worker #2 why Resident #64 was not asked to participate in planning his/her care and to acknowledge changes in his/her care and services. Social Worker #2 stated that the resident was not able to participate in the planning of his/her care at the time, due to his/her cognitive status. Social Worker #2 stated that the decision-making authority of the DPOA representative was placed into effect upon the date of the resident's signature on the DPOA document and not after the resident's physician determined that he/she was no longer able to make informed healthcare decisions. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265803 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Foxwood Springs Living Center | 1500 West Foxwood Drive<br>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 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42991<br><br>Based on interviews and record review, the facility failed to ensure the Notice of Medicare Non-Coverage and the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage were acknowledged by the resident. This was evidenced for one (1) of three (3) residents sampled for Notice of Medicare Non-Coverage and the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (Resident #64).<br><br>Findings include:<br><br>Review of Resident #64's Durable Power of Attorney (DPOA) for Health Care Decisions documents revealed, I appoint the person named below to be my agent to make health care decisions for me when and only when I cannot make decisions or communicate what I want done.<br><br>Review of Resident #64's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated moderate cognitive impairment.<br><br>In an interview on 1/10/25 at 4:25 p.m., Social Worker #1 stated that Resident #64 was not notified of the determination of non-coverage, because the resident was determined by his/her physician to lack capacity to make informed healthcare decisions. Social Worker #1 stated they did not document that a decline had occurred in the resident's cognitive status, nor could they provide documentation that Resident #64's physician determined the resident was no longer able to make his/her own informed healthcare decisions - to include acknowledging the receipt of the Beneficiary Notice of Non-Coverage.<br><br>In an interview on 1/10/25 at 4:30 p.m., Social Worker #2 stated that Resident #64 had a Durable Power of Attorney (DPOA) representative who was making healthcare decisions on behalf of the resident. The surveyor asked Social Worker #2 why Resident #64 was not asked to participate in his/her own healthcare decision-making - to include being informed of and acknowledging receipt of the Beneficiary Notice of Non-Coverage. Social Worker #2 stated that Resident #64 was not able to do so at the time due to his/her cognitive condition. Social Worker #2 stated that the decision-making authority of the DPOA representative was placed into effect upon the date of the resident's signature on the DPOA document and not after the resident's physician determined that he/she was no longer able to make informed healthcare decisions. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265803 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Foxwood Springs Living Center | 1500 West Foxwood Drive<br>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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16683<br><br>Based on observations, interviews, and review of the facility's cleaning checklist, the facility failed to maintain the physical environment in a safe, clean, comfortable and homelike manner on 200 Hall for two (2) residents who resided on this hall (Resident #48 and Resident #53), and failed to maintain in a safe, clean manner a lounge area and ice machine shared by residents from both 100 and 200 Halls. The combined census on the 100 and 200 Halls on 1/7/25, the first day of the survey, was 45.<br><br>Findings include:<br><br>During the initial tour of 200 Hall on 1/7/25, beginning at 12:55 p.m., observation found the carpeting on the hall was not clean, with small pieces of paper trash, small fragments of gauze, and debris noted throughout the length of the hallway from one (1) end of the residential corridor to the other. The carpeting on this hall was found to be in the same state when observed throughout the rest of the afternoon on 1/7/25 and throughout the day on 1/8/25.<br><br>An observation was made of Resident #48's semi-private room in the presence of a visiting family member at 1:01 p.m. on 1/7/25. At the time of the observation, Resident #48 was sitting upright in a specialty chair at bedside facing the TV as the visitor sat on the edge of Resident #48's bed. When asked if he/she had any concerns regarding care and/or services, Resident #48 shook his/her head no. When asked if the visitor had any concerns, the visitor pointed to trash on the floor (including cotton balls), expressed concern about the cleanliness of the room, and stated he/she would usually just pick up the trash himself. Further observation found trash under the center of Resident #48's bed and several pillows under the head of Resident #48's bed by the wall.<br><br>An observation was also made of the other half of Resident #48's semi-private room, which was occupied by Resident #53, who was out of the room at the time of this observation. This observation found trash on the floor in front of the foot of Resident #53's bed, as well as a cushion (labeled with Resident #53's name) on the floor under a wooden armchair positioned next to the sink and across from the foot of Resident #53's bed.<br><br>At 10:36 a.m. on 1/8/25, a repeat observation was made of the room shared by Resident #48 and Resident #53. This observation found the floor on Resident #53's side of the room was not clean, with trash, equipment (including the seat cushion labeled with Resident #53's name), and debris on floor under the sink and furniture. Trash was also observed on the floor at the foot of Resident #48's bed (including cotton balls) and pillows and paper trash under Resident #48's bed.<br><br>Beginning at 9:15 a.m. on 1/10/25, a tour was conducted of the shared lounge located across from the nursing station and at the juncture of 100 Hall and 200 Hall. This tour was conducted in the company of the Assistant Director of Nursing (ADON). When asked what this space was called, the ADON stated he/she always referred to as the common area. The common area was divided into a living room area (with a TV, tables, and chairs on vinyl plank flooring) and a sunroom area (with potted plants, floor-to-ceiling window panels, [NAME] tile flooring, and a door to an outside courtyard). During this tour, the following concerns were noted:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265803 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Foxwood Springs Living Center | 1500 West Foxwood Drive<br>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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - A disposable exam glove was under rear wheel of the medication cart parked by the piano; in the living room area;<br><br>- Accumulations of dirt were seen in the corners of walls and behind the potted plants in the sunroom area;<br><br>- Heavy accumulations of dust were found along the top surfaces of wooden chair rail molding along the walls of the perimeter of the common area; the dust was easily removed with rubbing by a finger;<br><br>- The wooden baseboards around the perimeter of the common area, including in the sunroom area, had heavy accumulations of dust; the dust was easily removed with rubbing by a finger;<br><br>- The [NAME] tile flooring in the sunroom area was generally clean, except within about two (2) inches of the wooden baseboard, where the tile was noticeably discolored;<br><br>- Multiple cobwebs were noted in the corners of the frames of the floor-to-ceiling windows in the sunroom area, in the corners of the walls and floors, and stringing from a wall-mounted light sconce to the frame and the automatic closing device on the adjacent door leading into a courtyard, which was marked with signage stating: NO PUBLIC USE and THIS IS NOT AN EXIT;<br><br>- Dust build-up was on the bottom rungs of all the chairs placed around two (2) tables in the common area, which was easily removed with rubbing by a finger;<br><br>- Pieces of paper trash was found on the open floor, as was a bottle cap under an end table in the living room area; and<br><br>- The doorknob to a door labeled HOSPICE SUPPLIES ONLY was loose from the door and missing one (1) of two (2) screws intended to secure the doorknob to the door.<br><br>The above findings were verified by the ADON at the time of the observations, after which the observations were halted to allow the ADON to invite supervisors for the Housekeeping and Facilities (Maintenance) departments to join the tour.<br><br>A tour of the 200 Hall began at approximately 9:35 a.m. on 1/10/25, in the company of the ADON, the Facilities Director (who was supervisory over Housekeeping and Facilities), the Facilities Supervisor, and Housekeeping Supervisor #5, with the following concerns noted:<br><br>- The left-hand leaf of the double doors going from the Health Care Center to the Administrative Offices, which had been held open by a magnetic holder, was closed, and the surveyor pointed to heavy accumulations of dark-colored dust, debris and webbing in the corner of the floor behind the door as well as on all three (3) door hinges.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265803 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Foxwood Springs Living Center | 1500 West Foxwood Drive<br>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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - The ice machine located across from the nursing station was noted to be dripping water into the collection tray. On the front of the ice machine and on the collection tray were heavy accumulations of a white substance consistent in appearance with lime build-up, which was easily removed by scrapping with a fingernail. The vent on the left side of the ice machine was coated with an accumulation of dust. The polyvinyl chloride (PVC) piping leading from the left side of the machine to an air-gapped drain in the wall beside the machine was coated with a heavy accumulation of dust. The floor under the machine was not clean. When interviewed at the time of the observation, the Facilities Director confirmed it was the responsibility of Facilities staff to maintain the cleanliness of the ice machines.<br><br>- As the group traveled down the 200 Hall from the nursing station, accumulations of dust and debris were observed along the top edge of the wooden baseboards, the top edge of the backboard to the wooden handrails, and inside the wells of the handrails lining both sides of the hall.<br><br>- The surveyor commented to the accompanying staff that the carpets looked clean today, but they were visibly soiled with pieces of trash and debris on Days 1 and 2 of the survey. The Housekeeping Supervisor confirmed the expectation that the carpets in the hallways were to be vacuumed daily. At 9:39 a.m. on 1/10/25, the surveyor released the left-hand leaf of the double doors between rooms [ROOM NUMBERS] to examine the carpeting behind the previously closed door. On the carpeting were multiple pieces of debris which were yellow-orange in color with an appearance consistent with food particles.<br><br>- Examination of a resident room whose occupant was not present (room [ROOM NUMBER]) found the open floor of the room to be generally clean, but the floor between the wall and the wardrobe near the window was found to have debris and a large particle of food (possibly a cookie) visible just inside the opening to that space. Examination of the vent to the packaged terminal air conditioner (PTAC) unit found an accumulation of debris inside the unit. The bottom rung of a wooden armchair (identical to the chairs seen in the common area) was found to have a heavy accumulation of dust easily removed with rubbing by a finger.<br><br>- A framed picture in the hallway outside of room [ROOM NUMBER] was tested for cleanliness, by running a finger across the top of the frame. This resulted in finding a heavy accumulation of dust.<br><br>- Debris, including a piece of medical tape with writing on it, was noted within the well of the handrail outside of room [ROOM NUMBER].<br><br>- The left-leaf of the double doors across from a door labeled HOUSEKEEPING CENTRAL STORAGE was released from the magnetic hold-open device. Examination of the carpeted flooring behind where the door had been held open against the wall found the carcass of a large, winged insect on the floor, as well as a heavy accumulation of debris in the corner behind the door.<br><br>All the above findings were verified by all staff members accompanying the surveyor at the time of the observations.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265803 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Foxwood Springs Living Center | 1500 West Foxwood Drive<br>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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | At 9:51 a.m. on 1/10/25, the surveyor asked the Facilities Director and Housekeeping Supervisor #5 about expectations for cleaning residents' rooms. They reported that at a minimum, on a DAILY basis, the residents' rooms were to be dusted, sinks cleaned, and floor swept and mopped (including under beds, sinks, and easily movable furniture, such as an armchair). When asked about routine cleaning of the hallways, they reported that the carpeting in the hallways was to be vacuumed daily and the handrails dusted/wiped down daily, including inside the wells of the handrails.<br><br>At approximately 9:55 a.m. on 1/10/25, the surveyor knocked on the door to Resident #48's room and obtained permission from his/her to enter and examine his/her room in the company of the same facility staff. Upon entering the room, the surveyor noted the open floor of the room had been swept and mopped, but on the floor under the head of Resident #48's bed were three (3) bed pillows. Under the wooden armchair beside the sink across from the foot of Resident #53's bed was the seat cushion labeled with Resident #53's name. The surveyor reported to the facility staff having observed pillows under Resident #48's bed on Day 1 and Day 2 for the survey, as well as trash on the floor around Resident #48's bed, including paper trash and cotton balls. Upon exiting Resident #48's room, the ADON reported the cotton balls were likely used to obtain the resident's capillary blood glucose levels, and the ADON re-entered the room to remove the pillows from the floor.<br><br>At approximately 10:00 a.m. on 1/10/25, the surveyor asked the Facilities Director and Housekeeping Supervisor #5 for the facility's policies and procedures for cleaning the resident rooms and common areas, as well as any cleaning schedules, cleaning checklists that had been completed during the current week, and the schedule as worked for the Housekeeping Department for the week of the survey (1/7/25 through 1/10/25). The Facilities Director stated he/she was not sure whether such policies and procedures existed, but they did have a sheet on each housekeeper's cart that provided direction to staff on what was to be cleaned and how often.<br><br>At 10:24 a.m. on 1/10/25, the Facilities Director presented a two-page document titled Health Center and stated, These tasks are to be done daily. No policies or procedures, completed cleaning checklists, or a copy of the Housekeeping Department's schedule as worked for the current week were provided.<br><br>Review of the document titled Health Centered contained the following (quoted verbatim):<br><br>Clean and disinfect all high touch surfaces to include door knobs, key pads hand rails, faucets, crash carts etc.<br><br>100 Hall<br><br>__ Clean Nurses Stations Daily (Sweep, Mop, Trash & Clean Counters)<br><br>__ Clean Med-Room Daily (Sweep, Mop, Clean Counters & Sink)<br><br>__ Clean Both Offices Daily (Sweep, Mop, Trash & Clean Counters)<br><br>__ Clean Soil Utility Room Daily (Sweep & Mop & Clean Sink)<br><br>__ Clean Linen Room Daily (Sweep & Mop) NOTHING ON TOP SHELVES!<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265803 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Foxwood Springs Living Center | 1500 West Foxwood Drive<br>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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | __ Clean Supply Room (Sweep & Mop) Daily<br><br>200 Hall<br><br>__ Clean Beauty Shop Daily (Sweep, Mop, Trash, Clean All Counters, Bathroom, & Mirrors)<br><br>__ Clean Soil Utility Room Daily (Sweep, Mop & Clean Sink)<br><br>__ Clean Ice Maker 2X [twice] A Daily<br><br>__ Clean Linen Room Daily (Sweep & Mop) NOTHING ON TOP SHELVES!<br><br>__ Clean HCC [Health Care Center] Lounge Daily (Sweep, Trash, Wipe Down Tables & Chairs, MOP 3X [three times] A Week)<br><br>__ Clean Restorative Therapy 2X A Week (Vacuum, Wipe Down Table, Trash)<br><br>__ Clean Chaplains Office 1X A Week (Vacuum, Wipe Down Tables, Trash, Dust)<br><br>__ Deliver Morning & Afternoon Personals (11AM & 2PM)<br><br>Clean and disinfect all high touch surfaces to include door knobs, key pads hand rails, faucets, crash carts etc.<br><br>Monday - Clean handrails on beds, overhead lights & glove boxes<br><br>Tuesday - Pull out nightstands and beds, sweep & mop behind them.<br><br>Wednesday - Dust all furniture and sprinkler heads and vents.<br><br>Thursday - Clean blinds & window sills<br><br>Friday - Clean janitor cart & closet. Clean floor sink, sweep & mop.<br><br>When interviewed again at 3:20 p.m. on 1/10/25, the Facilities Director confirmed there were no policies or procedures for cleaning the resident rooms or common areas and that a copy of the checklist identified above was kept on each housekeeping cart as a reference tool only. The Facilities Director confirmed that the checklist was not actually filled out by housekeeping staff each day, turned in, or retained. When asked how the facility verified that the tasks identified on the checklist were being completed at the frequencies specified, the Facilities Director stated it was the responsibility of the Housekeeping Supervisor to do spot checks daily. According to the Facilities Director, [He/She, referring to Housekeeping Supervisor #5] is supposed to 'spot check' at least one (1) room on every hall every day. The Facilities Director acknowledged that additional monitoring was indicated in view of the findings made during a tour of 200 Hall and the lounge or common area shared by the residents on 100 Hall and 200 Hall. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265803 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Foxwood Springs Living Center | 1500 West Foxwood Drive<br>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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42991<br><br>Based on interviews and record review, the facility failed to develop a Comprehensive Care Plan after a significant change in the status/condition of a resident. This was evidenced by Resident #10 having had an unwitnessed fall with major injury resulting in a right hip replacement and pubic bone fracture on 7/24/24. The Care Plan was not revised within seven (7) days to ensure timeliness of a person-centered comprehensive assessment to address the resident's needs for one (1) of one (1) resident sampled for Comprehensive Care Plan timeliness (Resident #10).<br><br>Findings include:<br><br>Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, with a revision date of March 2022, noted:<br><br>Policy Interpretation and Implementation . 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS [Minimum Data Set] assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.<br><br>Review of Resident #10's face sheet documented an admitted [DATE]. Medical diagnoses included Senile Degeneration of Brain, Major Depressive Disorder, Hypertension, Dementia and Type II Diabetes.<br><br>Review of Resident #10's significant change status/condition Care Plan dated 8/19/24 documented the resident had sustained a pubic bone fracture on 7/24/24.<br><br>An interview with the Assistant Director of Nursing (ADON), on 1/10/25 at 10:16 a.m., revealed Resident #10's Care Plan was not updated within the seven (7) day timeframe. The ADON stated the Care Plan, which reflected the fall on 7/24/24, was updated on 8/19/24. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265803 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Foxwood Springs Living Center | 1500 West Foxwood Drive<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>42991<br><br>Based on observation, interview and record review, the facility staff failed to ensure an environment free from accident hazards. Staff failed to secure the contents of an unattended treatment cart stored in a lounge used by residents on the 100 and 200 Halls. The cart contained medicated creams, ointments, and topical sprays, as well as bandage scissors. The unlocked treatment cart presented a potential hazard to all residents residing on 100 and 200 Halls.<br><br>Findings include:<br><br>Review of the facility policy titled Security of Medication Cart, revised April 2007, noted:<br><br>Policy Interpretation and Implementation . 4. Medication carts must be securely locked at all times when out of the nurse's view.<br><br>On 1/7/25 at 12:41 p.m., the surveyor observed an unlocked treatment cart in which were stored band aids, bandages, gauze, gauze tape, lidocaine pain spray, medicated ointments and creams, and bandage scissors. The cart was stored in an open lounge area, and multiple residents were observed to be within six (6) feet of the treatment cart.<br><br>In an interview on 1/7/25 at 12:42 p.m., Registered Nurse (RN) Charge Nurse #4 stated he/she accidentally left the cart unlocked after being called away to assist someone. RN Charge Nurse #4 stated he/she should have secured the cart by locking it before leaving it unattended. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265803 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Foxwood Springs Living Center | 1500 West Foxwood Drive<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>33516<br><br>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, the facility failed to clean the kitchen floors, preparation table, shelves and drawers, stove, the grill, grill area, ovens, sides and front of the deep fat fryer, refrigerators, and the steamer/convection ovens.<br><br>Findings include:<br><br>Review of the undated Sanitization policy read in part:<br><br>Policy Statement - The food service area shall be maintained in a clean and sanitary manner.<br><br>Policy Interpretation and implementation -<br><br>1. All kitchens, kitchen areas and dining areas shall be kept clean .<br><br>2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning .<br><br>3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions .<br><br>16. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime.<br><br>17. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265803 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Foxwood Springs Living Center | 1500 West Foxwood Drive<br>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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During the initial tour of the kitchen on 1/7/25 at 11:24 a.m., the following items were not clean in the kitchen. The kitchen floors had food debris, black colored grime and grease under the stove, grill, ovens, steamers and preparation tables. in the kitchen. The food preparation tables, shelves and drawers had food debris and crumbs on and in them; the stove had dried food debris and accumulated grease on the front, sides and back of it; the grill and grill area had food debris and accumulated grime and yellow colored grease on the front and sides of the table to include the wheels of the grill table; the ovens had black food debris built up inside and the outside of the ovens had food debris on the doors and sides; there was yellow grease build up on the sides and front of the deep fat fryer; the refrigerators had dried food substances inside to include dried beverages that had not been cleaned up, and the handles had food sticky debris stuck to them and in the crevices around the handle, the bottoms of the outside of the refrigerators had stains on them; the tilt skillet, and the steamer/convection ovens had black colored food debris inside, and the glass doors were yellowish/brownish in color with gunky handles. There was a sign posted on the steamer that read: Top steamer lunch cook clean after lunch is over. Evening cook check and reclean before leaving if needed.<br><br>During a second tour of the kitchen on 1/9/25 at 10:04 a.m., the following items were not clean the kitchen. The kitchen floors had food debris, black colored debris, grease under all areas in the kitchen. The preparation tables, shelves and drawers had food debris and crumbs; the stove had dried food debris and accumulated grease on the front, sides and back; the grill and grill area had food debris and accumulated grime and yellow colored grease on the front and sides of the table to include the wheels of the grill table; the ovens had black food debris built up inside and the outside of the ovens had food debris on the doors and sides; there was yellow grease build up on the sides and front of the deep fat fryer; the refrigerators had food debris inside to include beverages that had not been cleaned up, the handles had food debris stuck to them and in the crevices, the bottoms of the outside of the refrigerators had stains on them; the tilt skillet, and the steamer/convection ovens had black colored food debris inside, the glass doors were yellowish / brownish in color. There was a sign posted on the steamer that read: Top steamer lunch cook clean after lunch is over. Evening cook check and reclean before leaving if needed. Observation of the plate warmer revealed it had dried food substances inside and outside to include crevices.<br><br>During an observation and interview on 1/9/25 at 11:04 a.m., Chef #3 stated that all staff cleaned the kitchen. He/She pointed out a white board on the wall with the dates 12/28 and 12/29 that had a list of staff and items to be cleaned. Chef #3 stated that he/she had been out, and the whiteboard had not been updated. He/she stated that he/she and the Executive Chef were responsible for ensuring the kitchen was cleaned. He/she stated they were also responsible for monitoring to ensure that the tasks were completed. Chef #3 stated it was important to clean the kitchen to prevent illness to the residents and keep rodents and bugs out.<br><br>During an observation and interview on 1/9/25 at 12:08 p.m., the Director of Dining Services (DDS) agreed the aforementioned items were not clean. He/she said, Just needs to be cleaned. The DDS stated it was important to clean the kitchen to prevent cross contamination, not get people sick, keep bugs out, and not get dirt in the food. He/she also stated he/she had not been in the kitchen as often as he/she should have been. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265803 | A. Building<br>B. Wing | 01/10/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Foxwood Springs Living Center | 1500 West Foxwood Drive<br>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 0868<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have the Quality Assessment and Assurance group have the required members and meet at least quarterly<br><br>42991<br><br>Based on interviews and record review, the facility failed to maintain a Quality Assessment and Performance Improvement (QAPI) Committee with the participation of the Medical Director and Infection Control Preventionist (or designee) for three (3) out of six (6) quarterly meetings.<br><br>Findings include:<br><br>Review of the facility's Quality Assurance and Performance Improvement policy, dated 3/15/24, noted, Policy Interpretation and Implementation . 5 . The following individuals serve on the committee: Administrator, or designee who is in a leadership role; Director of Nursing Services; Medical Director; Infection Preventionist .<br><br>Review of QAPI committee meeting attendance sheets revealed all required committee members signed the attendance sheets for meetings held on 9/21/23, 3/21/24, and 6/20/24.<br><br>On 12/21/23, the signature of the Medical Director was not present on the sign-in sheet for this quarterly meeting. On 9/19/24, the signature of the Infection Control Preventionist was not present on the sign-in sheet for this quarterly meeting. On 12/19/24, the signatures for both the Medical Director and the Infection Control Preventionist were not present for this quarterly meeting.<br><br>In an interview on 1/10/25 at 10:16 a.m., the Assistant Director of Nursing (ADON) verified the sign-in sheets and identified the roles of the committee members. It was revealed that neither the Medical Director nor a designee participated in the 12/21/23, and 12/19/24 meetings and the Infection Control Preventionist did not participate in the 9/19/24 and 12/19/24 meetings. The ADON stated that he/she was new to the role of coordinating the QAPI Committee Meetings and he/she was not aware of required attendance of members. |