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	08/16/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on observation, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 74. Record review of the facility's Homelike Environment policy, revised February 2021, showed: - Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible; - Staff provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences; - The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting which include clean, sanitary and orderly environment. 1. Observations made on 08/13/24 at 10:38 AM and 08/14/24 at 12:38 P.M., showed a long piece of decorative trim with several areas of chipped and peeled paint on the left side of the kitchen door entrance. 2. Observation made on 08/13/24 at 11:04 A.M., of the wardrobe cabinet in room [ROOM NUMBER], showed: - Soiled rolled towels placed around the front outside edge; - The right side of the inside bottom flooring rotted out with an exposed hole. During an interview on 08/13/24 at 11:08 A.M., the resident in room [ROOM NUMBER] said his/her wardrobe cabinet had been like that since he/she was admitted in July. 3. Observations made on 08/13/24 at 11:29 P.M. and 08/14/24 at 3:32 P.M., showed several areas of chipped and peeled paint on the outside surface walls of the nurse's station. 4. Observations made on 08/13/24 at 1:39 P.M. and 08/14/24 at 1:32 P.M., of the 500 Hall, 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A buildup of dust and debris visible on the inside of a light fixture cover in hallway located between rooms [ROOM NUMBERS]; - A buildup of dust and debris visible on the inside of a light fixture cover in hallway located between rooms [ROOM NUMBERS]; - A buildup of dust and debris visible on the inside of a light fixture cover in hallway located between rooms [ROOM NUMBERS]; - A buildup of dust and debris visible on the inside of a light fixture cover in hallway located between rooms [ROOM NUMBERS]; - Several dark stained areas on the ceiling tiles throughout the therapy/exercise room. 5. Observation on 08/15/24 at 8:40 A.M. showed: - Two ceiling tiles with brown circles in room [ROOM NUMBER]; - One ceiling tile with brown circle around the air vent in room [ROOM NUMBER]; - One ceiling tile with a brown circle in room [ROOM NUMBER]; - Two ceiling tiles with brown circles near the air vent in room [ROOM NUMBER]; - Ceiling tile with dark stained area around the air vent in room [ROOM NUMBER]; - Four ceiling tiles with dark brown and black areas in room [ROOM NUMBER]. 6. Observation on 08/16/24 at 2:33 P.M., of the 500-hall shower room, showed five 12-inch (in.) x12 in. floor tiles cracked and/or missing located in front of the shower stall. Review of the repair requisition log, dated 07/14/24 through 08/15/24, showed no documentation of areas of concerns addressed. During an interview on 08/16/24 at 9:20 A.M., Housekeeper A said there is a maintenance log that staff writes down things that need to be repaired. He/She also verbally tells maintenance if there are any environmental concerns that need addressed. He/she has told maintenance about some ceiling tiles that needed replaced recently. During an interview on 08/16/24 at 9:24 A.M., Housekeeper B said any environmental concerns are written down on the maintenance log to be addressed. He/She will also take pictures and show the maintenance supervisor. During an interview on 08/16/24 at 09:35 A.M., the Maintenance Supervisor (MS) said he/she would expect staff to write down any environmental concerns to be addressed. There is a clip board posted by the employee breakroom that staff can write down anything that needs fixed or replaced. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/16/24 at 2:20 P.M., the previous Administrator said the ceiling tiles have been ordered. The MS has a few extra tiles and will replace the ones in room [ROOM NUMBER] immediately. During an interview on 08/16/24 at 3:03 P.M., the Administrator said all staff is responsible for seeing issues and filling out the requisition forms for maintenance. The Administrator said he makes rounds throughout the facility daily. MO239543 50260

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48532 Based on observation, interview and record review, the facility failed to provide a safe transfer for two residents (Residents #62 and #67) out of 18 sampled residents, when staff did not utilize a gait belt (a thick fabric or vinyl belt that is placed around a patient's waist to help with mobility and prevent falls) as directed by therapy recommendations and the resident's care plan. The facility census was 74. Review of the facility's policy titled, Safe Lifting and Movement of Residents, revised July 2017, showed: - Nursing staff, in conjunction with the rehabilitation staff, shall assess individual resident's needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. - Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. 1. Review of Resident #62's medical record showed: - An admitted [DATE]; - Diagnoses of Parkinson's Disease (a progressive disorder that affects the nervous system and the parts of the body controlled by nerves), Multiple system atrophy (a neurological disorder that causes progressive damage to nerve cells in the brain and spinal cord), Acute Respiratory Failure with hypoxia (a condition that occurs when the lungs have trouble exchanging oxygen and carbon dioxide with the blood); Review of the resident's admission Minimum Data Set (MDS) (a federally mandated assessment completed by facility staff), dated 06/20/24, showed: - Dependent on staff for activities of daily living (ADL's); - Required substantial to maximal assist for transfers; - Impairment to both sides of upper and lower extremities (arms and legs); - Sit to stand and all transfers to be substantial/maximal assist (where helper does more than half the work). Review of the resident's care plan, revised on 07/15/24, showed the resident required substantial-maximal assistance with ADLs, transfers, and toileting. Observation on 08/15/24 at 8:42 A.M., showed: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Registered Nurse (RN) C and Nurse Aide (NA) I in Resident #62's room to transfer from wheelchair to bed; - RN C and NA I grabbed the resident by the waist band of pants and stood resident up by placing staff arms underneath the residents' arms, pulled the resident up to standing position; - Resident unable to pivot, RN C pulled residents pant leg to move the residents' foot and leg; - NA I wore gait belt around shoulder. During an interview on 08/16/24 at 8:51 A.M., Physical Therapy Assistant (PTA) said Resident #62 requires maximal assistance with two staff using a gait belt and a stand-pivot transfer. 2. Review of Resident #67's medical record showed: - An admitted [DATE]; - Diagnoses of Cerebrovascular disease (condition affecting blood flow to your brain), Displaced fracture of the base of the neck of right femur (broken bone), and Dementia (a disease affecting memory, language and problem solving). Review of the resident's quarterly MDS, dated [DATE], showed chair/bed to chair transfers require substantial/max assist where helper does more than half of effort. Review of the resident's care plan, dated 05/06/24, showed the resident required substantial/max assist with transfers. Observation on 08/15/24 at 1:29 P.M., showed: - Certified Nurse Aide (CNA) J and CNA K in Resident #67's room to transfer from wheelchair to bed; - CNA K bent down and put both arms underneath resident's arms and lifted resident to standing position; - Resident unable to pivot, CNA K turned resident and sat resident on bed and assisted into a lying position. - After care, CNA K again reached around the resident underneath his/her arms and lifted the resident into a sitting position and then back into the wheelchair; - CNA J wore a gait belt around waist, no gait belt used for transfer. During an interview on 08/15/24 at 1:38 P.M., CNA J said he/she thinks Resident #67 is just a one person transfer because the resident can bear weight and assist. CNA K said he/she would normally use a gait belt for transfers. During an interview on 08/15/24 at 2:18 P.M., the Director of Nursing (DON) said that he/she would expect CNAs to use a gait belt for transfers, not lifting by using under resident's arms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50260

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 48532 Based on observation, interview and record review, the facility failed to ensure gastric residual volume (the amount of liquid that drains from the stomach after enteral feeding is administered) was measured prior to administering tube feeding for two residents (Residents #62 and #15) out of two sampled residents. The facility also failed to follow standards of practice by using a plunger (used to force liquid into feeding tube catheter) during tube feeding on one resident (Resident #15) out of two sampled residents. The facility census was 74. Record review of the facility's policy, Enteral Nutrition, last revised November 2018, showed: - The provider will consider the need for supplemental orders, including: -Checks for gastric residual volume (GRV) before feeding and medication - The facility did not provide a policy on plunger use during a tube feed. 1. Review of Resident #62's Physician's Order Sheet (POS), dated August 2024, showed: - An order for Isosource 1.5 calorie ((cal) a calorically dense complete nutrition formula with fiber for increased calorie needs to support bowel function), 250 millimeter (ml) four times daily; - An order for 120 cubic centimeters (cc) water flush four times daily; - An order to check placement; - An order to hold feeding if residual is more than 60 cc. Observation on 08/15/24 at 8:33 A.M., showed: - The resident sat in bed with a gastrostomy tube (G-tube, a tube surgically inserted into the stomach to provide nutrition and medication); - Registered Nurse (RN) C uncapped the resident's G-tube and attached the barrel of a syringe into the G-tube; - RN C did not check residual of the stomach contents per physicians' orders prior to feeding administration; - RN C flushed the resident's G-tube with 30 cc of water; - RN C administered Isosource 1.5 cal and flushed with 60 cc of water. Observation on 08/15/24 at 1:53 P.M., showed: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident sat in bed with G-tube; - RN C uncapped the resident's G-tube and attached the barrel of a syringe into the G-tube; - RN C did not check residual per physicians' orders prior to feeding administration; - RN C flushed the resident's G-tube with 30 cc of water; - RN C administered Isosource 1.5 cal and flushed with 180 cc of water. Observation on 08/16/24 at 9:33 A.M., showed: - The resident sat in bed with G-tube; - Licensed Practical Nurse (LPN) D uncapped the resident's G-tube and attached the barrel of a syringe into the G-tube; - LPN D checked for placement: with auscultation (listening for air movement in the stomach with a stethoscope) - LPN D did not check residual of the stomach contents per physicians' orders prior to feeding administration; - LPN D flushed the resident's G-tube with 60 cc of water; - LPN D administered Isosource 1.5 cal and flushed with 60 cc of water. 2. Review of Resident #15's POS dated, August 2024 showed: - An order for Isosource 1.5 calorie at 250 ml four times daily; - An order for 180 ml water flush six times daily; - An order flush feeding tube with 30 cc of water before and after medication administration. Observation on 08/14/24 at 9:45 A.M., showed: - The resident laying in bed with G-tube; - LPN D uncapped the resident's G-tube and attached the barrel of syringe in residents G-tube; - LPN D did not check for placement by auscultation, or check residual; - LPN D flushed resident's G-tube with 30 cc of water; - LPN D administered 40 cc of Isosource 1.5 cal; - LPN D added approximately 20 cc of water to syringe while Isosource remained in syringe; (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN D took a plastic straw laying on bedside table and used it to stir together Isosource and water inside the syringe; - LPN D added 50 cc more Isosource to syringe; - At 15 cc, LPN D added approximately 20 cc water to syringe and stirred with straw from bedside table. Observation on 08/14/24 at 10:15 A.M., showed: - LPN D uncapped residents G-tube and attached barrel of syringe in resident's G-tube; - LPN D flushed resident's G-tube with 30 cc of water; - LPN D added 120 cc of crushed medication mixed with water; - LPN D used plastic straw from bedside table to stir medication mixture in syringe; - LPN D added 60 cc of remaining medication mixture; - LPN D used plunger from syringe to force medication mixture into resident's G-tube; - LPN D added 30 cc of medication mixture to syringe, and used plunger to force medication into resident's G-tube. During an interview on 08/16/24 at 02:18 P.M., the Director of Nursing (DON) said he/ she would not expect staff to use a plastic straw to stir contents inside the syringe during a tube feed. The DON said he/she would not expect staff to add water to tube feedings or use the plunger to force feedings and/or medication into G-tube. During an interview on 08/14/24 at 3:36 P.M., LPN D said he/she checks for residual on residents sometimes. LPN D said he/she usually does not use the plunger to force feedings and medication through G-tube but does when it becomes thick or clogged. During an interview on 08/16/24 at 3:45 P.M., the DON said he/she expected staff to check for residual of a G-tube prior to medication administration or feeding.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48532 Based on observation, interview, and record review, the facility failed to implement procedures to ensure medications were accurately administered, documented, disposed of and reconciled for one resident (Resident #100) outside of the 18 sampled residents. The facility census was 74. Review of the facility's policy titled, Pharmacy and Medication Administration, undated, showed: - Narcotics must be counted at the beginning and end of each shift and signed on the narcotic log by the oncoming and off going nurse or medication technician; - Monitoring the log weekly can help identify any missed counts or lax in counting by particular staff. Observation on 08/16/24 at 12:30 P.M., of the locked refrigerator in the main mediation room showed one bottle of opened liquid lorazepam (a controlled medication used to treat anxiety) 2 milligram (mg) per milliliter (ml) with 29.5 ml left in the 30 ml bottle for Resident #100. Observation on 08/16/24 at 12:40 P.M., of Medication Cart One showed one bottle of opened liquid morphine (a controlled medication used to treat pain and shortness of breath) 100 mg per five milliliters with 29.5 ml left in the 30 ml bottle for Resident #100. Review Resident #100's medical record showed: - An admitted [DATE]; - An order for morphine 0.25 ml every 2 hours for pain, dated 08/07/24; - An order for lorazepam 0.25ml every 2 hours for anxiety, dated 08/07/24; - A discharge date of [DATE] for the resident. Review of the controlled substance record book showed no individual controlled substance records for Resident #100's morphine 0.25 ml every 2 hours for pain or lorazepam 0.25ml every 2 hours for anxiety. During an interview on 08/16/24 at 12:33 P.M., Licensed Practical Nurse (LPN) D said there should have been a paper in the book for Resident #100's controlled medication of morphine and lorazepam. When residents were discharged , the unused controlled medications were given to the Director of Nursing (DON). During an interview on 08/16/24 at 12:35 P.M., Certified Medication Technician F said he/she did count with the off going nurse this morning, but just skipped over this resident's medications because the resident had passed away. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/16/24 at 3:30 P.M., the Director of Nursing (DON) said he/she was unable to locate a controlled substance sheet for the morphine or lorazepam, and there should have been one for each medication. The DON did not know why the morphine of lorazepam had not been brought to him/her for destruction.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 26904 Based on observation, interview, and record review, the facility failed to use proper infection control techniques for glove use during wound care for two residents (Resident #24 and #56) and during incontinent care for two residents (Resident #62 and #67) out of four sampled residents. The facility census was 74. Review of the facility's policy, Infection Control, revised October 2018, showed: - This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections; - The objectives of our infection control policies and practices are to: - Prevent, detect, investigate, and control infections in the facility; - Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. Review of the facility's policy titled, Standard Precautions, revised September 2022, showed: - Gloves are worn when in direct contact with blood, body fluids, mucous membranes, non-intact skin, and other potentially infected material; - Gloves are changed and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care; - Gloves are changed as necessary, during the care of a resident to prevent cross-contamination from one body site to another; - Gloves are removed promptly after use, before touching non-contaminated items and environmental surfaces; - After gloves are removed, hands are washed immediately to avoid transfer of microorganisms to other residents or environments. 1. Review of Resident #56's Physician's Order Sheet (POS), dated August 2024, showed: - An order, dated 08/04/24, to cleanse unstageable pressure ulcer (a type of wound that occurs when prolonged pressure on the skin prevents blood and oxygen from reaching the tissue and can be covered by a layer of dead tissue) to right heel with wound cleanser, pat dry, apply calcium alginate with silver (topical wound dressing to help reduce infections and are used to treat wounds with moderate to heavy drainage), cover with an abdominal pad (ABD, a dressing used to treat large wounds that require high absorbency), wrap with kerlix (conforming gauze) and secure with tape two times daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/15/24 at 2:15 P.M., of wound care for Resident #56 showed: - Licensed Practical Nurse (LPN) C put on protective gown at the resident's door before entering the room, washed hands and put on gloves; - LPN C removed the old dressing from the resident's right heel; - LPN C removed his/her gloves, put on a clean pair of gloves and did not sanitize his/her hands; - LPN C cleansed the open area with wound cleanser (an antiseptic that helps reduce the risk of infection and prevent bacterial contamination) and gauze; - With the same soiled gloves, LPN C dried the area with gauze, applied calcium alginate with silver dressing placed over the open area, ABD dressing applied, wrapped with kling, secured with tape and removed the soiled gloves; - LPN C did not sanitize hands or change gloves between dirty and clean tasks. 2. Review of Resident #24's POS, dated August 2024, showed: - An order, dated 08/09/24, to apply barrier cream (a cream to provide protection from irritants) to bottom with incontinent episodes, every shift for stage II pressure injury (an open sore that occurs when the dermis, or deeper layer of skin, is partially lost). Observation on 08/15/24 at 4:35 P.M. of wound care for Resident #24 showed: - The resident stood on the side of his/her room near the bed, he/she removed pants and brief; - LPN C put on protective gown before entering the room, put on gloves and cleansed the resident's buttocks with wound cleanser and gauze; - LPN C dried the open area on the buttocks with gauze; - With the same soiled gloves, LPN C applied the barrier cream to the resident's buttocks; - LPN C removed the dirty gloves and did not sanitize hands or change gloves between dirty and clean tasks. 3. Observation on 08/15/24 at 1:29 P.M. of incontinent care for Resident #67 showed: - Certified Nurse Aide (CNA) J and K washed hands, and applied gloves; - CNA J and K assisted the resident into bed, removed pants and brief; - CNA J used a washcloth to clean the resident while CNA K assisted in positioning; - With the same soiled gloves, CNA J and K applied a clean brief to the resident and assisted with dressing the resident. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Observation on 08/16/24 at 12:52 P.M. of incontinent care for Resident #62 showed: - CNA L applied a gown at the doorway before entering the room; - CNA L left the room to get a privacy sheet from the hallway cart and did not remove or change gown; - CNA L left the room to get more washcloths from the hallway cart and did not remove or change gown. During an interview on 08/15/24 at 1:38 P.M., CNA J said that they do not normally change their gloves during incontinent care between dirty and clean. CNA K agreed that he/she does not change gloves between dirty and clean. During an interview on 08/15/24 at 4:40 P.M., LPN C said staff should have washed his/her hands and changed gloves between dirty and clean. LPN C said his/her hands should have been sanitized and gloves changed before the barrier cream was applied. During an interview on 08/16/24 at 2:18 P.M., the Director of Nursing (DON) said he/she would expect staff to remove gowns before leaving a room, and apply a new gown before entering. She also said staff should change gloves between dirty and clean, and should have also changed gloves before applying the barrier cream. 50260