

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 SS=D	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 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to thoroughly investigate and document bruises of unknown origin for one resident (Resident #15) out of one sampled residents as directed by the facility policy. The facility census was 55. 1. Review of the facility's policy titled, "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating", dated September 2022, showed all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, states, and federal agencies and thoroughly investigated by facility management. Review showed if resident abuse,	F 610			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 1 neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Review showed: -The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: -The state licensing/certification agency responsible for surveying/licensing the facility; -The local/state ombudsman; -The residents representative; -Law enforcement officials; -The resident attending physician; -The facility medical director; -Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions are needed for the protection of residents. 2. Review of Resident #15's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool used by staff, dated 02/10/25, showed staff assessed the resident as follows: -Severe Cognitive impairment; -Substantial/maximal assist from staff for toileting or shower/bathe; -Partial/moderate assist from staff for transfers, sitting to lying, and lying to sitting on bed; -Diagnoses of Non-Traumatic Brain Dysfunction, Aphasia, and Dementia; -Used wheelchair and walker. Review of the resident's plan of care, dated 03/25/25, showed staff assessed the resident impaired cognitive function/dementia or impaired	F 610			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 2 thought processes, at moderate risk for falls and an alternation in musculoskeletal status with an ataxic gait, difficulty walking, and reduced mobility. The resident's care plan did not contain documentation of a fall or bruise. Observation on 05/06/25 at 10:36 A.M., showed the resident in his/her wheelchair with a bruise on his/her left forehead and lateral left eye area. Observation on 05/07/25 at 10:07 A.M., showed the resident in his/her wheelchair with a bruise on his/her left forehead, lateral left eye area, and underneath left eye. Review of the resident's electronic medical record, showed the record did not contain documentation of the resident's bruises, or a facility investigation of the injury of unknown origin. During an interview on 05/06/25 at 2:12 P.M., Licensed Practical nurse (LPN) F said he/she was unsure where the bruise came from on the resident's face. He/She said resident may have fallen. He/She reviewed residents' electronic chart and could not find anything about the bruise or where it came from. During an interview on 05/07/25 at 10: 41 A.M., Certified Nurses Aide (CNA) G said he/she is unsure what happened to the resident's face. He/She said he/she last worked on Sunday 05/04/25 from 7 A.M. to 7 P.M. and the bruise was not on his/her face at that time. During an interview on 05/07/25 at 11:22 A.M., the Director of Nursing (DON) said he/she was informed about the bruise on Monday 05/05/25 in	F 610			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 3 the afternoon. He/She said he/she is unsure how the resident got the bruise on face. He/She said he/she has not started an investigation at this time or has not notified the doctor or family regarding the bruise because, "I just haven't had a chance." He/She said he/she is unsure of what the policy says regarding injury of unknown origin. During an interview on 05/08/25 at 8:41 A.M., the administrator said the resident can get his/herself back up after a fall. He/She said the bruise was discovered Monday morning, but nothing was put into the chart, and it should have been. He/She said the facility is now investigating the bruise. He/She said the injury of unknown origin should have been reported to state when it was discovered Monday morning.	F 610			
F 637 SS=C	Comprehensive Assessment After Significant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to complete a Significant Change Minimum Data Set (MDS), a federally mandated	F 637			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 637	Continued From page 4 resident assessment tool, for three residents (Resident #18, #44, and #47) out of 14 sampled residents who had either improvements and/or declines in condition. The facility census was 55. 1. Review of the facility's policies showed staff did not provide a policy for completion of a Significant Change of Status Assessment. Review of the Resident Assessment Instrument (RAI) manual version 3.0, dated October 2024, Omnibus Budget Reconciliation Act (OBRA)-required Assessment Summary showed assessment time frames as follows: -A significant change in status assessment (SCSA) is appropriate when there is a determination that significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent quarterly assessments and the resident's condition is not expected to return to baseline in two weeks; -A significant change is any decline in two or more of the following: decision making has changed; presence of a resident mood item no previously reported by the resident or staff and /or an increase in symptom frequency in Section E; changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since last assessment; any decline in an Activities of Daily Living (ADL) physical functioning area where a resident is newly coded as partial/moderate assistance, substantial/maximal assistance, dependent, resident refused, or the activity was not attempted since last assessment and does not reflect	F 637			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 637	Continued From page 5 normal fluctuations in that individual functioning; residents incontinence patterns changes or placement of indwelling catheter; emergence of unplanned weight loss, emergence of a new pressure ulcer at stage II (partial-thickness skin loss) or higher, a new unstageable pressure ulcer/injury (depth and extent of the tissue damage cannot be determined), a new deep tissue injury or worsening in pressure ulcer status (where the skin remains intact, but the underlying tissues are damaged); -A significant change is any improvement in two or more of the following: any improvement in ADL physical functioning area where a resident is newly coded independent, set up or clean-up assistance, or supervision or touching assistance since last assessment and dates does not reflect normal fluctuations in that individuals functioning; a decrease in areas where behavioral symptoms are coded as being present and/or the frequency of a symptom decreases; resident's decision making improves; and the resident's incontinence pattern improves; -A significant change assessment must be completed within 14 days after a determination has been made that a significant change in status has occurred and submitted within 14 days of the care plan completion date. 2. Review of Resident #18's Quarterly MDS, dated 11/04/24, showed staff assessed the resident as: -Not feeling down, depressed or hopeless, or rejection of care; -Did not have poor appetite or overeating; -Mood severity the potential for depression symptoms; -Functional limitation of range of motion to both	F 637			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 637	Continued From page 6 lower extremities; -Dependent on staff for eating, oral hygiene, upper body dressing, personal hygiene and rolling left to right; -Had pain; -No weight gain; -No presence of a stage one or greater pressure wound or Moisture Associated Skin Damage (MASD). Review of the residents quarterly MDS, dated 02/04/25, showed staff assessed the resident as: -Felt down, depressed or hopeless 7-11 days; -Had a poor appetite or overeating 2-6 days; -Mood severity score potential for depression symptoms; -Rejected care one to three days; -No functional limitation of range of motion to lower extremities; -Required substantial to maximum assistance for eating, oral hygiene, upper body dressing, personal hygiene and rolling left to right; -No pain; -Gained weight; -Had a stage one or greater pressure wound and MASD. Review of the resident's medical record showed facility staff did not complete a significant change in status assessment when the resident had a decline in feeling down, depressed or hopeless, poor appetite or overeating, new rejection of care behavior, gained weight and developed a stage one or greater pressure wound and MASD and had an improvement in pain, range of motion, eating, oral hygiene, upper body dressing, personal hygiene and rolling left to right.	F 637			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 637	Continued From page 7 During an interview on 05/08/25 at 4:24 P.M., the Corporate MDS nurse said he/she does not believe staff were coding activities of daily living correctly and a correction should have been completed but missed. 3. Review of Resident #44's Quarterly MDS, dated 11/09/24 showed staff assessed the resident as: -Moderate cognitive impairment; -Did not reject care; -No oxygen therapy; -Required partial to moderate assistance with toileting, and shower/bathing. Review of the Resident's Annual MDS, dated 02/08/25 showed staff assessed the resident as: -Severe cognitive impairment; -Rejection of care four to six days; -Required oxygen therapy; -Required substantial to maximal assistance for shower/bathing; -Dependent for toileting. Review of the resident's medical record showed facility staff did not complete a significant change in status assessment when the resident had a decline in cognition, new rejection of care behavior, required oxygen therapy, and required more assistance for toileting and bathing. 4. Review of Resident #47's Admission MDS, dated 02/19/25, showed staff assessed the resident as: -Mood severity score of one;	F 637			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 637	Continued From page 8 -Required set up assistance from staff for oral hygiene; -Dependent on staff for showers and sit to lying; -Frequently incontinent of bowel and bladder; -No pain; -No stage one or greater pressure wound. Review of the resident's 5-day Medicare Assessment, dated 04/13/25, showed staff assessed the resident as: -Mood severity score of zero; -Required partial to moderate assistance for oral hygiene; -Required substantial to maximum assistance for showers and sit to lying; -Always incontinent of bowel and bladder; -Had pain; -Presence of a stage one or greater pressure wound. Review of the resident's medical record showed facility staff did not complete a significant change in status assessment when the resident declined in mood, oral hygiene assistance, showers and sit to lying, bowel and bladder function, pain and presence of new stage one or greater pressure wound. During an interview on 05/08/25 at 4:11 P.M., the Corporate MDS nurse said a significant change should have been completed on the resident but missed it. 5. During an interview on 05/08/25 at 3:35 P.M., the Director of Nursing (DON) said staff use the RAI manual to determine a significant change of status and would include things like new referral to hospice, decline in activities or daily living,	F 637			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 637	Continued From page 9 weight loss and new pressure wounds. He/She is not sure why the assessments were not completed but should have been. He/She said the MDS Coordinator is currently a corporate nurse who is filling in until a full time staff member can be hired and trained and is responsible to ensure the MDS assessments are completed timely. During an interview on 05/08/25 at 4:11 P.M., the Corporate Nurse said he/she is currently trying to keep up with the MDS assessments along with her other responsibilities. He/She said a significant change of status is completed when there has been a significant change in the resident that would not correct itself within 14 days. He/She said if there is a determination made that a significant change of status assessment will not be completed, then a note should be put into the medical record. During an interview on 05/08/25 at 4:24 P.M., the administrator said he/she is trying to hire a full time MDS Coordinator and is using the corporate nurse for assistance to complete the MDS assessments with the help of the DON.	F 637			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 656	Continued From page 10 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to develop a	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 656	Continued From page 11 comprehensive person-centered care plan to meet the resident's medical, nursing, mental and psychosocial needs for four residents (Resident #18, #29, #40 and #47) out of five sampled residents. The facility's census was 55. 1. Review of the facility's Care Plans Goals and Objectives policy, dated April 2009, showed: -Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and are resident oriented, behaviorally stated, are measurable and contain timeframes to meet the resident's needs in accordance with the comprehensive assessment; -Goals and objectives are reviewed and/or revised when there has been a significant change in the resident's condition, when the desired outcome has not been achieved, when the resident has been readmitted to the facility from a hospital/rehabilitation stay and at least quarterly. 2. Review of Resident #18's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/04/25, showed staff assessed the resident as: -Cognitively impaired; -Limited range of motion to both upper extremities; -Dependent on staff for all care; -Diagnosis of Multiple Sclerosis (a disease that damages the nerves) and Alzheimer Dementia. Review of the resident's care plan, dated 02/13/25, showed the care plan did not contain direction or guidance for contracture management.	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 656	Continued From page 12 Observation on 05/05/25 at 1:17 P.M., showed the resident hands contracted. 3. Review of Resident #29's Admission MDS, dated 04/12/25, showed staff assessed the resident as: -Cognitively impaired; -Impaired range of motion to one upper and one lower extremity; -Diagnosis of dementia and hemiplegia (weakness or paralysis of one side of the body). Review of the resident's care plan, dated 05/05/25, showed the care plan did not contain direction or guidance for contracture management. Observation on 05/06/25 at 3:13 P.M., showed the resident left hand contracted. 4. Review of Resident #40's Annual MDS, dated 03/31/25, showed staff assessed the resident as: -Cognitively intact; -No smoking; -Diagnosis of depression. Review of the resident's care plan, dated 01/24/25, showed the care plan did not contain guidance or preference related to smoking. During an interview on 05/05/25 at 09:57 A.M., the resident said he/she smokes and keeps his/her smoking materials with him/her. He/She does not have staff supervision and goes out whenever he/she wants to the smoking area.	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 656	Continued From page 13 5. Review of Resident #47's Medicare 5-day MDS, dated 04/13/25, showed staff assessed the resident as: -Severely cognitively impaired; -Wears corrective lenses for vision; -Requires set up/clean up assistance for eating; -Required partial to moderate assistance for oral hygiene; -Required substantial to maximum assistance for rolling from left to right, sitting to lying, showers and upper body dressing; -Dependent on staff for lying to sitting, transfers, toilet hygiene, lower body dressing and putting on and taking off footwear; -Incontinent of bowel and bladder; -Presence of pain; -Prescribed a mechanically altered diet; -Presence of a stage one or higher pressure wound; -Risk for pressure wound; -Received an antipsychotic medication, antidepressant medication and an antibiotic medication; -No restraints; -Goal to remain in the facility -Diagnosis of stroke. Review of the resident's medical record, showed the record did not contain a comprehensive care plan. 6. During an interview on 05/08/25 at 3:35 P.M., the Director of Nursing (DON) said care plans should include code status, discharge planning, activities of daily living, weight/nutrition, pressure wounds, skin integrity, behaviors, tobacco use, contracture management, use of bars on the beds, or rails. He/She said the MDS Coordinator is	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 656	Continued From page 14 responsible to ensure the care plans are kept up to date, but the facility has been without a care plan coordinator and the corporate nurse is helping out. During an interview on 05/08/25 at 4:11 P.M., the Corporate Nurse said care plans should include code status, activities of daily living, discharge planning, high risk medication use, bed rails, contracture management, pain management, urinary status, falls and pressure risks, and use of psychotropic medications. He/She said the MDS nurse is responsible to update the care plans, but the facility has been without one. He/She is trying to keep them updated along with his/her other responsibilities.	F 656			
F 657 SS=C	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 657	Continued From page 15 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to hold care plan meeting with the resident and/or the resident's representative, and failed to ensure the Interdisciplinary Team (IDT) participated in care conferences for four residents (Resident #29, #31, #40, and #51) of 14 sampled residents reviewed for care planning. The facility census was 55. 1. Review of the facility's Care Plans Goals and Objectives policy, dated April 2009, showed the policy did not contain direction on contacting or inviting the resident and/or resident representative to the care planning conferences. 2. Review of Resident #29's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/12/25, showed the staff assessed the resident as cognitively impaired. During an interview on 05/06/25 at 3:15 P.M., the	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 657	Continued From page 16 resident said he/she has not been invited to a meeting to discuss his/her care plan. During an interview on 05/08/25 at 11:29 A.M., the resident's family member said he/she had not been invited to a care plan meeting. Review of the resident's medical record showed the record did not contain documentation of a care plan meeting or the IDT team attended a care plan conference. 3. Review of Resident #31's Quarterly MDS, dated 03/31/25, showed the staff assessed the resident as cognitively intact. During an interview on 05/05/25 at 2:30 P.M., the resident said he/she has never attended care plan meeting. Review of the resident's medical record showed the record did not contain documentation of a care plan meeting or the IDT team attended a care plan conference. 4. Review of Resident #40's Annual MDS, dated 03/31/25, showed the staff assessed the resident as cognitively intact. During an interview on 05/05/25 at 9:57 A.M., the resident said he/she had not been invited to a care plan meeting since September. Review of the resident's medical record showed the record did not contain documentation of a care plan meeting or the IDT team attended a care plan conference. 5. Review of Resident #51's dated 02/07/25,	F 657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 657	Continued From page 17 showed the staff assessed the resident as cognitively impaired. During an interview on 05/06/25 at 2:15 P.M., the resident said he/she has never attended care plan meeting. During an interview on 05/06/25 at 2:16 P.M., the resident family member said he/she had not been invited to a care plan meeting. 6. During an interview on 05/07/25, at 2:07 P.M., the Care Plan Coordinator/Corporate nurse said he/she has not been doing care plan meetings, he/she has just not had time. During an interview on 05/07/25 at 2:08 P.M., the Director of Nursing (DON) said he/she has not done care plan meetings, and there is no documentation to provide. During an interview on 05/07/25 at 02:09 P.M., the administrator said the MDS Coordinator/Corporate nurse/Care Plan Coordinator, with the help of the DON is responsible for care plan meetings. The facility is currently without a full time MDS Coordinator/Care Plan coordinator so the corporate nurse is trying to help keep up with all these responsibilities.	F 657			
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 658	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to meet professional standards of practice when they failed follow a treatment order for one resident (Resident #2) out of three sampled residents, notify the physician or follow up with the pharmacy when a medication was unavailable for one resident (Resident #4) out of one sampled residents, failed to ensure one resident (Resident #17) out of five sampled residents oxygen was in place, and one resident (Resident #25) out of five sampled residents oxygen delivery was at the prescribed flow rate. Staff failed to follow physician orders when they failed to document one resident's weight (Resident #51) out of two sampled residents daily, and perform a urinalysis test for one resident (#55) out of one sampled residents. The facility census was 55. 1. Review of facility's Medication and Treatment Orders policy, dated July 2016, showed staff were directed as follows: -Medication shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medication in this state; -Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills are readily available. 2. Review of Resident #2's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/18/25 showed the staff assessed the resident as cognitively intact.	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 658	Continued From page 19 Review of the resident's Physician Order Sheet (POS), dated April 2025, showed the following orders: -Apply Hydrocortisone 2.5% cream (a topical steroid medication used to treat skin conditions that cause inflammation, itching, and redness) mixed with Ketoconazole (to treat skin infections caused by fungi) to under arms, chest, and groin area one time a day; -Clobetasol Propionate external cream 0.05% (reduces swelling, redness, itching and rashes) apply to skin folds topically every shift. Review of the resident's Treatment Administration Record (TAR), dated April 2025, showed staff documented the Hydrocortisone 2.5% Cream as not administered due to "doing different treatment" on the following dates: -April 11; -April 15; -April 16; -April 19; -April 20; -April 24; -April 30. Review of the resident's TAR, dated May 2025, showed staff documented the Hydrocortisone 2.5% Cream as not administered due to "doing different treatment" on the following dates: -May 3; -May 5. During an interview on 05/05/25 at 11:14 A.M., the resident said he/she has treatment orders for	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 658	Continued From page 20 his/her sores and he/she is supposed to have a treatment twice a day, but it maybe only gets done once a day. During an interview on 05/08/25 at 3:45 P.M., the Director of Nursing (DON) said he/she is not 100% sure why the resident has two different cream orders. He/She said he/she saw the two orders this morning and agrees it needs to be clarified on which order should be done. He/She said the nurse doing the treatment should clarify with physician which treatment should be done instead of putting "using different treatment." He/She said he/she is responsible for ensuring that all orders are correct. During an interview on 05/08/25 at 4:25 P.M., the administrator said if there are conflicting treatment orders the charge nurse should clarify the order with the physician on which treatment should be done. He/She said the Assistant Director of Nursing (ADON) and DON should be doing chart checks and audits on all the charts when a resident goes out to the hopsital and comes back, with significant changes, and quarterly. 3. Review of Resident #4's Annual MDS, dated 03/20/25, showed the staff assessed the resident as cognitively intact. Review of the resident's POS, dated April 2025, showed the physician directed staff to administer: -Norco (to relieve moderate to severe pain) oral tablet 10-325 milligram (mg), give one tablet by mouth every four hours for pain; -Norco oral tablet 5-325mg, give two tablets by mouth six times a day for pain. May use two	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 658	Continued From page 21 5/325mg Norco from Omnicell (automated dispensing cabinets are used to store and dispense medications) until residents Norco 10/325 tabs arrive, then discontinue 5/325mg order. Review of the resident's Medication Administration Record (MAR), dated April 2025, showed staff documented: -Norco 10-325mg unavailable on 04/19/25 at 4:00 A.M. through 04/23/25 at 4:00 P.M.; -Norco 5-325mg unavailable from Omnicell from 04/22/25 at 12:00 P.M. through 04/23/25 at 4:00 P.M. Review of the residents nurse notes, dated 04/19/25 through 04/21/25, showed staff did not document contact with the physician or the pharmacy until 4/21/25 at 9:10 P.M. when the resident did not receive his/her Norco 10-325mg. Review of the nurses notes, dated 4/22/25 through 4/23/25 showed staff did not document contact with the physician or the pharmacy when the resident did not receive his/her Norco 5-325mg 2 tablets due to medication unavailable from Omnicell. During an interview on 05/06/25 at 09:32 A.M., the resident said in April the facility was out of his/her medication for about six days before they finally received it from the pharmacy. During an interview on 05/08/25 at 3:45 P.M., the Director of Nursing (DON) said he/she was aware of resident pain medication not being available in April. He/She said they were waiting on the script from pharmacy. He/She said he/she was not	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 658	Continued From page 22 aware that the substitution order of Norco 5/325mg two tablets were unavailable from the Omnicell for any period of time nor that the resident missed more doses of pain medication. He/She said it is the charge nurse's responsibility to call the pharmacy and see about the medication when it is not available. He/She said the charge nurse should contact the physician to get another order and to ensure the pharmacy received the script. During an interview on 05/08/25 at 4:25 P.M., the administrator said the Charge nurse should notify the pharmacy of a needed refill five days before the script runs out. He/She said the charge nurse should notify the physician if a medication is not available to get a new order. 4. Review of Resident #17's Quarterly MDS, dated 01/23/25 showed the staff assessed the resident as severely cognitive impairment. Review of the resident's POS, dated April 2025, showed: -Oxygen at two Liter (L) per nasal cannula, every shift; -Oxygen Tubing and humidifier change, clean concentrator filter every Wednesday night. Observation on 05/05/25 at 1:18 P.M., showed the resident in the lounge area without oxygen in place. The wheelchair did not have an oxygen tank or tubing on the back. Observation on 05/06/25 at 9:15 A.M., showed the resident in the lounge area without oxygen in place. The wheelchair did not have an oxygen tank or tubing on the back.	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 658	Continued From page 23 Observation on 05/07/25 at 10:10 A.M., showed the resident in the bed without oxygen in place and no oxygen concentrator in room. Observation on 05/08/25 at 11:05 A.M., showed the resident in the lounge area without oxygen in place. The wheelchair did not have an oxygen tank or tubing on the back. During an interview on 05/08/25 at 3:20 P.M., LPN E said residents' oxygen saturation is checked every shift. He/She said he/she believes the resident has an oxygen order as needed if oxygen gets below a certain level. During an interview on 05/08/25 at 3:45 P.M., the DON said resident does not use oxygen. He/She said he/she was aware of the oxygen order but thought it was as needed. During an interview on 05/08/25 at 4:35 P.M., the administrator said he/she would expect oxygen to be on resident if it is ordered. He/She said the ADON and DON should be doing chart checks and audits on all the charts when a resident goes out to hospital and comes back, with significant changes, and quarterly. 5. Review of Resident #25's Annual MDS, dated 03/08/25 showed the staff assessed the resident as cognitively intact. Review of the resident's POS, dated April 2025, showed continuous oxygen at two liters per nasal cannula. Observation on 05/05/25 at 10:22 A.M., showed	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 658	Continued From page 24 resident in bed with oxygen via nasal cannula at 3.5 liters. Observation on 05/07/25 at 1:30 P.M., showed resident in bed with oxygen via nasal cannula at 3.5 liters. Observation on 05/08/25 at 11:18 A.M., showed resident in bed with oxygen via nasal cannula at 3.5 liters. During an interview on 05/07/25 at 1:30 P.M. the resident said his/her oxygen should be on two liters. During an interview on 05/08/25 at 3:20 P.M., LPN E said he/she is agency and only works about once a month. He/She said he/she knows they checked the resident oxygen every shift. He/She said he/she is unsure of what liter of oxygen without looking in chart, but he/she believes the resident told her five liters last time he/she worked. During an interview on 05/08/25 at 3:45 P.M., the DON said it is not okay for oxygen to be on a different liter then what is ordered. He/She said the charge nurse is responsible for checking every shift to ensure oxygen is on the correct liter as ordered. During an interview on 05/08/25 at 4:25 P.M., the administrator said he/she expects oxygen to be on same liter that is ordered. He/She said the charge nurse is responsible for checking oxygen every shift and correct the oxygen liter if it is wrong. He/She said the DON oversees that the orders are being followed.	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 658	Continued From page 25 6. Review of facility's policy's, Weight Assessment and Intervention, revised March 2022, showed: -Resident weights are monitored for undesirable or unintended weight loss or gain; -Residents are weighed upon admission and at intervals established by the interdisciplinary team; -Weights are recorded in the individual's medical record. 7. Review of Resident #51's Admission MDS, dated 04/03/25, showed staff assessed the resident as follows: -Moderate cognitive impairment; -Dependent on staff for mobility, and transfers; -Diagnosis of Congestive Heart Failure. Review of the resident's POS, dated 03/29/25, showed an order for daily weights, notify physician if weight increases or decreases by three pounds in one day or three pounds in one week. Every day shift. Review of the resident's medical record, dated 03/29/25 through 05/08/25, showed the following dates and weights for the resident: -03/29/25- 229.3 Lbs; -03/30/25- did not contain a weight; -03/31/25- 209.1 Lbs. -04/01/25- 212.8 Lbs; -04/02/25- 213.2 Lbs; -04/03/25- did not contain a weight; -04/04/25- 213.0 Lbs; -04/05/25- did not contain a weight; -The record did not contain a daily weight, or	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 658	Continued From page 26 documentation of physician notification with a increase or decrease in weight by three pounds daily or for the week -04/06/25- did not contain a weight; -04/07/25- 215.0 Lbs; -04/08/25- 214.6 Lbs; -04/09/25- did not contain a weight; -04/10/25- did not contain a weight; -04/11/25- did not contain a weight; -04/12/25- 215.2 Lbs; -The record did not contain a daily weight for this week. -04/13/25 - 214.4 Lbs; -04/14/25- did not contain a weight; -04/15/25- 213.9 Lbs; -04/16/25 - did not contain a weight; -04/17/25- 207.0 Lbs; -04/18/25- 206.0 Lbs; -04/19/25- 206.8 Lbs; -The record did not contain a daily weight, or documentation of physician notification with a increase or decrease in weight for the week. -04/20/25- 205.0 Lbs; -04/21/25- did not contain a weight; -04/22/25- did not contain a weight; -04/23/25- did not contain a weight; -04/24/25- 203.8 Lbs; -04/25/25- did not contain a weight; -04/26/25- did not contain a weight; -The record did not contain a daily weight for this week. -04/27/25- 215.4 Lbs; -04/28/25- 218.4 Lbs; -04/29/25- 217.2 Lbs; -04/30/25- did not contain a weight;	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 658	Continued From page 27 -05/01/25- did not contain a weight; -05/02/25- 222.4 Lbs; -05/03/25- did not contain a weight; -The record did not contain a daily weight, or documentation of physician notification with a increase or decrease in weight by three pounds daily or for the week. -05/04/25- 219.6 Lbs; -05/05/25- did not contain a weight; -05/05/25- did not contain a weight; -05/06/25- 216.2 Lbs; -05/07/25- did not contain a weight; -05/08/25- did not contain a weight; -The record did not contain a daily weight, or documentation of physician notification with a increase or decrease in weight by three pounds daily or for the week. During an interview on 05/07/25 at 1:50 P.M., the resident said he/she is not weighed every day and said he/she does not refuse to be weighed. During an interview on 05/08/25 at 1:10 P.M., LPN A said it is the responsibility of the charge nurse to make sure weights are done. LPN A said the resident is in and out of the facility often with his/her family member that maybe why some weights are missing. The LPN said staff should still try to get a weight when the resident is back in the facility. LPN A said he/she does not know if the doctor has been contacted about fluctuation of weights on this resident, but if it was done it would be documented in the resident's medical record. During an interview on 05/08/25 at 3:35 P.M., the DON said the resident has congestive heart failure and possible swelling which is more then	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 658	Continued From page 28 likely why he/she has weights ordered daily. The DON said the resident can be noncompliant but will usually do the weights. The DON said she did not know the order said to notify the weight change to the doctor, therefore does not is unsure of it being done. During an interview on 05/08/25 at 4:25 P.M., the administrator said he is unsure about weights being done, but would expect staff to follow physician orders. 8. Review of the facility's policies showed staff did not provide a policy for physicians orders. 9. Review of Resident #55's Admission MDS, dated 04/0/25, showed staff assessed the resident as follows: -Cognitively intact; -Indwelling catheter. Review of the residents progress note, dated 05/05/25, showed the facility Nurse Practitioner (NP) documented the resident continued to have foul urine, previous urine test was not sent off to lab, new orders given to repeat. Review of the resident's POS, dated 05/08/25, showed the record did not contain an order for urine test. During an interview on 05/05/25 at 10:45 A.M., the resident said he/she has had some symptoms of a possible Urinary Tract Infection (UTI), and had spoken with the NP several days ago and a urine test should have been ordered, but he/she has not heard anything.	F 658			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 658	Continued From page 29 During an interview on 05/08/25 at 1:12 P.M., LPN A said new orders are put into the residents chart as they are given, the charge nurse will confirm orders at the start of shift. The LPN said not all nurses have access to the doctors or nurse practitioner's notes. LPN A was not aware of a urinalysis test ordered for the resident. During an interview on 05/08/25 at 3:39 P.M., the DON said they will obtain the urine test today, he/she said the NP sits down with her and goes over any new orders after his/her rounds. The DON said he/she is responsible to transcribe the orders given to him/her by the NP. The DON said the order must have been missed being put onto the residents POS. During an interview on 05/08/25 at 4:27 P.M., the Administrator said he is unsure why the order was not put on the residents POS, the DON is responsible to put the order in as she sits down with the NP and goes over this after he/she sees the residents.	F 658			
F 725 SS=C	MO00253550 Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 725	Continued From page 30 and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to provide a sufficient number of staff members to ensure call lights were answered in timely manner. The facility census was 55 . 1. Review of the facility assessment tool, dated 02/13/25, showed: -Average census of 63 residents; -Direct care staff needed for a 24-hour period of time: -Licensed Nurses: two for each shift; -Certified Medication Technicians (CMT's): two on dayshift; -Certified Nurse Aides (CNA's): One to 15 residents on dayshift and one to 19 residents on	F 725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 725	Continued From page 31 nightshift. Review of the facility's Call Lights Policy, dated March 2021, showed the procedure is to ensure timely responses to resident's requests and needs. The policy did not contain direction for who may answer the call light. 2. Review of the Nursing staff time clock report, dated 05/02/25, showed: -Dayshift: One Registered Nurse (RN), Three Licensed Practical Nurse (LPN), three CMT, three CNA, and three Nurse Aides (NA); -Nightshift: two LPN, one CMT and two CNA. Review of the facility's wireless call light report, dated 05/02/25 showed: -At 1:07 A.M., Room 308 with call light response time of 31 minutes; -At 3:35 A.M., Room 308 with call light response time of 50 minutes; -At 4:33 A.M., Room 505 with call light response time of 49 minutes; -At 5:02 A.M., Room 308 with call light response time of 36 minutes; -At 6:20 A.M., Room 304 with call light response time of 30 minutes; -At 6:20 A.M., Room 510 with call light response time of 34 minutes; -At 6:21 A.M., Room 308 with call light response time of 1 hour and 4 minutes; -At 8:09 A.M., Room 511 with call light response time of 31 minutes; -At 9:35 A.M., Room 306 with call light response time of 46 minutes; -At 9:41 A.M., Room 507 with call light response time of 39 minutes;	F 725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 725	Continued From page 32 -At 10:35 A.M., Room 303 with call light response time of 42 minutes; -At 11:19 A.M., Room 303 with call light response time of 1 hour and 6 minutes; -At 11:31 A.M., Room 10 with call light response time of 41 minutes; -At 12:23 P.M., Room 306 with call light response time of 42 minutes; -At 12:43 P.M., Room 6 with call light response time of 40 minutes; -At 12:48 P.M., Room 308 with call light response time of 30 minutes; -At 1:29 P.M., Room 411 with call light response time of 30 minutes; -At 3:37 P.M., Room 509 with call light response time of 39 minutes; -At 3:49 P.M., Room 415 with call light response time of 30 minutes; -At 4:22 P.M., Room 308 with call light response time of 1 hour and 41 minutes; -At 4:38 P.M., Room 306 with call light response time of 47 minutes; -At 4:44 P.M., Room 9 with call light response time of 38 minutes; -At 5:32 P.M., Room 303 with call light response time of 55 minutes; -At 5:32 P.M., Room 510 with call light response time of 35 minutes; -At 5:44 P.M., Room 304 with call light response time of 35 minutes; -At 6:19 P.M., Room 510 with call light response time of 38 minutes; -At 6:58 P.M., Room 510 with call light response time of 1 hour and 33 minutes; -At 7:17 P.M., Room 10 with call light response time of 43 minutes; -At 7:48 P.M., Room 507 with call light response time of 1 hour; -At 8:09 P.M., Room 502 with call light response	F 725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 725	Continued From page 33 time of 1 hour and 14 minutes; -At 8:44 P.M., Room 510 with call light response time of 54 minutes; -At 9:05 P.M., Room 511 with call light response time of 32 minutes; -At 11:06 P.M., Room 303 with call light response time of 47 minutes; -At 11:54 P.M., Room 510 with call light response time of 34 minutes. 3. Review of the Nursing staff time clock report, dated 05/03/25, showed: -Dayshift: one RN, one LPN, two CMT, five CNA, and one NA; -Nightshift: two LPN, three CNA, and two NA. Review of the facility's wireless call light report, dated 05/03/25 showed: -At 6:27 A.M., Room 5 with call light response time of 35 minutes; -At 6:31 A.M., Room 510 with call light response time of 36 minutes; -At 9:42 A.M., Room 510 with call light response time of 35 minutes; -At 12:15 P.M., Room 6 with call light response time of 36 minutes; -At 3:18 P.M., Room 303 with call light response time of 56 minutes; -At 3:26 P.M., Room 407 with call light response time of 30 minutes. 4. Review of the Nursing staff time clock report, dated 05/04/25, showed: -Dayshift: two LPN, three CMT, four CNA and one NA; -Nightshift: two LPN, three CNA, and two NA.	F 725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 725	Continued From page 34 Review of the facility's wireless call light report, dated 05/04/25 showed: -At 10:06 A.M., Room 502 with call light response time of 42 minutes; -At 10:40 A.M., Room 405 with call light response time of 1 hour and 52 minutes; -At 12:44 P.M., Room 405 with call light response time of 34 minutes; -At 2:58 P.M., Room 505 with call light response time of 31 minutes; -At 10:46 P.M., Room 4 with call light response time of 33 minutes; -At 10:48 P.M., Room 301 with call light response time of 32 minutes; -At 11:10 P.M., Room 303 with call light response time of 33 minutes. 5. Review of the Nursing staff time clock report, dated, 05/05/25, showed: -Dayshift: two LPN, three CMT, three CNA and two NA; -Nightshift: one RN, one LPN, one CMT, five CNA and one NA. Review of the facility's wireless call light report, dated 05/05/25 showed: -At 3:19 A.M., Room 510 with call light response time of 39 minutes; -At 4:31 A.M., Room 510 with call light response time of 37 minutes; -At 5:35 A.M., Room 402 with call light response time of 1 hour and 16 minutes; -At 6:21 A.M., Room 407 with call light response time of 31 minutes; -At 7:04 A.M., Room 510 with call light response	F 725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 725	Continued From page 35 time of 1 hour; -At 7:59 A.M., Room 4 with call light response time of 33 minutes; -At 12:01 P.M., Room 306 with call light response time of 37 minutes; -At 12:03 P.M., Room 306 with call light response time of 35 minutes; -At 1:26 P.M., Room 406 with call light response time of 31 minutes; -At 3:08 P.M., Room 9 with call light response time of 52 minutes; -At 3:52 P.M., Room 306 with call light response time of 1 hour and 17 minutes; -At 4:01 P.M., Room 303 with call light response time of 1 hour and 21 minutes; -At 4:40 P.M., Room 207 with call light response time of 1 hour and 5 minutes; -At 5:05 P.M., Room 510 with call light response time of 36 minutes; -At 5:15 P.M., Room 1 with call light response time of 36 minutes; -At 5:18 P.M., Room 4 with call light response time of 36 minutes; -At 5:24 P.M., Room 7 with call light response time of 32 minutes; -At 6:21 P.M., Room 10 with call light response time of 38 minutes; -At 6:54 P.M., Room 12 with call light response time of 31 minutes; -At 11:37 P.M., Room 303 with call light response time of 33 minutes; -At 11:52 P.M., Room 308 with call light response time of 38 minutes. 6. During an interview on 05/05/25 at 9:39 A.M., Resident #24 said call lights sometimes go unanswered for over 15-20 minutes and gets tired of waiting. He/She said he/she is supposed to wait for staff to help him/her transfer and walk.	F 725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 725	Continued From page 36 Sometimes there is two aides on each hall, but my hall is the one that gets hit with only one. He/She said staff is shorter mostly on the day hours but does happen on the nights too. During an interview on 05/05/25 at 9:57 A.M., Resident #39 said staffing is a huge issue. Staff take a really long time to answer call lights and makes him/her feel like they don't matter. He/She said sometimes he/she scoots down in the bed and it hurts his/her bottom when staff cannot come in a decent timeframe. During an interview on 05/05/25 at 9:57 A.M., Resident #29 said often call lights take over 30 to 40 minutes to be answered and is unacceptable. He/She said he/she has anxiety and one time it was elevated and it took over an hour to get a staff member to get his/her something for his/her anxiety. He/She said the aides are notified when the light is sounded, then if not answered, goes to the nurse, then the management. He/She said he/she has expressed his/her concern with management but has not heard back. The resident said he/she is not a high call bell user, but when pressing it, there is a need. He/She believes staff should answer the lights within 15 minutes or less. During an interview on 05/05/25 at 10:27 A.M., Resident #26 said there isn't enough staff to ensure he/she is out of bed for activities. The resident said he/she requires a mechanical lift to get into and out of bed and requires an extra staff member. Often times, he/she puts on the call light and staff push it off, leave to get help and either do not return or its 30 minutes to an hour later. He/She said one night he/she pushed the call light and requested to go to bed. He/She said	F 725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 725	Continued From page 37 it took over three hours to get put to bed. The resident said he/she brought the concern to the management but is told they are doing the best they can and/or they cannot find good people to work. He/She feels like since he/she takes a little bit longer for care, he/she is put on the bottom of the aides list. During an interview on 05/05/25 at 11:17 A.M., Resident #35 said staff do not get him/her up when he/she wants to get up, and is often told it's because they don't have enough help, he/she is a mechanical lift transfer. The resident said staff will often come into their room, shut the call light off, and say they will come back but don't. During an interview on 05/05/25 at 2:53 P.M., Resident #21 said there isn't enough staff. He/She said it takes over 40 minutes to answer his/her light he/she hates to sit in bowel movement. He/She gets tired of the staff that are just working for a paycheck. The resident said he/she is at the facility because he/she needs care and expects staff to provide it, timely. During an interview on 05/06/25 at 9:23 A.M., Resident #4 said call light times are long on days and evenings. The resident said, "I've waited over two hours quite often." During an interview on 05/08/25 at 10:18 A.M., Certified Nurse Aide (CNA) D said call lights could take a little longer when the facility is short staffed but most of the time the average time to answer call lights is around five to eight minutes and does not know of any resident complaints of long call light times. He/She said 10 minutes or longer to let a call light to go unanswered is unacceptable because to a resident, it may feel a	F 725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 725	Continued From page 38 lot longer or the resident may have fell or some other accident may have happened. He/She said when there are times when there isn't enough staff, the current staff will team up and work together to get things done. During an interview on 5/8/25 at 11:15 A.M., Licensed Practical Nurse (LPN) E said the average call light wait time is around 20-30 minutes but should be less than 15. He/She said the time of day plays a part in long call lights such as around meals and right after supper, which is when staff are assisting a lot of residents, treatments are being completed, and that some of the residents can be demanding. He/She said having to wait that long can increase the risk of resident harm, depending on their critical care needs. The nurse said that he/she believes that only nursing staff have access to the nurse call system and are the only ones who can access the call lights. Residents do complain about having to wait, but staff do the best they can. During an interview on 05/08/25 at 12:58 P.M, LPN A said the average call light response time is between eight and 10 minutes but during meals may go up to 15 minutes. He/She said the staff do the best they can for what they have. Some days more help is needed but the management is good about getting agency staff to help out. If call lights go beyond 15 minutes or longer, the resident could be in distress or there might be an emergency. During an interview on 05/08/25 at 03:35 P.M., the Director of Nursing (DON) said the average call light response time is around 11 minutes and would be considered unacceptable to go beyond 15 minutes. He/She said staff don't know if there	F 725			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 725	Continued From page 39 is an emergency or not or life and death. He/She said just nursing has access to the call light system and is set up to go through an application on either the facility provided device or the staff's personal cell phone. He/She said he/she reviews the call light log but was not aware of the call lights going beyond 30 minutes as presented in the call light report. During an interview on 5/8/25 at 4:24 P.M., the Administrator said staff call light response time for the past month and half has been 10-15 minutes. He/She said going over 15 minutes to respond to a residents call light is unacceptable. The Administrator said that sometimes the staff will answer the call light and if unable to meet the needs will leave the light on so that they don't forget. The call light logs are discussed in the facility Interdisciplinary Team meetings and notifications come up on his/her phone all the time. He/She said he/she calls the facility weekly to discuss with staff how to improve time management and is aware call lights are an issue. There is enough staff but the current staff need better training in time management.	F 725			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 812	Continued From page 40 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to maintain and serve food items at temperatures adequate to prevent food borne illness. This failure has the potential to affect all residents. The facility census was 55. 1. Review of the facility's Serving Temperatures for Hot and Cold Foods policy, dated 2020, showed the cook will take temperatures of hot and cold food items using approved food thermometers prior to each meal service. Hot foods will be served at 135 to 170 degrees Fahrenheit (F). Each facility should check state specific regulations for minimum temperatures. Review showed cold foods will be served at 41 degrees F or below. Review showed the policy did not contain guidance related to cold food storage between meals. Observation on 05/05/25 at 11:27 A.M., showed the area below the kitchen service window contained a four-drawer refrigerator, which contained a cold table on top. Observation showed the cold table contained ham, sliced cheese, shredded cheese, lettuce, sliced tomatoes, jalapeno peppers and boiled eggs. Observation showed the food temperatures on	F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 812	Continued From page 41 the cold table: -Shredded cheese, 46 degrees F; -Ham, 47 degrees F; -Sliced cheese, 48 degrees F; -Boiled eggs in the table well, 49 degrees. Observation showed a second metal bin of boiled eggs set on top of the bin, which set in the table. The temperature of the top boiled eggs was 71 degrees F. Observation showed kitchen staff used items from the cold table during lunch service. Observation on 05/05/25 at 11:48 A.M., showed the Dietary Manager (DM) served the residents the lunch meal. Observation showed the temperature of the pureed chicken and pureed vegetables, which were being held in steam table pans, were both 122 degrees F. Observation showed the DM served the pureed items to two residents. Observation showed the temperature of the chicken, which was served to residents who received regular diets was 131 degrees F. Observation on 05/06/25 at 12:05 P.M. showed the cold table contained ham, cheese, lettuce, sliced tomatoes, jalapeno peppers and boiled eggs. Observation showed the temperature of the ham and boiled eggs were 46 degrees F when checked using a calibrated digital thermometer. Observation on 05/07/25 at 11:46 A.M., showed the temperature of the ham on the cold table was 45 degrees F when checked with a calibrated digital thermometer. During an interview on 05/06/25 at 12:05 P.M. the DM said cold table food should be held at 40	F 812			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 812	Continued From page 42 degrees or below. The DM said the cook was responsible for checking food temperatures. The DM said he/she checked the thermometer in the four-drawer refrigerator below the cold table, but he/she never checked the food temperatures on the cold table. The DM said the cold table was covered with a metal lid at the end of the day so the food items remained in the cold table between meals. The DM said he/she ran out of alcohol wipes the day prior, so he/she did not check food temperatures. The DM said hot foods should be held at 135 degrees F or higher. During an interview on 05/06/25 at 12:10 P.M., Cook C said food on the cold table should be held at 30 to 35 degrees, but not frozen. Cook C said he/she checked meat and egg temperatures but did not check the temperature of other food items which were held on the cold table. Cook C said he/she did not document cold table food temperatures. During an interview on 05/06/25 at 1:30 P.M., the administrator said the DM and cooks were responsible for ensuring all cold foods were held below 40 degrees and hot foods were held at greater than 140 degrees. The administrator said he/she was not aware of any issues with food holding temperatures.	F 812			
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must	F 947			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 947	Continued From page 43 be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to ensure continuing competence of nurse aides of no less than 12 hours in-service education per year and address areas of weakness as determined in nurse aides' performance reviews and the facility assessment. The facility census was 55. 1. Review of the facility's policies showed staff did not provide a policy for staff training. Review of the Facility Assessment, dated 02/13/25, showed the following new hire training for nursing staff: -Advanced directives; -Effective communication; -Preventing, recognizing and reporting abuse; -Workplace safety; -Hand hygiene; -Health Insurance Portability and Accountability (HIPAA), a law that protects the privacy of	F 947			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 947	Continued From page 44 medical information, overview; -Infection prevention and control; -Protecting Resident rights in nursing facilities; -Safe transfers; -Perineal Care check list; -Dementia care: managing challenging behaviors; -Emergency Disaster Preparedness; -Electronic Medical Record charting; -Annual education includes all the new hire training plus the topics of corporate compliance, overview of the aging process and pressure ulcer prevention; -Training is provided through direct 1:1 education, group in-servicing, return demonstration and online web-based curriculum. -Additional education and training resources are available as needed through contracted companies/vendors. Review of the facility's web-based curriculum training plan, undated showed the plan did not contain pressure ulcer prevention education. Review of the group based in-service training showed the following: -July 2024, training included oxygen safety, emergency preparedness and medication storage; -October 2024, training included Hipaa/Privacy, abuse reporting and investigating, medication and treatment orders, medication administration, medication storage, and needle handling; -December 2024, training included showers, timely call lights, wheelchair cleansing, dependent care for residents, passing ice water, and Enhanced Barrier Precautions (EBP); -March 2025, training included activities of daily living, care of nails, and advanced directives;	F 947			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 947	Continued From page 45 -The group-based in-services did not contain documentation of length of training, pressure ulcer prevention or any training for the months of March, April, May, June, August, September, October or November of 2024 or January and February of 2025. 2. Review of Certified Nurse Aide (CNA) H's employee file showed a hire date of 06/21/23. Review of the CNA's web-based training record showed he/she did not complete the assigned fire safety, flooding, corporate compliance essentials of quality improvement, hazardous chemicals, minimizing slips, trips and falls, preventing/recognizing/reporting of abuse, sharps injury, transferring safely, essentials of HIPPA, and dementia care module 1, 2, and 3 training. The training did not contain the number of hours of completed courses. 3. Review of Certified Medication Technician (CMT) B's employee file showed a hire date of 11/20/23. Review of the CMT's web-based training record showed he/she did not complete the assigned advanced directives, infection prevention and control, communication, preventing/recognizing/reporting abuse, essentials of resident rights, or dementia care modules 1-5. The training did not contain the number of hours of completed courses. 4. Review of CMT I's employee file showed a hire date of 06/24/24. Review of the CMT's web-based training record showed he/she did not complete any assigned	F 947			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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 947	Continued From page 46 web-based training. 5. Review of CMT J's employee file showed a hire date of 03/18/24. Review of the CMT's web-based training record showed he/she did not complete the assigned active shooter, equipment failure, emergency preparedness, earthquake preparedness, flooding, fire safety, advanced directives, quality improvement, hazardous chemicals, minimizing slips/trips/falls, oxygen safety, essentials of HIPPA, and tornado watch training. The training did not contain the number of hours of completed courses. 6. During an interview on 05/07/25 at 10:39 A.M., the Administrator said that the required training is posted in the employee breakroom with a list of topics and a list of staff who are behind. Staff are expected to get them done. During an interview on 05/08/25 at 10:18 A.M., CNA D said there is in-house group training once a month that goes over facility concerns. He/She said he/she is not sure how long they are and has not received an evaluation or review. The CNA said he/she will be employed one year next month. During an interview on 05/08/25 at 03:35 P.M., the Director of Nursing (DON) said staff training is completed and monitored by the DON and the Administrator using a web-based training program. He/She said he/she does not know how the 12-hour required training is tracked or who is responsible to track it. Education is determined by what is going on in the facility at the time of the training and said annual reviews	F 947			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265285		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/08/2025	
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109			
(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 947	Continued From page 47 are completed by the DON and Administrator and reviewed with the staff member. During an interview on 05/08/25 at 04:24 P.M., the Administrator said the web based program tracks the hours of completion and should be monitored by the DON. The DON and Administrator are responsible to ensure nursing staff receive all the required training to include topics in the facility assessment and based on resident needs. Yearly performance reviews are completed at the administrator level and staff are given wage increases based off of them, but do not determine education. Education is determined at a corporate level using best practice and Centers for Medicare and Medicaid Services (CMS) guidelines. He/She was unaware staff did not have the required education completed.			F 947			

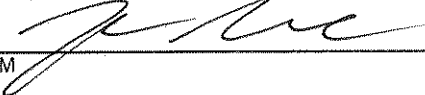
Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 03870	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/08/2025
---	---	--	--

NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109
---	--

(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
A4046	19 CSR 30-85.042(37) Nursing Staff Sufficient/Qualified All facilities shall employ nursing personnel in sufficient numbers and with sufficient qualifications to provide nursing and related services which enable each resident to attain or maintain the highest practicable level of physical, mental and psychosocial well-being. Each facility shall have a licensed nurse in charge who is responsible for evaluating the needs of the residents on a daily and continuous basis to ensure there are sufficient, trained staff present to meet those needs. I/II This regulation is not met as evidenced by: Class II Refer to F725	A4046		
A4075	19 CSR 30-85.042(66) Nursing Care per Res Condition Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II This regulation is not met as evidenced by: Class II Refer to F658	A4075		
A5005	19 CSR 30-85.052(5) Hot Food Hot, Cold Food Cold Provision shall be made to assure that hot food is served hot and cold food is served cold. II This regulation is not met as evidenced by: Class II	A5005		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE
Admin

(X6) DATE
5/30/25

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 03870	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/08/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY MANOR CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1720 VIETH DR JEFFERSON CITY, MO 65109		
(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
A4108	Continued From page 1 This regulation is not met as evidenced by: Class III Refer to F645	A4108		
A5005	19 CSR 30-85.052(5) Hot Food Hot, Cold Food Cold Provision shall be made to assure that hot food is served hot and cold food is served cold. II This regulation is not met as evidenced by: Class II Please refer to F812	A5005		
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 Refer to F610	A8023		

PLAN OF CORRECTION		
Provider/Supplier Name:	Jefferson City Manor	
Street Address, City, Zip:	1720 Vieth Dr Jefferson City MO 65109	
Date of Survey:	05/08/2025	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
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 state and federal laws. The submission of this plan of correction does not constitute an admission on the part of the skilled nursing facility as to the accuracy of the surveyor's findings or the conclusion drawn there from. The plan of correction does not constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied. Any changes to facility policy and procedures should be considered remedial measures as that concept is employed in rule 407 of the federal rules of evidence and should be inadmissible in any proceeding on that basis. The facility submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the facility or any employee, agent, officer, director or shareholders of the facility. The facility has not waived any of its rights to contest any of these allegations or any allegation or action. This plan of correction serves as the allegation of substantial compliance.	
Tag F610 A8023	1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes: Resident #15 was fully assessed, doctor and family notified and investigation into injury of unknown origin completed. Residents Care Plan has been updated.	
	2. The corrective actions for other residents having potential to be affected by the same deficient practice includes: All residents have the potential to be effected.	
	3. Measures put in place to ensure the deficient practice does not recur includes: Administrator and or designee will ensure all Staff have been educated on Reporting practices per the Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating Policy, including but not limited to Injuries of Unknown origin.	

	4. The facility will monitor its performance to make sure the solutions are sustained by conducting the following: Review 24 hour report Monday through Friday in Leadership Morning Meeting. If any injuries of unknown origin are found an investigation will be conducted, staff will be re-educated regarding reporting guidelines. Results will be reviewed weekly in IDT for 12 weeks. Review those findings in QAPI monthly for 3 months	
	5. The corrective actions will be completed on or before: 06/17/25	

Tag F637	1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes Resident #18 was assessed by IDT and sig change MDS completed. Resident #44 was assessed by IDT and determined not to have a significant change. Resident #47 was assessed by IDT and significant change completed.	
	2. The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes: All residents have the potential to be affected.	
	3. Measures put in place to ensure the deficient practice does not recur includes: Clinical Services Director will educate DON/ADON, Future hired MDS and Regional MDS Coordinator on criteria to determine a significant change in status. Including when to and not complete them. DON/MDS and or designee will audit charting/documentation Weekly for 12 weeks	
	4. The facility will monitor its performance to make sure the solutions are sustained by conducting the following: The above audits will be reviewed weekly in IDT X12weeks and monthly in QAPI for 3 months.	
	5. The corrective actions will be completed on or before: 06/17/25	

F656	1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes: Resident #18 was assessed by therapy for the contracture, Careplan was updated based on that Guidance. Resident #29 was assessed by therapy for the contracture, Careplan was updated based on that guidance.	

	Resident #40 was assessed for smoking, Careplan updated based on the assessment. Resident #47 comprehensive Care Plan created.	
	2. The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes: All residents have the potential to be affected.	
	3. Measures put in place to ensure the deficient practice does not recur includes: Clinical Services Director educated DON/ADON, Corporate MDS and future hired MDS Director on Care Plans update and accuracy. DON, MDS and or designee have reviewed all CarePlans for accuracy. DON/ADON and or designee will audit 10 CP per week for 12 weeks.	
	4. The facility will monitor its performance to make sure the solutions are sustained by conducting the following These audits will be reviewed in IDT for 12 weeks and then monthly in QAPI for 3 months.	
	5. The corrective actions will be completed on or before: 06/17/25	

Tag 657	1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes: . Resident #29, #31, #40, #51 have received care conferences. Documentation has been entered in EMAR.	
	2. The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes: All residents have the potential to be affected.	
	3. Measures put in place to ensure the deficient practice does not recur includes: All department heads will be educated on Care Conference process. Care Conferences will be conducted based on MDS calendar provided Monthly by MDS and or designee. All new Admissions will have a care plan conference set up by our admissions coordinator and or designee with in 72 hours of admission.	
	4. The facility will monitor its performance to make sure the solutions are sustained by conducting the following: The administrator will audit the calendar and new admissions 1 time per week for 8 weeks. These audits will be discussed in IDT for 8 weeks and QAPI for 2 months.	

	5. The corrective actions will be completed on or before: 06/17/25	
Tag 658 A4075	1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes: Resident #2 treatment orders have been clarified and corrected. Resident #4 Doctor notified, and Pharmacy contacted. Meds received and available. Resident #17 Oxygen orders have been changed to PRN per doctor's orders. Resident #25 Oxygen is set to the same liter flow as the ordered. Resident #51 Weight was obtained and doctor notified of missing weights. No new orders. Resident #55 was discharged home on 5/10/25.	
	2. The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes: All residents have the potential to be affected.	
	3. Measures put in place to ensure the deficient practice does not recur includes: Clinical Services Director will in-service DON, ADON and charge nurse on following: current physician orders, documenting notification to pharmacy when meds are not available, notify the physician when meds or treatments orders have not been completed or followed, and documentation of all notification on patient record.	
	4. The facility will monitor its performance to make sure the solutions are sustained by conducting the following: DON/ADON and or designee will audit new orders after physician visits 2x weekly for 12 weeks. DON/ADON will audit TAR 3x per week for 12 weeks. These audits will be reviewed in IDT for 12 and QAPI for 3 months.	
	5. The corrective actions will be completed on or before: 06/17/25	

Tag 725 A4046	1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes: Administrator and or Designee have educated all staff on Call light response time regulation. All call lights have been answered within a reasonable time.	
	2. The corrective act7 by the same deficient practice includes: All residents have the potential to be affected.	
	3. Measures put in place to ensure the deficient practice does not recur includes: DON/ADON will	

	review schedule 3 times a week, to ensure staffing levels are appropriate per facility assessment. DON/ADON will find coverage or cover the floor themselves in the event a member of the team fails to show up for their shift. ADMIN/DON and ADON will all get notifications from call light system to their phones via email or text to ensure timely follow up.	
	4. The facility will monitor its performance to make sure the solutions are sustained by conducting the following: Admin/DON and or designee will review call light times 3x per week. . Then weekly for 3 months. The findings of these reports will be discussed weekly in IDT for 12 weeks. And monthly in QAPI for 3 months.	
	5. The corrective actions will be completed on or before: 06/17/25	

Tag F812 A5005	1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes: Food on cold table discarded. Puree, Mechanical Soft food was discarded.	
	2. The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes: All residents have the potential to be affected.	
	3. Measures put in place to ensure the deficient practice does not recur includes: Admin will in-service DM on holding temperatures for hot and cold food. DM and or designee will in-service all dietary staff on holding temperatures for hot and cold food.	
	4. The facility will monitor its performance to make sure the solutions are sustained by conducting the following: DM and or Designee will conduct a temperature audit of hot and cold food at each meal for 1 week, then 3 different meals per week for 4 weeks. Then 1 meal per week for 8 weeks. These audits will be discussed in IDT weekly for 12 weeks. Those findings will be discussed in QAPI for 3 months.	
	5. The corrective actions will be completed on or before: 06/17/25	

Tag F947	1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes: Web based Training plan has been updated to include Pressure Ulcer Prevention. All staff have completed the required	
-------------	--	--

	web based training. Pressure ulcer prevention included.	
	2. The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes: All residents have the potential to be affected.	
	3. Measures put in place to ensure the deficient practice does not recur includes: Human Resources and or Designee will provide Reports on Web Based Training. Report will be provide on the 15th and 30 of each month. These reports will be posted in the break room and given to each department head. All staff who have not completed their web based training by the end of the month will be removed from the schedule until it is completed.	
	4. The facility will monitor its performance to make sure the solutions are sustained by conducting the following:. All findings will be discussed monthly in QAPI for 6 months.	
	5. The corrective actions will be completed on or before: 06/17/25	

Tag E 018	1. The corrective actions accomplished for the resident(s) found to have been affected by the deficient practice includes: Clinical Services Director educated Administrator on Emergency Preparedness policies and procedures to include tracking of on duty staff. The Emergency Preparedness Policy has been updated to include staff tracking.	
	2. The corrective actions for other resident(s) having potential to be affected by the same deficient practice includes: All residents and on duty staff have the potential to be affected.	
	3. Measures put in place to ensure the deficient practice does not recur includes: Annual review of policy to ensure acclimate to current systems.	
	4. The facility will monitor its performance to make sure the solutions are sustained by conducting the following:. Ensure process is followed during annual evacuation and emergency drills moving forward.	
	5. The corrective actions will be completed on or before: 06/17/25	