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	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jefferson City Manor Care Center	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)
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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to maintain professional standards of care, when staff failed to document they administered wound treatments as directed by the physician for two residents (Resident #1 and #2) out of three sampled residents. The facility census was 64.1. Review of the facility's Charting and Documentation policy, revised July 2017, showed documentation of procedures and treatments will include care-specific details, included: -The date and time the procedure/treatment was provided;-The name and title of the individual(s) who provided the care;-Whether the resident refused the procedure/treatment;-The signature and title of the individual documenting. 2. Review of Resident #1's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/10/25, showed staff assessed the resident as cognitively intact, one venous and arterial ulcer (wound in the skin of the lower leg or foot), and rejected care one to three days in the seven-day review period. Review of the resident's Physician Order Sheet (POS), dated 10/01/25 through 10/31/25, showed staff were directed to cleanse the right lower leg with wound cleanser, pat dry, apply skin prep (a protective skin-protectant film) to entire area daily every day shift; and cleanse the left lower leg with wound cleanser, apply betadine paint (to prevent and treat skin infections) to peri-wound/intact skin, apply calcium alginate (to absorb moisture and minimize infection) to open wound bed, apply extra-large ABD pad (to absorb drainage and protect wounds), wrap with elastic bandage, change daily every day shift and as needed if heavily soiled/saturated. Review of the resident's Treatment Administration Record (TAR), dated 10/01/25 through 10/31/25, showed the record did not contain documentation staff provided wound treatment as directed by the physician or that the resident refused his/her treatment on 10/06/25, 10/11/25, 10/15/25, 10/16/25, and 10/29/25. During an interview on 11/17/25 at 2:56 P.M., the Director of Nursing (DON) said the resident sometimes refuses his/her treatments and he/she expects the nurse to document any refusal on the TAR. 3. Review of Resident #2's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact, received surgical wound care, and did not reject care. Review of the resident's POS, dated 10/01/25 through 10/31/25, showed a physician order directed staff to provide pin-site care: cleanse with warm soapy water, pat dry, massage around pin sites, non-woven sponge 2x2 secure with paper tape, foam dressing to medial ankle, every shift for treatment. Review of the resident's TAR, dated 10/01/25 through 10/31/25, showed the record did not contain documentation staff provided wound treatment as directed by the physician on 10/06/25, 10/08/25, 10/09/25, 10/10/25, 10/13/25, 10/17/25, 10/18/25, 10/22/25, 10/23/25, 10/24/25, 10/26/25, and 10/30/25. Review of the resident's POS, dated 11/01/25 through 11/17/25, showed staff were directed to provide pin-site care: cleanse with warm soapy water, pat dry, massage around pin sites, non-woven sponge 2x2 secure with paper tape, foam dressing to medial ankle, every shift for treatment. Review of the resident's TAR, dated 11/01/25 through 11/17/25, showed the record did not contain documentation staff provided wound treatment as directed by the physician on 11/06/25, 11/14/25, and 11/16/25. During an interview on 11/17/25 at 1:15 P.M., the resident said staff have not been doing his/her treatments every shift (twice daily) like his/her physician has ordered. During an interview on 11/17/25 at 2:56 P.M., the DON said he/she was not aware of the resident refusing his/her treatments and he/she expects the nurses to administer the treatments twice daily as directed by the physician to reduce the risk of infection. 4. During an interview on 11/17/25 at 2:20 P.M., Licensed Practical Nurse (LPN) B said the charge nurse is responsible to provide treatments as directed by the POS and document on the TAR once completed. LPN B said if there are missing documentation/signatures on a resident's TAR it is uncertain if the treatments were completed. The LPN said he/she thinks the DON audits for missing documentation on residents' TAR. During an interview on 11/17/25 at2:38 P.M., the administrator said the nurses are expected to administer treatments as ordered by the physician and document on the TAR when completed. He/She said if there are missing documentation/signatures on the TAR, then the treatment probably wasn't administered. He/She said the DON is responsible to conduct weekly audits for missing treatments and address any concerns with the nurses. Complaint #2649088