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 _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS CARE CENTER	1001 NORTH WALNUT STEELE, MO 63877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: 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.	F 600	The event was investigated on 11/14/24 by DHSS. The POC for the immediate jeopardy was competed on 11/14/24 and is attached. 1. All residents have the potential to be affected by this practice. All allegations/reports of any abuse, neglect, misappropriation of resident property or exploitation will be fully investigated immediately by the administrator or designee and reported. 2. Residents #1 and #2 continue to reside in the building. Follow-up interviews will be completed with the residents by the administrator or designee and no additional findings discovered. 3. CNA 2 was terminated on November 12, 2024. 4. Any employee involved in any allegation of abuse/neglect will be suspended until the investigation is completed 5. Termination of employees when indicated will be completed by the administrator or designee. 6. A full assessment was completed of all residents by 11/15/2024. 7. The Regional corporate team provided education to the administrator, director of nursing and assistant director of nursing on 11/14/2024 on the process of thorough investigation after each event to ensure timely investigation and appropriate treatment if required is implemented and timely reporting is completed according to the facility policy. 8. A log will be implemented to record all investigated, reportable allegations of abuse/neglect. 9. The administrator will be the abuse coordinator for the log. 10. Events will be monitored by the clinical team in the daily clinical/stand-up meeting five times weekly. 11. Education on the Abuse and Neglect policy/protocol to include injuries of unknown origin was completed and will be repeated with all staff in the facility monthly for three months,	12/16/2024

Admin
12/13/24

			quarterly times two and then annually in addition to each time an allegation of abuse and/or neglect is reported. 12. Incidents of abuse/neglect follow-up investigations will be reviewed by the director or regional consulting or regional nurse consultant within 72-96 hours per instance for 3 months, monthly times 3 months, quarterly times 3 and ongoing until deemed no longer necessary by the committee. 13. The abuse log, investigations completed, and findings will continue to be reviewed at the monthly Quality Assurance Quality Improvement meeting monthly times three, quarterly times three and ongoing until deemed no longer necessary by the committee. 14. Any areas of concern will be addressed at the time of discovery.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 12/13/24

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.

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F 600	Continued From page 1	F 600		

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 03/23/23;
- 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).

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

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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.

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2. Review of Resident #1's medical record showed:
- The resident was admitted on 08/04/23;
- 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 11/06/24, 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.

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

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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

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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.

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.

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F 600	Continued From page 6 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).	F 600		
F 610 SS=J	Complaint #MO245031 Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 610		

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incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:
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

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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 03/23/23;
- 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).

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.

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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 08/04/23;
- No documented history of behaviors;
- Diagnoses of anxiety, depression, dementia (a group of conditions that interfere with daily living)

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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 11/06/24, 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.

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

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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.

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 _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS CARE CENTER	1001 NORTH WALNUT STEELE, MO 63877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 12	F 610		

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.

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

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 _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS CARE CENTER	**1001 NORTH WALNUT STEELE, MO 63877**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 13 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	F 610		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06672	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS CARE CENTER	1001 NORTH WALNUT STEELE, MO 63877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class I* Refer to F610. *The higher classification merited due to the extent of the violation. NOTE: At the time of the complaint investigation, the violation was determined to be at an imminent danger Class I level. Based on observation, 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 final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the Class I was able to be lowered to a Class II.	A4074		
A8022	19 CSR 30-88.010(22) Free From Abuse Each resident shall be free from abuse. Abuse is the infliction of physical, sexual, or emotional injury or harm and includes verbal abuse, corporal punishment, and involuntary seclusion. I	A8022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06672	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS CARE CENTER	1001 NORTH WALNUT STEELE, MO 63877

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8022	Continued From page 1 This regulation is not met as evidenced by: Refer to F600. NOTE: At the time of the complaint investigation, the violation was determined to be at an imminent danger Class I level. Based on observation, 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 final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the imminent danger was addressed.	A8022		
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class II* 1. Refer to F610. * The higher classification merited due to the	A8023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06672	A. BUILDING: _____ B. WING _____	C 11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER OAKS CARE CENTER	**1001 NORTH WALNUT STEELE, MO 63877**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8023	Continued From page 2 extent of the violation.	A8023		

PLAN OF CORRECTION

Provider/Supplier Name:	River Oaks Care Center
Street Address, City, Zip:	1001 North Walnut Street Steele, MO 63877
Date of Survey:	November 20, 2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265210

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under the State Law. The submission of this plan does not constitute an admission on the part of River Oaks Care Center as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. The plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the scope and severity regarding any of the deficiencies cited are correctly applied. The facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil action or criminal action against the facility or any employee, agent, officer, director or shareholder of the facility. Any changes to the facility policies and procedures should be considered to be subsequent remedial measures as that employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. Please accept this plan of correction with completion dates as our written credible allegation of compliance.	
F600	**1. Corrective Action for Affected Resident(s):**	12/16/24
A8022	The facility will protect residents' right to be free from physical and verbal abuse by staff for Residents #1 and #2 and all other residents residing in the facility.	
	2. Procedure for Identifying potentially Affected residents:	
	All residents have potential to be affected by this deficiency.	

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	3. Measure(s) adopted for Systemic Change:	
	• The facility Governing body provided re-education to the facility Administrator and Nursing leadership team, to include DON and ADON regarding the Abuse and Neglect policy, investigation, reporting, follow up, logging, proper documentations, and interventions. • Education began at 4PM on 11/14/24, by the Administrator, Director of Nursing, and/or designee for facility Licensed Nursing staff and all other facility staff currently in the facility and will continue education for all other staff, prior to the start of their shift ongoing on the following to include: Abuse and Neglect policy including reporting, investigation, follow up, logging investigations, proper documentations, and interventions. • An Abuse log was implemented 11/14/24. • The Abuse Coordinator for the facility was assigned to the Administrator on 11/14/24. • Head to Toe body assessment was completed for residents #1 and #2 on 11/14/24. No other concerns were noted at that time.	
	4. Corrective Action for Affected Resident(s):	
	• A Head-to-Toe body assessment will be completed and documented for all residents residing in the facility by 11/15/24. Any concerns will be addressed at time discovery. • Facility Abuse and Neglect allegations, Incidents and Accidents will be reviewed at the facility morning stand up meeting by the facility Abuse Coordinator, the facility Abuse Coordinator will report all allegations to the Director of Regional Consulting and/or Regional Nurse Consultant immediately. • The facility staff to include Therapy Department, Nursing Department, Department Managers, Environmental Services, Nutritional Department,	

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	and ancillary staff will continue to be educated on-going regarding the importance of abuse reporting, investigation, intervention, proper documentation, logging investigations, and follow up. compliance is achieved, monthly for 3 months, then quarterly X 2 until compliance is met; then annually, and to include with each allegation of abuse and neglect. • Facility staff will continue to receive annual education on Abuse and Neglect ongoing through Relias Learning and In-Person annual staff training. • Abuse investigations conducted will be reviewed and approved by the Director of Regional Consulting and/or Regional Nurse Consultant within 72-96 hours, this will be completed per instance for 3 months, monthly times 3, and quarterly times 3, and ongoing until substantial compliance is achieved. • Abuse log, investigations completed, and findings will be reviewed at the monthly QAPI meeting, monthly times 3, quarterly times 3, and ongoing until deemed no longer necessary by the committee. • Areas of concern will be addressed at the time of discovery.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

Administrator's Signature: A Beamer **Date:** 12/13/24

PLAN OF CORRECTION

Provider/Supplier Name:	River Oaks Care Center
Street Address, City, Zip:	1001 North Walnut Street Steele, Mo 63877
Date of Survey:	11/20/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 265210	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under the State Law. The submission of this plan does not constitute an admission on the part of River Oaks Care Center as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. The plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the scope and severity regarding any of the deficiencies cited are correctly applied. The facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil action or criminal action against the facility or any employee, agent, officer, director or shareholder of the facility. Any changes to the facility policies and procedures should be considered to be subsequent remedial measures as that employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. Please accept this plan of correction with completion dates as our written credible allegation of compliance.	
	1. Corrective Action for Affected Resident:	
F610	The facility will thoroughly investigate reports of abuse and neglect and report to DHSS timely.	12/16/2024
A4074	**2. Procedure for Identifying Potentially Affected Residents**	
A8023	All residents have the potential to be affected by the deficiency	

12/13/24

	3. Measures adopted for Systemic Change	
	Head to toe body assessment is completed on Resident #2 and Resident #1 on 11/14/2024. No further concerns were noted at that time. Head to toe body assessments will be completed and documented on all residents residing in the facility by 11/15/2024. Any concerns will be addressed at time of discovery. The facility Governing body provided education to the Administrator and clinical leadership team to include Registered/Licensed nurses and facility staff on the Abuse investigation/reporting Policy and procedure, abuse coordinator, investigation, reporting policy and procedure on 11/14/2024 and/or prior to their next shift. An abuse log was implemented on 11/14/2024. Education provided to all staff that the Administrator is the Abuse Coordinator for River Oaks Care Center.	
	4. Monitoring of Corrective Action	
	Facility Abuse Allegations will be reported to the Abuse Coordinator/Administrator at the time of abuse allegation. Abuse Coordinator will report all abuse allegations to the Director of Regional Consulting and/or the Regional Nurse Consultant at the time of the report. The Director of Regional Consulting and/or Regional Nurse Consultant will review facility completed abuse investigations withing 72-96 hours, this will be completed per instance for 3 months, monthly times 1 quarter and ongoing until substantial compliance is achieved. Areas of concern will be addressed at the time of discovery The abuse log and abuse investigation reviews will be reviewed at the monthly QAPI meeting monthly times three, quarterly times three and ongoing until deemed no longer necessary by the committee.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

Adminstrator Signature: [signature] **Date:** 12/13/24