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	08/08/2025

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 67. Review of the facility's policy titled, Homelike Environment, revised February 2021, showed: - Residents are provided with a safe, clean, comfortable, homelike environment and encouraged to use their personal belongings to the extent possible; - The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting such as a clean, sanitary and orderly environment. Observations on 08/05/25 at 3:03 P.M., and 08/06/25 at 8:00 P.M., of the 300 Hall showed: - A ceiling vent with a buildup of dust and rust in the hallway outside room [ROOM NUMBER]; - A ceiling vent with a buildup of dust and rust in the hallway outside room [ROOM NUMBER]; - A two-plug electrical outlet with a protective plate cover moved with minimal effort over the bed near the window in room [ROOM NUMBER]. During an interview on 08/05/25 at 3:07 P.M., the resident in room [ROOM NUMBER] said he/she had been shocked at different times when plugging and unplugging devices from the electrical outlet. He/She wasn't harmed from being shocked and had told the last Maintenance Supervisor about it. Observations on 8/05/25 at 3:32 P.M., 08/06/2025 at 10:32 A.M., and 08/07/2025 at 9:34 A.M., of the 400 Hall showed: - An exit door with both bottom sides of the frame deteriorated with exposed jagged edges near the classroom; - Two ceiling vents with a buildup of dust and rust in the hallway outside room [ROOM NUMBER]; - Two ceiling vents with a buildup of dust and rust in the hallway between room [ROOM NUMBER] and room [ROOM NUMBER]. (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: 265210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER River Oaks Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 North Walnut Steele, MO 63877	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 08/05/25 at 3:43 P.M., 08/06/2025 at 11:55 A.M., and 08/07/2025 at 1:36 A.M., of the 500 Hall showed; - Two ceiling vents with a buildup of dust and rust in the hallway outside room [ROOM NUMBER]; - Two ceiling vents with a buildup of dust and rust in the hallway between room [ROOM NUMBER] and room [ROOM NUMBER]; - A large window mini blind hung down on the top and lower left side with several broken slabs held together with clear tape by the bed next to the window in room [ROOM NUMBER]. Observations on 08/07/25 at 1:44 P.M., and 08/08/25 at 1:44 P.M., of the laundry room showed: - Three feet (ft) of cracked, worn, and loose linoleum flooring in the dirty linen room; - Three broken floor tiles in front of the doorway near the laundry sink; - 12 broken floor tiles in front of the chemical storage platform and both side-by-side washers; - Five broken floor tiles in front of the doorway leading to the clean linen room. Review of the Maintenance Requisition form, dated May 2025 - [DATE], showed: - No documentation of the area of concerns addressed. During an interview on 08/08/25 at 9:16 A.M., Laundry Aide A said any repairs or environmental concerns were reported to the Maintenance Supervisor or written down on a maintenance requisition form. If a resident reported an electrical issue, he/she would report it immediately to the maintenance department. He/She tripped and almost fell in the dirty linen room on the cracked linoleum floor because it moved and didn't stay down. He/She reported the concern in the past to his/her supervisor. During an interview on 08/08/25 at 9:21 A.M., Housekeeper B said any repairs or environmental concerns were reported to the Maintenance Supervisor or written down on a maintenance requisition form. If a resident reported an electrical issue, he/she would report it immediately to the maintenance department. During an interview 08/08/25 at 9:37 A.M., Housekeeper C said any repairs or environmental concerns were reported to the Maintenance Supervisor or written down on a maintenance requisition form. If a resident reported an electrical issue, he/she would report it immediately to the maintenance department. He/She tripped on the floors in the laundry area due to the cracked floor tiles and loose flooring. During an interview on 08/08/2025 at 10:24 A.M., the Maintenance Supervisor said staff should write down any repairs or environmental concerns on the requisition form. Staff told him/her in passing but he/she would rather have the concern be written down so it can be documented, addressed, and/or repaired. During an interview on 08/08/25 at 3:03 P.M., the Administrator said he would expect staff to write down any repairs or environmental concerns on the maintenance requisition form. If staff verbally (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	told maintenance about a needed repair, he/she still needed to write the concern down for documentation purposes and to be addressed in a timely manner. He was not aware of the outlet issue in room [ROOM NUMBER] and would have maintenance to look at it. He would expect maintenance to repair any electrical issue with an outlet in a timely manner.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan for one resident (Resident #70) out of three sampled closed resident records that included the instructions needed to provide effective and person-centered care to meet professional standards of quality care. The facility census was 67. Review of the facility's policy titled, Care Plans - Baseline, revised March 2022, showed:- A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission;- The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meets professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to initial goals based on admission orders, discussion with the resident/representative, and physician orders;- The baseline care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed;- Provision of the summary to the resident and/or resident representative is documented in the medical record. 1. Review of Resident #70's closed medical record showed:- admitted on [DATE];- discharged on 06/02/25;- No baseline care plan completed within 48 hours after admission to the facility. During an interview on 08/07/25 at 2:47 P.M., Registered Nurse (RN) A said nursing should initiate the baseline care plan within two hours of a resident's admission to ensure it had been completed in a timely manner. During an interview on 08/07/25 at 2:49 P.M., the Director of Nursing (DON) said there should be a baseline care plan completed within 48 hours when a new resident was admitted to the facility. During an interview on 08/07/25 at 3:09 P.M., the Administrator said there should be a baseline care plan completed within 48 hours when a new resident was admitted to the facility.

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

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview, and record review, the facility failed to identify, assess, and provide supportive interventions for two residents (Residents #7 and #17) out of four sampled residents with a diagnosis of post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event). The facility's census was 67. Review of the facility's policy titled, Trauma Informed Care and Culturally Competent Care, revised August 2022, showed: - To guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice; - To address the needs of trauma survivors by minimizing triggers and/or re-traumatization; - Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being; - All staff are provided in-service training about trauma and trauma-informed care in the context of the healthcare setting; - Nursing staff are trained on trauma screening and assessment tools; - All staff are guided in evidence-based organizational and interpersonal strategies that support trauma-informed and culturally competent care; - All staff receive orientation and in-service training regarding cultural competency as an aspect of resident-centered care; - Develop individualized care plans that address past trauma in collaboration with the resident and family as appropriate; - Identify and decrease exposure to triggers that may re-traumatize the resident. 1. Review of Resident #7's medical record showed: - admission date of 10/28/18; - Diagnoses of PTSD, anxiety (persistent worry and fear about everyday situations), schizoaffective disorder (a mental health condition characterized by symptoms of both schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations) and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life)), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and insomnia (persistent problems falling and staying asleep). (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Trauma Care Informed Assessments, dated 06/18/24, 09/03/24, 03/04/25, and 06/24/25, showed: - No triggers. Review of the resident's August 2025 Physician Order Sheet (POS) showed: - An order for depakote (an anti-convulsant medication) delayed release 125 milligram (mg) by mouth two times a day for mood disorder, dated 04/16/25; - An order for citalopram (an anti-depressant medication) 20 mg daily for depression, dated 04/10/25; - An order for valium (an anti-anxiety medication)10 mg by mouth every 8 hours as needed (PRN) for anxiety, dated 10/02/24; - An order for mirtazapine (an anti-depressant medication) 7.5 mg by mouth at bedtime for anxiety, dated 06/16/25. Review of the resident's Care Plan, dated 08/06/25, showed: - Takes a psychotropic (medications that affect mental function, behavior, and experience) medication related to PTSD; - Did not address the resident's past trauma or any triggers that would cause resident to have behaviors. 2. Review of Resident #17's medical record showed:- admission date of 12/21/15;- Diagnoses of PTSD, bipolar disorder, schizoaffective disorder bipolar type, insomnia, alcohol abuse, major depressive disorder, and unspecified dementia (cognitive decline affecting memory, language, thinking and logic). Review of the resident's Trauma Care Informed Assessments, dated 08/12/24, 11/12/24, 02/14/25, and 05/15/25, showed: - No triggers . Review of the resident's August 2025 POS showed:- An order for Celexa (an anti-depressant) 10 mg by mouth daily for major depressive disorder, dated 06/05/25. Review of the resident's Care Plan, dated 08/05/25, showed:- Takes psychotropic medications related to PTSD;- Did not address past trauma or any triggers that would cause resident to have behaviors. During an interview on 08/07/25 at 2:56 P.M., the Director of Nursing (DON) said she would expect triggers to be addressed on the care plan for a resident diagnosed with PTSD. During an interview on 08/08/25 at 3:30 P.M., the Administrator said he would expect a resident with a diagnosis of PTSD to have triggers and interventions in place.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to maintain a medication error rate of less than 5 percent (%). There were 26 opportunities with 10 errors made, resulting in an error rate of 38.46% for one resident (Resident #40) in the sample and one resident (Resident #10) outside the sample of six sampled residents. The facility's census was 67.Review of the facility's policy titled, Administering Medications, revised April 2019, showed:- Medications are administered in accordance with prescribers' orders, including any required time frame;- Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. - The individual administering the medication checks he label to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication;- The individual administering the medication initials the resident's MAR (medication administration record) on the appropriate line after giving each medication and before administering the next ones;1. Review of Resident #10's Physician Order Sheet (POS), dated August 2025, showed:- admission date of 05/08/12;- Diagnoses of kyphosis (excessive curvature of the upper back), major depressive disorder (persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), anxiety (excessive and persistent worry, fear, and nervousness), hyperlipidemia (high cholesterol), hemiplegia and hemiparesis following cerebrovascular disease (paralysis of one side of the body following a stroke), cerebral infarction (stroke), dysphagia (difficulty swallowing), aphasia (difficulty speaking), dementia (cognitive decline affecting memory, thinking, and language), hypertension (high blood pressure)- An order for metoprolol (treats high blood pressure) 50 milligrams (mg), give one tablet by mouth two times daily. Hold is systolic blood pressure (top number of blood pressure) is less than 110 or diastolic blood pressure (bottom number of blood pressure) is less than 70, dated 11/06/24.Review of the resident MAR, dated August 2025, showed:- The resident's blood pressure was 148/70;- Licensed Practical Nurse (LPN) E documented the metoprolol oral tablet administered on 08/06/25 at 8:00 A.M., LPN E did not administer the medication to the resident.Observation on 08/06/25 at 8:38 A.M., of the resident's medication pass showed:- LPN E did not administer the metoprolol tablet and charted that he/she administered the medication.2. Review of Resident #40's POS, dated August 2025, showed:- admission date of 02/21/22;- Diagnoses of chronic diastolic (congestive) heart failure (the heart can't pump enough blood), vascular dementia (cognitive impairment caused by a disruption of blood flow), cerebral infarction (stroke), neuropathy (nerve pain), hypertension (high blood pressure), benign neoplasm of colon, hyperlipidemia (high cholesterol), anemia (condition where the blood doesn't have enough healthy red blood cells or enough hemoglobin, a protein that carries oxygen), glaucoma (damage to the optic nerve), type 2 diabetes mellitus (when the body cannot use insulin correctly and sugar builds up in the blood), respiratory failure, fluid overload, dependence of renal dialysis, gastro-esophageal reflux disease (GERD-), - An order for aspirin (prevents blood clots) 81milligram (mg), give one tablet by mouth one time a day, dated 02/02/25;- An order for Dialyvite/Zinc oral tablet (B-complex w/C-zinc and folic acid)(supplement for people on dialysis), give one tablet by mouth one time a day, dated 12/24/24;- An order for ferrous sulfate (iron supplement) 325 mg, give one tablet by mouth one time a day, dated 03/21/24;- An order for Megestrol Acetate (appetite stimulant) tablet 20 mg, give two tablets by mouth one time a day, dated 12/24/24;- An order for torsemide (treats fluid retention) tablet 20 mg, give one tablet by mouth one time a day, dated 04/11/25;- An order for Trajenta (decreases blood sugar) tablet 5 mg, give one tablet by mouth one time a day, dated 06/17/24;- An order for gabapentin (treats nerve pain) capsule 100 mg, give one capsule by mouth two times a day, dated 02/01/25;- An order for pantoprazole sodium (treats heartburn) tablet (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	delayed release 40 mg, give one tablet every morning and at bedtime, dated, 03/20/25;- An order for Prilosec (treats heartburn) tablet delayed release 20 mg, give one tablet two times a day, dated, 06/17/24;- An order to crush all medications and mix with pudding or applesauce every shift for difficulty swallowing, dated 01/07/25Review of the resident's MAR, dated August 2025, showed:- LPN E documented Dialyvite/Zinc oral tablet administered on 08/06/25 at 8:00 A.M., LPN E did not administer the medication to the resident;- LPN E documented the medications administered on 08/06/25 A.M. medication pass were crushed and LPN E did not crush the medications.Observation of Resident #40's medication pass on 08/06/25 at 8:48 A.M., showed:- LPN E did not administer Dialyvite/Zinc oral tablet (B-complex w/C-zinc and folic acid) and charted he/she administered the medication;- LPN E charted he/she crushed the resident's medications and mixed with pudding or applesauce and the LPN did not crush or mix the medications.During an interview on 08/07/25 at 11:45 A.M., LPN E said that Resident #40 doesn't typically require his/her medications to be crushed. LPN E said sometimes when the resident comes back from dialysis the resident is groggy or tired, so there is an order for his/her medications to be crushed if needed, but the resident always takes them whole for LPN E. LPN E did not know that Resident #10's metoprolol had not been given. During an interview on 08/08/25 at 1:50 P.M., the Director of Nursing (DON) said staff passing medications should follow physicians' orders as to what route the medications are given. If there is an order for medications to be crushed and mixed with pudding or applesauce every shift, the DON said he/she would expect staff to administer the resident's medications crushed in applesauce or pudding. The DON said staff should not chart medications have been given when they have not. During an interview on 08/08/25 at 2:15 P.M. the Administrator said if there is an order to crush resident's medications, he would expect staff to crush the resident's medications. He said staff should follow physician orders and administer medications as ordered.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to provide and document that residents received or declined Influenza (a viral infection of the respiratory system) immunizations and failed to provide and document pertinent education to the resident or resident representative regarding the benefits, side effects, or warnings of those immunizations for five residents (Residents #1, #9, #40, #41, and #49) out of five sampled residents. The facility's census was 67.Review of the facility's policy titled, Influenza Vaccine, revised August 2016, showed:- All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza;- The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or resident's legal representatives); for example, risk factors that have been identified for specific age groups or individuals with risk factors such as allergies or pregnancy;- Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees, unless the vaccine is medically contraindicated, or the resident or employee has already been immunized;- Employees hired or residents admitted between October 1st and March 31st shall be offered the vaccine within five (5) working days of the employee's job assignment or the resident's admission to the facility;- Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident/employee's medical record;- For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of the vaccination will be documented in the resident/employee's medical record;- A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenzas Vaccine and placed in the resident's medical record.1. Review of Resident #1s medical record showed:- admission date of 03/03/25;- No documentation the facility provided information and education for the influenza vaccination to the resident and/or the resident representative for this year's influenza season;- No documentation of the consent or refusal for the influenza vaccination for this year's influenza season;- No documentation the influenza vaccination was administered or declined for this year's influenza season.2. Review of Resident #9's medical record showed:- admission date of 08/26/20;- No documentation the facility provided information and education for the influenza vaccination to the resident and/or the resident representative for this year's influenza season;- No documentation of the consent or refusal for the influenza vaccination for this year's influenza season.3. Review of Resident #40's medical record showed:- admission date of 02/21/22;- No documentation the facility provided information and education for the influenza vaccination to the resident and/or the resident representative for this year's influenza season;- No documentation of the consent or refusal for the influenza vaccination for this year's influenza season.4. Review of Resident #41's medical record showed:- admission date of 02/10/09;- No documentation the facility provided information and education for the influenza vaccination to the resident and/or the resident representative for this year's influenza season;- No documentation of the consent or refusal for the influenza vaccination for this year's influenza season;- No documentation the influenza vaccination was administered or declined for this year's influenza season.5. Review of Resident #49's medical record showed:- admission date of 01/19/23;- No documentation the facility provided information and education for the influenza vaccination to the resident and/or the resident representative for this year's influenza season;- No documentation of the consent or refusal for the influenza vaccination for this year's influenza season.During an interview on 08/08/25 at 1:50 P.M., the Director of Nursing (DON), said consents (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be obtained prior to administration of immunizations. Refusals should also be signed by the resident or the resident representative.During an interview on 08/08/25 at 2:10 P.M., the Administrator said the admitting nurse obtains consent during the admission. The admitting nurse is responsible for administering any immunizations, but the Infection Preventionist and Director of Nursing should be conducting audits of those new admissions.