

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  12/12/2025
NAME OF PROVIDER OR SUPPLIER  Jefferson City Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1720 Vieth Dr Jefferson City, MO 65109	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, facility staff failed to replace the resident's wanderguard (a device used to protect at-risk-residents from wandering outside a facility without staff's awareness) after staff identified the resident did not have a wanderguard in place as ordered by the physician, which resulted in the resident leaving the facility without staff's knowledge before he/she was taken back to the facility by a member of the community. The facility census was 68. The administrator was notified on 12/12/25 of past Non-Compliance, which occurred on 12/05/25 when staff reported the resident had left the facility without staff knowledge. Staff immediately assessed the resident for physical injuries and presence of the wanderguard, replaced the wanderguard, initiated new orders from the physician to increase the wanderguard checks from two to six times daily, in-serviced staff on wanderguard placement checks and to replace if a resident's wanderguard is missing, and updated the resident's care plan. 1. Review of the facility's Wandering and Elopements policy, revised 03/2019, showed the facility will identify residents who are at risk for unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. 2. Review of the facility's Staff Quick Guide to the Resident Guard System, undated, showed staff are directed: -Residents will be evaluated for their elopement risk on admission and periodically;-Any resident that is determined to be an elopement risk will have a resident tag placed on them;-The device must be activated by the charge nurse prior to placing it on the resident;-If a resident attempts to elope from the building, the charge nurse will contact the physician, Director of Nursing (DON), and administrator, and a resident tag will be placed on the resident immediately. 3. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 09/26/25, showed staff assessed the resident as moderate cognitive impairment, independent with ambulation, and no wandering behaviors in the seven-day review period. Review of resident's face sheet, dated 12/11/25, showed the resident admitted to the facility on [DATE] with primary diagnosis of Alzheimer's Disease, and is his/her own responsible party. Review of the resident's care plan, revised 06/14/25, showed staff assessed the resident requires a wanderguard to his/her left ankle related to resident wanders aimlessly. Review of the resident's quarterly elopement/wandering assessment form, dated 06/15/25, showed staff assessed the resident wanders, and with a history of or attempted elopements. Review of the resident's quarterly elopement/wandering assessment form, dated 09/24/25, showed staff assessed the resident wanders, and with a history of or attempted elopements. Review of the resident's physician order sheet (POS), dated 10/01/25 through 10/31/25, showed an order for wanderguard bracelet to left ankle, check placement every shift and as needed, start date of 06/15/25. Review of the resident's progress notes, dated 10/01/25 through 10/31/25, showed staff documented the resident did not have a wanderguard on 10/04/25, 10/05/25, 10/06/25, 10/08/25, 10/09/25, 10/10/25, 10/14/25, 10/18/25, 10/19/25, 10/22/25, 10/23/25, 10/27/25, and 10/28/25. The record did not contain documentation staff replaced the wanderguard, or reason the resident did not have a wanderguard on. Review of the resident's POS, dated 11/01/25 through 11/30/25, showed an order for wanderguard bracelet to left ankle, check placement every shift and as needed, start date 06/15/25. Review of the resident's progress notes, dated 11/01/25 through 11/30/25, showed staff documented the resident did not have a wanderguard on 11/01/25, 11/02/25, 11/05/25, 11/06/25, 11/07/25, 11/10/25, 11/11/25, 11/12/25, 11/13/25, 11/14/25, 11/15/25, 11/16/25, 11/18/25, 11/19/25, 11/20/25, 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/25/25, 11/26/25, 11/29/25, and 11/30/25. The record did not contain documentation staff replaced the wanderguard, or reason the resident did not have a wanderguard on. Review of the resident's POS, dated 12/01/25 through 12/04/25, showed an order for wanderguard bracelet to left ankle, check placement every shift and as needed, start date 06/15/25. Review of the resident's progress notes, dated 12/01/25 through 12/04/25, showed staff documented the resident did not have a wanderguard on 12/01/25, 12/02/25, 12/03/25, and 12/04/25. The record did not contain documentation staff replaced the wanderguard, or reason the resident did not have a wanderguard on. Review of the facility's investigation, dated 12/05/25, showed staff documented a member of the community saw the resident sitting on a curb on a residential street close to the facility and transported the resident back to the facility. The resident had been outside the facility for approximately one hour, was dressed appropriately for the weather, assessed with an abrasion to his/her buttock, and did not have a wanderguard in place when he/she returned to the facility. During an interview on 12/11/25 at 12:30 P.M., the DON said he/she was not aware the resident did not have a wanderguard prior to 12/05/25. The DON if a</p>		