STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265285	A. Building B. Wing	09/26/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 37131 Based on observation and interview, facility staff failed to ensure residents' privacy were protected, when six resident's (Resident's #2, #3, #7, #8, #9 and #16) out of 16 sampled residents, medical information were face up on the nurse station desks, in a public area visible by other residents and visitors to the facility. Facility census was 71. 1. Review of the facility's policy titled Confidentiality of Information and Personal Privacy, dated October 2017, showed the facility will strive to protect the resident's privacy in regards to his/her: accommodations; medical treatment; and personal care. Access to resident personal and medical records will be limited to authorized staff and business associates. 2. Observation on 09/25/24 at 10:27 A.M. and 10:31 A.M., showed the nurses station desk unattended with the resident report sheet face up, and contained Resident #2, #3, #7, #8, #9 and #16 code status, date of birth, allergies, and diagnoses. Observation showed multiple resident near the nurses station. 3. Observation on 09/25/24 at 10:33 A.M., showed Licensed Practical Nurse (LPN) E at the nurses station desk with the resident report face up. Observaton showed a visitor approached the desk. During an interview on 09/25/24 at 10:39 A.M., LPN E said the visitor is a friend of Residentwho had been discharged from the facility yesterday. During an interview on 09/25/24 at 1:19 P.M., LPN E said the paper on the desk is a report sheet and should not be face up on the desk. LPN said staff should flip the report sheet over on the desk when the staff leave the desk, where the resident's information is not visible. LPN E said that is LPN G's nurse report. During an interview on 09/26/24 at 3:00 P.M., LPN G said the nurse's report is supposed to be face down, if it's not, it could be a violation of the resident's privacy. The LPN G said he/she did not turn it upside down. During an interview on 09/26/24 at 11:39 A.M., the Director of Nursing (DON) said staff are supposed to keep papers turned over and covered at the Nurse's desk. The DON said the Nurse's report sheet has resident's private information and needs to be protected. The DON said he/she would expect staff to keep it covered, or turned over. (continued on next page)

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

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Observation on 09/25/24 at 1:50 P.M., showed the nurses desk with a physician visit note for Resident #16 face up with the residents medical information visible to the public and other residents. During an interview on 09/25/24 at 1:56 P.M., LPN A said he/she had been at the nurse's station and got up for a call light. The LPN said the physician note should not be face up for the resident's privacy. During an interview on 09/26/24 at 11:39 A.M., the Director of Nursing (DON) said progress notes have protected information on it and he/she would expect staff to keep it covered, or turned over. During an interview on 09/26/24 at 1:42 P.M., the administrator said staff should make sure resident's medical information is not available to public and he/she would expect staff to put it in a folder, flip over, or put in chair under desk. The administrator identified the two documents as a Nurse's report and a physician note. The administrator said the two documents should not be face up on the nurse's desk. MO00242199

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37131 Based on interviews and record reviews, facility staff failed to report allegations of misappropriation of money for two residents (Residents #1 and #5) of 16 sampled residents to other officials in accordance with State law (including the State survey and certification agency). The facility census was 71. 1. Review of the facility's policy titled Abuse and Neglect , dated March 2018, showed the management and staff, with physician support, will address situations of suspected or identified abuse and report them in a timely manner to appropriate agencies, consistent with applicable laws and regulations. 2. Review of Resident #1's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 08/27/24, showed staff assessed the resident as moderate cognitive impairment. During an interview on 09/25/26 at 11:42 A.M., the resident said he/she had $3,000 dollars in his/her wallet, in the drawer when he/she went to sleep and the next day it was gone. The resident said the money went missing two days after he/she got to the facility. The resident said it could have been $2,500 dollars, but it was close to $3,000 dollars. The resident said he/she reported it to the nurse at the nurse's desk, but did not know the name of the nurse. During an interview on 09/25/24 at 12:04 P.M., the Maintenance Director said he/she heard about the resident's missing money last week. The Maintenance Director said he/she did not think much about the resident saying he/she had missing money, because the resident changed the amount of money missing from $4,000 dollars to $8,000 and then to $2,000 dollars. The Maintenance Director said staff thought the resident making the allegation may be due to the resident's illness. The Maintenance Director said the administrator knew about the missing money when he/she heard about it, because he/she asked the administrator about the allegation and the administrator said he/she was going to do some investigating. During an interview on 09/25/24 at 1:47 P.M., the Maintenance Director said the Therapy Director is who the resident came to first about his/her missing money. During an interview on 09/25/24 at 2:30 P.M., the Therapy Director said the resident reported missing money to him/her last week, the resident said he/she is missing $4,000 dollars. The Therapy Director said the resident told him/her, he/she checked his/her wallet and the money was gone. The Therapy Director asked the resident where the money was and he/she said it was in his wallet in a drawer in his/her room. The Therapy Director said he/she checked in the drawer and there was a bag with a wallet in it, but no money. The Therapy Director said he/she went and talked to the administrator and then the driver. The driver said he/she did not take the resident anywhere. The Therapy Director said the resident reported the money was all 20's and 50's, he/she had it to pay his/her bills. The Therapy Director said the resident's inventory sheet had been checked and it did not have the money on it. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/24 at 11:02 A.M., the SSD said the resident said he/she had $4,000 dollars missing at a mini care plan meeting he/she had been attendance for. The SSD said he/she went in and had a verbal conversation with the administrator about it. The SSD said he/she did not complete a grievance, probably should have. The SSD said he/she thinks it was 09/18/24 the resident reported it in a meeting. The SSD said the facility has two hours to report it to state. The SSD said he/she is a mandated reporter and she did not report it to state. The SSD said he/she does not know if it had been reported to state. During an interview on 09/26/24 at 11:39 A.M., the DON said he/she had been in the area of the care plan meeting, when the resident reported the missing money and the SSD reported it to the administrator. The DON said the facility two hours to report to state, but he/she is not sure it had been reported to state. The DON said he/she know the administrator had been aware and was investigating. The DON said the facility has to report to state if there is allegation of missing money. During an interview on 09/26/24 at 1:42 P.M., the administrator said the same day Resident #5's wallet went missing, is when the Maintenance Director and Therapy Director Resident #1's missing money to him/her. The administrator said the first time he/she talked to the resident, the resident did not know what the administrator was talking about. The administrator said he/she went back to the resident and the resident said he/she had $9,000 dollars and then the Therapy Director said the resident reported $4,000 dollars to him/her. The administrator said the resident kept changing to different amounts of money. The administrator said he/she told the resident the inventory sheet showed he/she did not have a wallet. The administrator said the resident does have a wallet and a check book, the resident had it tucked away. The administrator said he/she had the SSD call the resident's family and the family said the resident has been known to carry large amounts of cash on him/her, but did not think the resident had the money on him/her, that he/she reported missing. The administrator said the resident is his/her own responsible party. The administrator said he/she did not notify law enforcement, no one had asked him/her to. The administrator said he/she did not report to state. The administrator said he/she did not feel like it was reportable, and did not feel like there was any missing money. The administrator said he/she thought he/she is supposed to report to state, based off of his/her investigation results. 3. Review of Resident #5's Admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact. During an interview on 09/25/24 at 9:58 A.M., the resident said his/her first night at the facility someone stole his/her wallet. The resident said the Maintenance Director got his/her wallet back. The resident said he/she had under 20 dollars in his/her wallet and it was gone. The resident said the Maintenance Director gave him/her 20 dollars and told him/her he/she would not see the staff back in the facility. The resident did not know who the staff was, the Maintenance Director was talking about. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/25/24 at 12:04 P.M., the Maintenance Director said the resident's wallet was found in the housekeeping supply closet. The Maintenance Director said Housekeeper D found the resident's wallet, while they both were in the supply closet. The Maintenance Director said the housekeeper reached up to grab some gloves off the shelf in the housekeeping supply closet and the wallet fell out. The Maintenance Director said he/she immediately took the wallet to the administrator. The Maintenance Director said the housekeeping supply closet is locked with a code to unlock it. The Maintenance Director said he/she does not know if it had been investigated, the administrator usually does his/her own investigation. During an interview on 09/25/24 at 1:10 P.M., housekeeper D said he/she had been stocking the utility room closet and went into the housekeeping room. The housekeeper said the Maintenance Director was in there with him/her. The housekeeper said he/she found a wallet wrapped in a paper towel behind some gloves, on the top shelf of the supply closet. He/She said the Maintenance Director opened the wallet and it had the resident's picture in the wallet. He/She said the Maintenance Director took the wallet to the administrator and he/she does not know what happened from there. The housekeeper said it looked like the wallet had been hidden, because he/she does not know why it would be wrapped in paper towels, behind supplies on top shelf. He/She said the supply closet stays locked and only staff can have the code to unlock the door. During an interview on 09/25/24 at 1:19 P.M., Licensed Practical Nurse (LPN) E said the administrator came to him/her and was investigating the resident's missing wallet, because he/she was the one who sent the resident to the hospital and when the resident's returned from the hospital, his/her wallet was missing. During an interview on 09/26/24 at 11:02 A.M., the Social Services Designee (SSD) said he/she had been aware of the resident's wallet missing on 09/12/24. The SSD said he/she told the administrator and he/she and the administrator searched the resident's room, the facility van, called the hospital to see if the wallet was there. He/She said the resident's wallet showed up the next day. The SSD said he/she thinks the resident's wallet had been found somewhere in housekeeping. The SSD said he/she did not complete a grievance for it, because the wallet had been found and returned to the resident. The SSD said he/she reported the missing wallet to the administrator and he/she helped him/her to search for the wallet. The SSD said he/she is a mandated reporter and did not report the missing wallet to state. During an interview on 09/26/24 at 11:39 A.M., the Director of Nursing (DON) said he/she had heard the resident's wallet had been missing. The DON said the SSD and administrator were involved in the investigation of the missing wallet and it had been found and returned to the resident. The DON said he/she does not know if there had been money in the wallet. The DON said he/she heard the resident's wallet had been found in the cleaning closet. The DON said the cleaning closet is always locked and has a code on it, so logically would think staff would have had to taken the resident's wallet. The DON said he/she believes it should be reported to state. The DON said he/she has not idea why it was not reported to state. The DON said he/she does not know if law enforcement had been notified, but it is supposed to be. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/24 at 1:42 P.M., the administrator said the Maintenance Director notified him/her of the resident's missing wallet. The administrator said he/she went and talked to the resident and checked the resident's inventory sheet. The administrator said he/she searched the resident's room three times. The administrator said at this point he/she thought the resident's wallet was a lost item. The administrator said the Maintenance Director opened the housekeeping closet and the wallet was setting on a rack. The administrator said he/she took the wallet back to the resident. The administrator said maybe it would be reportable, but he/she is not sure the wallet was stolen. The administrator said in theory staff have access to the closet. The administrator said he/she did not feel it rose to the level to report. The administrator said he/she did not find it suspicious the wallet was found in a locked closet, wrapped in a paper towel, behind supplies on top shelf. The administrator said the resident reported the missing wallet the day of his/her admission and it had been found on the third day the resident had been at the facility. The administrator said he/she talked to all housekeeping staff and no staff admitted to taking the resident's wallet. MO00242476 MO00242610

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 37131 Based on interview and record review, the facility staff failed to document they provided the physician ordered wound treatments for one resident (Resident #14) of 16 sampled residents. The facility census was 71. 1. Review of the facility's policy titled Administering Medications, dated April 2019, showed the Director of Nursing (DON) supervises and directs all personnel who administer medications and/or have related functions. Medications are administered in accordance with prescriber orders, including any required time frame. Topical medications used in treatments are recorded on the resident's treatment record (TAR) 2. Review of Resident #14's Significant Change Minimum Data Set (MDS) a federally mandated assessment tool, dated 07/24/24, showed staff assessed the resident as follows: -Cognitively intact; -Did not refuse care; -Incontinent of urine; -Three stage three pressure ulcers (a full-thickness tissue loss that extends into the fat tissue below the skin). Review of the resident's care plan, dated 05/03/24, showed staff assessed the resident with stage three pressure ulcer to the sacrum. Review showed staff intervention to apply a wet to dry topical antiseptic to treat and prevent infections dressing daily. Review of the resident's Physician Order Sheet (POS), dated September 2024, showed an order for staff to remove the old wound packing and cleanse wound with wound solution, pack the wound with dry guaze to reach all edges of the wound, cover wound with abdominal guaze pad and secure with medical tape. Change dressing twice a day, as close to 12 hours apart as possible to the residents sacral wound. Review of the resident's Treatment Administration Record (TAR), dated 09/01/24, showed staff did not document they provided the residents wound treatment to his/her sacral wound on 09/07/24 and 09/20/24 from 7:00 P.M. to 7:00 A.M., and 09/11/24 from 7:00 A.M. to 7:00 P.M. During an interview on 09/26/24 at 9:15 A.M., the resident said he/she has a wound on his/her bottom. The resident said he/she is supposed to get dressing changes on the wound twice a day and evenly spaced apart. The resident said the day shift is good at getting the dressing changed, but the night shift either don't change the dressing, or waits until 5 A.M. to change the dressing. The resident said when night shift waits until 5 A.M. to change the dressing, the day shift comes in and and changes it three or four hours later at 9 A.M. The resident said he/she has reported his/her concerns to staff and even talked to the DON several times. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/24 at 10:29 A.M., Licensed Practical Nurse (LPN) G said the resident did complain to him/her the day shift did not change his/her dressing and asked if the LPN could come in and change the dressing right away, because it is to be done twice a day. During an interview on 09/26/24 at 11:39 A.M., the DON said he/she did see some holes on the TAR. The DON said he/she passed the information in shift report, to make sure the bandage is getting changed. The DON said if staff didn't sign the TAR, he/she would typically assume it didn't get done. The DON said he/she did not check what staff worked during the missed signatures. During an interview on 09/26/24 at 1:14 P.M., the DON said he/she is the facility wound nurse. The DON said he/she but the resident's bandage change on the nurse's shift report, after the resident came to him/her on two separate occasions. The DON said he/she is responsible to follow up on the report, to ensure the bandage is getting changed. The DON said he/she should have been checking TARS and running reports, but he/she got behind. During an interview on 09/26/24 at 1:42 P.M., the administrator said the resident's dressing should be changed twice a day. The administrator said it looks like there is some holes on the TAR. The administrator said if the dressing change is not documented, it was not done. The administrator said if staff doesn't document on the TAR they completed the dressing change, then the DON should investigate. MO00242610 MO00242797 MO00242840

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37131 Based on observation, interview, and record review, facility staff failed to ensure medications were monitored and stored in a safe and effective manner. The facility census was 71. 1. Review of the facility's policy titled Administering Medications, dated April 2019, showed during the administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. Observation on 09/25/24 at 10:12 A.M., showed an unlocked medication cart, on the rehabilitation hall unattended. Resident #6 propelled self in wheelchair past unlocked medication cart. During an interview on 09/25/26 at 10:16 A.M., Certified Medication Technician (CMT) C said he/she forgot to lock the medication cart. The CMT said he/she gave a medication, then went off the hall to check on showers and forgot to lock the cart. During an interview on 09/26/24 at 11:39 A.M., DON said staff should lock the medication cart, when not at the cart. The DON said the medication cart should have been locked, when CMT C walked away from the cart. During an interview on 09/26/24 at 1:42 P.M., the administrator said staff should lock the medication cart, when the staff leaves the cart. The administrator said residents could get in the medication cart and hurt themselves, or take medications that is not theirs. 2. Review of the facility's policy titled Storage of Medications, dated April 2019, showed drugs and biologicals used in the facility are stored in locked compartments. Compartments include but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended. Only persons authorized to prepare and administer medications have access to locked medications. Observation on 09/25/24 at 11:12 A.M., showed Resident #11's a Inhaler Disc and a bottle of nasal spray on top of a puzzle in the community area without staff present. Observation showed multiple residents in the community area. During an interview on 09/25/24 at 11:14 A.M., Resident #11 said the CMT was going to come back and get the medications in a little bit, but never came back. During an interview on 09/25/24 at 1:19 P.M., the LPN said he/she was not aware a medication was left out and unattended on a table. The LPN said they should not be left out, a resident could get a hold of the medication and put it in their mouth. The LPN said staff should watch the medication being given anyway, to make sure it is working and is the right dose. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/26/24 at 11:39 A.M., DON said he/she is aware of the two medications left unattended in the activity area. The DON said it's not safe, even if the resident is alert and orientated. The DON said staff should watch residents to ensure the medications are taken correctly. The DON said the facility has residents with memory issues and those residents could get a hold of those medications and take them. During an interview on 09/26/24 at 1:42 P.M., the administrator said medications should not be left out, because residents could take medications that is not theirs. The administrator said staff need to stay and make sure the resident took the medication and ensure the resident doesn't give the medications to another resident. MO00242610