STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265210	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** Based on observation, interview, and record review the facility failed to follow physician's orders and standards of practice for one (Resident #1) of four sampled residents. The facility census was 54. Record review of the facility's medication policy, dated December 2016, defined a medication error as the preparation or administration of drugs or biological, which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional providing services. An example of this would be an omission, meaning a drug is ordered, but not administered. Record review of the Physician's Order Sheet (POS), dated 6/16/20 to 7/15/20, showed an order on 7/15/20 to start Keflex 500 milligram (mg) by mouth three times a day for 14 days, written under orders and listed under medications. Review of the POS [REDACTED]. Record review of the Medication Administration Record [REDACTED]. three times a day for a wound infection, the date was circled and initialed as not given. Documented on a second undated page, an order to give Keflex 500 mg three times a day for 14 days, dated 7/21/2020. Staff gave the medication three times a day on 7/21, 7/22, 7/23, 7/24, 7/25, 7/26, 7/27 and twice on 7/28. The MAR indicated [REDACTED]. Review of a photocopied prescription from Resident #1's surgeon, dated 7/14/20, showed Keflex 500 mg. three times a day for 14 days. A hand written note showed Faxed- CN 7/15/20. A Medication Error Report, dated 7/27/20, documented Certified Medication Tech (CMT A) found the error and reported it to the Director of Nursing (DON) on 7/27/20. The report documented it as a transcription error. During an interview on 8/11/20 at 10:30 A.M., the Assistant Director of Nursing (ADON) said as soon as they receive a prescription, they fax it to the pharmacy. If it is late, the medication can be obtained from the emergency kit. During a telephone interview on 8/12/20 at 1:54 P.M., CMT A said he/she found the antibiotic in the cart and asked the charge nurses if the resident was supposed to be getting them. They checked the chart and the resident was supposed to have already been taking them. She gave the resident the first dose on 7/21/20. Complaint #MO 4 #MO 6

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