

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 03/21/2025
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to obtain a timely advanced directive who received Cardiopulmonary Resuscitation (CPR) when he/she elected to be a Do Not Resuscitate (DNR - indicates that, in case of respiratory or cardiac failure, the resident has directed that no cardiopulmonary resuscitation or other life-sustaining treatments or methods are to be used) and failed to document residents' code status consistently as a DNR for one resident (Resident #1). The facility census was 62.</p> <p>1. Review of the facility's Advance Directives policy, revised [DATE], showed advanced directives will be respected in accordance with state law and facility policy. The resident has the right to refuse treatment. A resident will not be treated against his/her wishes. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The plan of care for each resident will be consistent with his/her documented treatment preferences.</p> <p>2. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> -admitted to facility on [DATE]; -Expired at facility on [DATE]; -A signed DNR form dated [DATE]. <p>Review of the resident's Physician Order Sheet (POS), dated February 2025, showed the record did not contain an order for his/her code status or advanced directive.</p> <p>Review of the resident's care plan, dated [DATE], showed staff documented the resident code status as DNR.</p> <p>Review of the resident's nurses notes, dated [DATE] at 5:49 A.M., showed staff documented staff found the resident with no pulse, no respirations and cyanotic (a bluish discoloration of the skin resulting from poor circulation or inadequate oxygenation of the blood). Uncertain of code status CPR s started until discovered the resident code status of DNR on his/her facesheet.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 9:59 A.M., the Director of Nursing (DON) said all residents code statuses are kept at the nurses station in a binder and on outside of their doors with a green sticker indicating full code and a red sticker indicating DNR. He/She does not know why staff did not follow the residents wishes.</p> <p>During an interview on [DATE] at 10:00 A.M., the administrator said code statuses are displayed next to the resident's name on the outside of their door and there is a book with the residents DNR forms at the nurses stations. The administrator said he/she does not know why the staff did not look before performing CPR and the expectation is the code statuses are able to be identified quickly for staff to make the right medical decision.</p> <p>During a phone interview on [DATE] at 11:19 A.M., Licensed practical nurse (LPN) A said he/she did not know the residents code status and he/she erred on the side of caution and started to perform CPR. He/She said an aide called emergency medical services and they took over CPR upon arrival. He/She said he/she found the residents advanced directive and they stopped life saving measures. He/She said he/she was not aware there was a book at the nurses station with code statuses and does not remember if the resident had a green sticker on his/her name plate outside his/her room but his/her room mate did and was a full code. He/She said he/she thought he/she was doing the right thing.</p> <p>MO00251388</p>		