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	02/11/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, facility staff failed to notify the physician and resident's responsible party after allegations of abuse for one resident (Resident #1) out of one sampled resident. The facility census was 62.1. Review of the facility's Change in a Resident's Condition or Status policy, revised February 2021, showed facility staff will promptly notify the physician and resident representative of changes in the resident's medical/mental condition and/or status.2. Review of Resident #1's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/09/25, showed staff assessed the resident:-Severe cognitive impairment, -Daily rejection of care;-Always incontinent of bowel and bladder;-Diagnosed with non-Alzheimer's dementia, depression.Review of the resident's progress notes, dated 1/27/26 to 2/4/26, did not contain documentation the physician or family had been notified CNA A slapped the resident on the leg while he/she provide his/her care. During an interview on 2/4/26 at 10:59 A.M., the resident's family member said he/she was not notified by facility staff related to the allegation of employee to resident abuse until he/she visited the resident the following day and the administrator asked him/her if he/she knew about the abuse.During an interview on 2/4/26 3:35 pm, the administrator said he/she expected the physician and family to be notified if there are allegations of employee to resident abuse, but he/she could not locate a progress report showing the physician or resident representative had been notified. The administrator reviewed the incident report that surveyor did not have access to, and it also did not contain documentation that the physician or family were notified. During an interview on 2/26/26 at 1:30 P.M., the Nurse Practitioner (NP) said he/she had no record and did not receive a call from the facility related to a CNA who slapped the resident while the resident received care. Complaint # 2727980

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
	265285	A. Building B. Wing	02/11/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to prevent physical abuse to one resident (Resident #1) out of four sampled residents, when Certified Nursing Assistant (CNA) A slapped Resident #1 on the leg while he/she provided care. The facility census was 62.The administrator was notified on 2/11/26 of past Non-Compliance which occurred on 0/27/26 when the administrator began in-servicing all staff 1/28/26 on abuse and neglect after he/she substantiated a report of abuse that CNA A slapped the resident on the leg while he/she provided care.1. Review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program and Clinical Protocol policy, revised April 2021, showed the facility will develop and implement policies and protocols to prevent and identify abuse or mistreatment of residents.Review of the facility's investigation, 1/28/26, showed staff notified the administrator Nurse Assistant (NA) B witnessed CNA A hit the resident on the leg five times. Witness statements were collected, and resident interviews obtained. Based on the investigation it was found substantiated, and CNA A was terminated on 1/28/26. Administrator completed in-services with staff on abuse neglect 1/28/26. 2. Review of Resident #1's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/09/25, showed staff assessed the resident as:-Severely cognitively impaired;-Daily rejection of care;-Always incontinent of bowel and bladder;-Diagnosed with non-Alzheimer's dementia, and depression.Review of the resident's Care Plan, dated 04/08/24, showed staff assessed the resident as: -Impaired cognitive function/dementia or impaired thought process;-Activities of Daily Living (ADL) self-care performance deficit, -Physically aggressive; -Bowel and bladder incontinence.Review of the resident's progress notes, dated 1/24/26 to 1/28/26, did not contain documentation that CNA A slapped the resident on his/her leg while he/she performed care. 3. Review of CNA A personnel records showed he/she completed and signed new hire orientation on 5/19/25 which included Abuse and Neglect training. Review of the training log showed the CNA attended an additional Abuse and Neglect in-service on 10/16/25.During an interview on 2/4/26 at 12:15 P.M., Resident #4 said he/she is Resident #1's roommate. He/She said he/she has not seen anything because the curtain is closed but he/she could hear it. During an interview on 2/4/26 at 12:46 P.M., CNA A. said he/she has been employed at facility since June, 2025. CNA A said on 1/27/26 at 10:45 P.M., he/ she was helping Resident #1 to bed. He/Said the resident always resists. The resident's brief was soaked with urine. CNA A said he/she had to work alone because there was no one to help him/her. He/She struggled to remove the wet brief and wipe the resident clean. CNA A said he/she instructed the resident to open her legs, but he/she would tighten them. CNA A said he/she pushed the brief through her legs. The resident was in bed and he/she was washing cups at the sink in the room when the charge nurse, Registered Nurse (RN) C, from the other hall came into the room and told him/her it had been reported he/she hit the resident five times. He/She told RN C he/she has never hit or slapped anyone. He/She said he/she was surprised by the accusation. CNA A said he/she was embarrassed when told he/she could no longer work at the facility because he/she had abused a resident. During an interview on 2/4/26 3:35 pm, the administrator said he/she received a call around 11:00 P.M. on 1/27/26 from RN C that NA B witnessed CNA A strike Resident #1 five times on the leg while performing pedicare. The Administrator said CNA A was immediately suspended pending investigation. The Administrator said based on the investigation, he/she believed CNA A did not have an intent to harm, but that CNA A did not show a sufficient understanding of the difference between the potential harmful act and a physical prompt to gain cooperation from a resident. CNA A was terminated on 1/28/26. The Administrator said all staff receive Abuse and Neglect training upon hire, and an (continued on next page)

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	02/11/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inservice was given on 10/16/25. The Administrator said though he/she has a reasonable doubt the circumstances around the incident met the facility policy's definition of abuse, he/she stands by the decision to terminate the employee to prevent future occurrences. The Administrator said he/she can't say it was deliberate, given the employee's apparent lack of understanding of inappropriate action, there was a risk to residents. During an interview on 2/5/26 at 3:30 P.M. NA B said he/she has been employed at the facility since 12/17/25. NA B said he/she received Abuse/Neglect training during orientation. NA B said he/she learned if you see something, say something. NA B said on 1/27/26 at 10:30 P.M., he/she was walking down the 300 Hall on the way to the laundry room, and as he/she was passing room [ROOM NUMBER], he/she heard a smacking noise. He/She said the sound was clear because the hall was very quiet at that time of night. The NA said the slaps sounded forceful since he/she could hear them in the hall. He/She looked into the room without entering and saw the resident hit CNA A, then CNA A hit the resident on the outer part of her left thigh with an open hand. The resident was on his/her right side at the time wearing a brief. The resident hit CNA A again, and CNA A hit the resident again. He/She believed, between what he/she heard and saw, the resident was hit or slapped a total of five times. NA B said he/she has worked with this resident before and knows he/she is a fighter when care is being performed, but you are not supposed to hit them back. NA B said when CNA A saw NA B looking into the room, CNA A's eyes got big. NA B immediately went to tell his/her charge nurse, RN C. NA B said RN C said let's go see what is going on. When NA B and RN C returned to room [ROOM NUMBER], CNA A was still in the room, and the resident was lying quietly in bed. NA B said RN C asked CNA A what was happening and was told he/she was trying to lay the resident down, but the resident was fighting him/her. Complaint #2727980