STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265210	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Oaks Care Center	1001 North Walnut Steele, MO 63877

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32751 Based on interview and record review, the facility failed to ensure two residents (Residents #1 and #2) were free from physical and verbal abuse by staff. On 11/07/24, Certified Nurse Aide (CNA) A hit Resident #2 on the hand with a mug. The resident reported this to the administrator, in front of a witness. CNA A continued to work and measures were not taken after this incident to protect residents from further abuse. On 11/11/24, CNA A cursed at, shook and roughly threw Resident #1 into bed. This was witnessed by another staff member who reported up the command chain and the administrator was informed. The facility census was 73. The administrator was notified on 11/14/24 at 4:15 P.M., of an Immediate Jeopardy (IJ) which began on 11/07/24. The IJ was removed on 11/14/24, as confirmed by surveyor onsite verification. Review of the facility's policy titled, Abuse Prevention Program, dated September 2019, showed: - This facility will not tolerate verbal, sexual, physical or mental abuse, corporal punishment, involuntary seclusion, neglect, or misappropriation of resident property; - All allegations will be investigated; - The Administrator and the Director of Nursing Services have an open door policy for reports of abuse, neglect, mistreatment, or misappropriation of resident property and confidential reports can be made at any time. 1. Review of Resident #2's medical record showed: - admitted on [DATE]; - Diagnoses of depression, hemiplegia (partial or total paralysis on one side of the body), Chronic Kidney Disease (kidneys fail to function leading to renal failure), stroke, and cognitive communication deficit (difficulty communicating due to cognition). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 09/24/24, showed the resident was moderately cognitively impaired and required moderate to partial assistance with all activities of daily living (ADLs). (continued on next page)

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/14/2024 at 11:15 A.M., Resident #2 said around 11/07/24, CNA A provided care to him/her. CNA A emptied the ice out of the resident's insulated pitcher, then hit him/her hard on the back of his/her right hand while saying I ain't got time to fucking mess with you to the resident. Resident #2 said he/she is afraid of CNA A. Resident #2 said he/she reported the incident to the Social Service Worker (SSW) and the Administrator (ADM). Observation on 11/14/2024 at 11:15 A.M., of Resident #2 showed a reddish-purple mark on the back of his/her right hand measuring 5 centimeters (cm) by 2 1/2 cm. The facility did not provide an investigation or facility reported incident (FRI) for the source of Resident #2's bruising. Review of the resident's medical record showed no documentation of the source of the resident's bruising or notes regarding the abuse allegation. During an interview on 11/14/24 at 11:35 A.M., the SSW said on 11/07/24, the ADM was sitting in his/her office, when Resident #2 came in. The resident reported CNA A had hit his/her hand and cussed at him/her. The ADM was sitting in the chair across from his/her desk, heard the resident and responded by saying this is the first I have heard of this and walked out of his/her office. The SSW said, he/she assumed the ADM was going to start an investigation. During an interview on 11/14/24 at 2:45 P.M., the ADM said he had never been informed of any incident with Resident #2 or any prior reports against CNA A. He denied the resident had informed him. The ADM said CNA A was not removed from the schedule. During an interview on 11/21/24, by phone CNA A denied hitting Resident #2 on the hand. He/she said he had no information on this matter. 2. Review of Resident #1's medical record showed: - The resident was admitted on [DATE]; - No documented history of behaviors; - Diagnoses of anxiety, depression, dementia (a group of conditions that interfere with daily living) without behaviors, borderline personality disorder (a mental disease characterized by unstable moods), Bi-Polar Disorder (a mental disease characterized by episodes of mood swings), and an amputation of the left leg above the knee. Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively impaired and required maximum assistance with all ADLs. Review of the facility reported incident, received on 11/12/24 showed: - Resident #1 told staff that CNA A had used inappropriate language during care; - The resident denied any physical abuse; - No written statements provided from staff. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a written statement provided on 11/14/24 at 2:45 P.M. by the ADM, showed CNA B witnessed CNA A yelling and then shaking Resident #1 on 11/11/24. During an interview on 11/14/24 at 11:30 A.M., CNA B said on 11/11/24 he/she was taking dirty laundry down the hallway to the dirty laundry barrel which was parked beside Resident #1's room. CNA B said there was yelling coming from Resident #1's room. CNA B looked in the room of the resident and heard CNA A yelling and cursing the resident. CNA A was shaking the wheelchair with the resident in the chair, and then shook the resident by the shoulders and lifted the resident up and threw him/her into the bed. CNA B said he/she immediately went to find a charge nurse, but was unsuccessful. CNA B saw staff members Human Resources (HR) and Licensed Practical Nurse (LPN) C and reported the incident to them. LPN C went directly to the hallway to find the charge nurse to remove CNA A. HR told CNA B to write a statement. CNA B said he/she wrote a statement. During an interview on 11/14/24 at 11:40 A.M., HR said CNA B told her and LPN C that he/she had just witnessed CNA A cursing and shaking Resident #1. HR said she had CNA B confirm that CNA A had been physical, shaking Resident #1 and CNA B said 100%. HR and LPN C then informed the charge nurse, LPN D. They all addressed this with CNA A who did not write a statement and did not deny the allegation. CNA A cursed, left the room and building. HR notified the DON of the physical abuse by phone. During an interview on 11/14/24 at 12:00 P.M., LPN C said CNA B told him/her and HR that he/she had just witnessed CNA A cursing and shaking Resident #1. HR continued talking with CNA B while LPN C left to go find the charge nurse and report the incident. CNA A came to the conference room where LPN C, CNA A, HR and LPN D had gathered. CNA A did not deny the allegation and was asked to leave. The DON was contacted and informed of physical abuse. The charge nurse, LPN D, assessed the resident. LPN C said he/she asked the resident if he/she had been shaken and Resident #1 said yes. During an interview on 11/14/24 at 2:10 P.M., LPN D said he/she received a report of abuse from LPN C and asked CNA A into the conference room. CNA A denied knowing anything, cursed, and walked away. LPN D said the DON was informed of physical abuse by phone and came back to the facility. Resident #1 told LPN D that CNA A had been rough and had shaken his/her wheelchair and his/her body by the shoulders while cursing. During an interview on 11/14/24, at 2:00 P.M., the DON said on 11/11/24 after he had left the building for the evening, LPN D called to report CNA B had reported to have witnessed CNA A shake Resident #1's wheelchair as well as by the shoulders. The DON went back to the facility and CNA A had been sent home. The DON said he started a Resident Questionnaire and had CNA B write a statement. The DON was aware of the allegation of verbal and physical abuse and called and informed the ADM which is their protocol. During an interview on 11/14/2024 at 2:45 P.M., the ADM said, on 11/11/24, the DON contacted him and reported CNA A had used inappropriate language with Resident #1. The ADM denied being told of an allegation of physical abuse. On 11/12/24, the ADM interviewed the resident, who said there had been no physical abuse. At that time, the ADM concluded the investigation. The ADM said he had just now found a written statement from CNA B on his desk alleging physical abuse from CNA A to Resident #1, but felt the allegation was unclear. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/14/24 at 5:15 P.M., CNA A denied yelling at or shaking Resident #1. He/she said that no one could have seen in the room, because the door was closed. He/she said CNA B may have heard him/her grunting while doing care, but he/she was not yelling. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). Complaint #MO245031

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32751 Based on interview and record review, the facility failed to thoroughly investigate reports of abuse for two residents (Residents #1 and #2), out of seven sampled residents. While providing care, on 11/07/24, Certified Nurse Aide (CNA) A hit Resident #2 on the hand with a mug. This was reported to the Administrator (ADM) by the resident. The allegation was not investigated and CNA A continued to work. On 11/11/24, Resident #1 was shaken and thrown on the bed by CNA A. The ADM did not investigate the allegations as per the facility policy and procedure. The facility census was 73. The administrator was notified on 11/14/24 at 4:15 P.M., of an Immediate Jeopardy (IJ) which began on 11/07/24. The IJ was removed on 11/14/24, as confirmed by surveyor onsite verification. Review of the facility's policy titled, Abuse Prevention Program, dated September 2019, showed: - This facility will not tolerate verbal, sexual, physical or mental abuse, corporal punishment, involuntary seclusion, neglect, or misappropriation of resident property; - All allegations will be investigated; - The Administrator and the Director of Nursing Services have an open door policy for reports of abuse, neglect, mistreatment, or misappropriation of resident property and confidential reports can be made at any time. Review of the facility's policy titled Abuse Investigation and Reporting, dated July 2017 showed: - All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulation) and thoroughly investigated by facility management. Findings of abuse investigation will also be reported. 1. Review of Resident #2's medical record showed: - admitted on [DATE]; - Diagnoses of depression, hemiplegia (partial or total paralysis on one side of the body), Chronic Kidney Disease (kidneys fail to function leading to renal failure), stroke, and cognitive communication deficit (difficulty communicating due to cognition). Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/24/24, showed the resident was moderately cognitively impaired and required moderate to partial assistance with all activities of daily living (ADLs). (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/14/2024 at 11:15 A.M., Resident #2 said around 11/07/24, CNA A provided care to him/her. CNA A emptied the ice out of the resident's insulated pitcher, then hit him/her hard on the back of his/her right hand while saying I ain't got time to fucking mess with you to the resident. Resident #2 said he/she is afraid of CNA A. Resident #2 said he/she reported the incident to the Social Service Worker (SSW) and the ADM. Observation on 11/14/2024 at 11:15 A.M. of Resident #2 showed a reddish-purple mark on the back of his/her right hand measuring 5 centimeters (cm) by 2 1/2 cm. During an interview on 11/14/24 at 11:35 A.M., the SSW said on 11/07/24, the ADM was sitting in his/her office, when Resident #2 came in. The resident reported CNA A had hit his/her hand and cussed at him/her. The ADM was sitting in the chair across from his/her desk, heard the resident and responded by saying this is the first I have heard of this and walked out of his/her office. The SSW said he/she assumed the ADM was going to start an investigation. The SSW said he/she failed to document the allegations and did not follow up, but the facility policy would direct staff to initiate an investigation. During an interview on 11/14/24 at 2:45 P.M., the ADM said he had never been informed of any incident with Resident #2. He denied the resident had informed him. The ADM said CNA A was not removed from the schedule. The facility did not provide an investigation or facility reported incident (FRI) for the source of Resident #2's bruising. Review of the resident's medical record showed no documentation of the source of the resident's bruising or notes regarding abuse allegation. 2. Review of Resident #1's medical record showed: - The resident was admitted on [DATE]; - No documented history of behaviors; - Diagnoses of anxiety, depression, dementia (a group of conditions that interfere with daily living) without behaviors, borderline personality disorder (a mental disease characterized by unstable moods), Bi-Polar Disorder (a mental disease characterized by episodes of mood swings), and an amputation of the left leg above the knee. Review of Resident #1's quarterly MDS), dated [DATE], showed the resident was cognitively impaired and required maximum assistance with all ADLs. Review of the facility reported incident, received on 11/12/24 showed: - Resident #1 told staff that CNA A had used inappropriate language during care; - The resident denied any physical abuse; - No written statements provided from staff. (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a written statement provided on 11/14/2024 at 2:45 P.M. by the ADM, showed CNA B witnessed CNA A yelling and then shaking Resident #1 on 11/11/24. During an interview on 11/14/24 at 11:30 A.M., CNA B said on 11/11/24 he/she was taking dirty laundry down the hallway to the dirty laundry barrel which was parked beside Resident #1's room. CNA B said there was yelling coming from the resident's room. CNA B looked in the room of Resident #1 and heard CNA A yelling and cursing the resident. CNA A was shaking the wheelchair with the resident in the chair, and then shook the resident by the shoulders and lifted the resident up and threw him/her into the bed. CNA B said he/she immediately went to find a charge nurse but was unsuccessful. CNA B saw staff members Human Resources (HR) and Licensed Practical Nurse (LPN) C and reported the incident to them. LPN C went directly to the hallway to find the charge nurse to remove CNA A. HR told CNA B to write a statement. CNA B said he/she wrote a statement. During an interview on 11/14/24 at 11:40 A.M., HR said CNA B told him/her and LPN C that he/she had just witnessed CNA A cursing and shaking Resident #1. HR said she had CNA B confirm that CNA A had been physical, shaking Resident #1 and CNA B said 100%. HR and LPN C then informed the charge nurse, LPN D. They all addressed this with CNA A who did not write a statement and did not deny the allegation. CNA A cursed said and left the room and building. HR notified the DON of the physical abuse by phone. During an interview on 11/14/24 at 12:00 P.M., LPN C said CNA B told him/her and HR the he/she had just witnessed CNA A cursing and shaking Resident #1. HR continued talking with CNA B while LPN C left to go find the charge nurse and report the incident. CNA A came to the conference room where LPN C, CNA A, HR and LPN D had gathered. CNA A did not deny the allegation and was asked to leave. The DON was contacted and informed of physical abuse. LPN C said he/she asked the resident if he/she had been shaken and Resident #1 said yes. During an interview on 11/14/2024 at 2:10 P.M., LPN D said he/she received a report of abuse from LPN C and asked CNA A into the conference room. CNA A denied knowing anything, cursed, and walked away. LPN D said the DON was informed of physical abuse by phone and came back to the facility. Resident #1 told LPN D that CNA A had been rough and had shaken his/her wheelchair and his/her body by the shoulders while cursing. During an interview on 11/14/24, at 2:00 P.M., the DON said on 11/11/2024 after he had left the building for the evening, LPN D called to report that CNA B had reported to have witnessed CNA A shake Resident #1's wheelchair, as well as by the shoulders. The DON went back to the facility and CNA A had been sent home. The DON said he started a Resident Questionnaire and had CNA B write a statement. The DON was aware of the allegation of verbal and physical abuse and called and informed the ADM, which is their protocol. During an interview on 11/14/2024 at 2:45 P.M., the ADM said, on 11/11/24, the DON contacted him and reported CNA A had used inappropriate language with Resident #1. The ADM denied being told of an allegation of physical abuse. On 11/12/24, the ADM interviewed the resident, who said there had been no physical abuse. At that time, the ADM concluded the investigation. The ADM said he had just now found a written statement from CNA B on his desk alleging physical abuse from CNA A to Resident #1, but felt the allegation was unclear. The ADM said he did not further investigate or question CNA B for clarity. The ADM said it is the facility policy and procedure to thoroughly investigate all allegations of abuse. (continued on next page)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). Complaint #MO245031