

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/06/2025
NAME OF PROVIDER OR SUPPLIER  River City Living Community		STREET ADDRESS, CITY, STATE, ZIP CODE  3038 West Truman Blvd 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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review, facility staff failed to notify the physician in a timely manner for two residents (Resident #1 and Resident #2) when Resident #1 made an accusation that Resident #2 touched him/her in an inappropriate manner. The facility census was 38.</p> <p>1. Review of the facility's Resident condition change - observing, recording and reporting, not dated, showed staff were directed to observe, record and report any condition change to the attending physician so that proper treatment can be implemented.</p> <p>2. Review of Resident #1's annual Minimum Data Set (MDS), a federally mandated assessment tool used to plan care, dated 3/19/25, showed staff assessed the resident as follows:</p> <p>-Cognitively intact;</p> <p>-Diagnosis of anxiety disorder.</p> <p>Review of the resident's nurses' notes, dated 5/05/25, showed staff documented resident tearful because he/she was touched inappropriately by another resident. Administrator notified and contacted Department of Health and Senior Services (DHSS) , corporate and the police department. Review showed staff did not document the physician notified.</p> <p>Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as follows:</p> <p>-Moderately cognitively impaired;</p> <p>-Diagnosis of bipolar disorder.</p> <p>Review of the resident's nurse's notes, dated 5/05/25, showed staff documented resident placed on fifteen minute checks because of accusations made by another resident in regards to inappropriate touching and foul language. Administrator spoke with resident, DHSS, corporate and police. Review showed staff did not document the physician notified.</p> <p>Review of the facilities investigation, dated 5/5/25, showed staff did not document notification of the physician.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/6/25 at 12:52 P.M., the administrator said the physician should have been notified when the allegation of unwanted sexual contact was made but notification fell through the cracks. He/She said the Director of Nursing (DON) or himself/herself is responsible for notification of the physician, but he/she was in charge of the investigation.</p> <p>MO00253738</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, facility staff failed to document they administered medications for three residents (Resident #1, Resident #2 and Resident #3). The facility census was 39.</p> <p>1. Review of the facility's medication administration guidelines, dated 2/7/2013, showed residents receive their medications on a timely basis and in accordance with established policies. Drug administration shall be defined as an act in which an authorized person in accordance with all laws and regulations governing such acts, gives a single dose of a prescribed drug or biological to a resident. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the information. The person administering the medication must chart medications immediately following the administration. The date, time administered, dosage, etc. must be entered in the medical record and signed by the person entering the data.</p> <p>2. Review of Resident #1's Significant Change Minimum Data Set, dated [DATE], a federally mandated assessment tool, showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Severe cognitive impairment;</li> <li>-Feeding tube;</li> <li>-Diagnoses of stroke, seizure or epilepsy, depression, cerebral palsy and anxiety.</li> </ul> <p>Review of the resident's Medication Administration Record (MAR), dated March 2025, showed staff did not document medications administered to the resident's as directed for:</p> <ul style="list-style-type: none"> <li>-Ascorbic Acid (Vitamin C) on 3/16/25;</li> <li>-Gabapentin (anti-seizure medication) on 3/15/25, 3/25/25 and 3/29/25;</li> <li>-Levetiracetam (anti-seizure medication) on 3/25/25 and 3/29/25;</li> <li>-Lexapro (anti-depressant medication) on 3/25/25;</li> <li>-Valproic Acid (anti-seizure medication) on 3/15/25, 3/16/25 and 3/29/25;</li> <li>-Buspirone (cerebral palsy medication) on 3/15/25 and 3/29/25;</li> <li>-Risperidone (cerebral palsy medication) on 3/15/25, 3/16/25 and 3/29/25.</li> </ul> <p>Review of the resident's Medication Administration Record (MAR), dated April 2025, showed staff did not document medications administered to the resident's as directed for:</p> <ul style="list-style-type: none"> <li>-Ascorbic Acid (Vitamin C) on 4/29/25;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Valproic Acid (anti-seizure medication) on 4/13/25.</p> <p>Review of the resident's Medication Administration Record (MAR), dated May 2025, showed staff did not document medications administered to the resident's as directed for Gabapentin (anti-seizure medication) on 5/3/25.</p> <p>3. Review of Resident #2's admission MDS, dated [DATE], showed staff assessed the residents as:</p> <p>-Cognitively intact;</p> <p>-Diagnoses of Diabetes.</p> <p>Review of the resident's Medication Administration Record (MAR), dated March 2025, showed staff did not document they administered the resident's medications as directed for:</p> <p>-Lantus Solostar Insulin (diabetes medication) on 3/15/25 and 3/30/25;</p> <p>-Novolog Insulin (diabetes medication) on 3/15/25, 3/22/25, 3/30/25.</p> <p>Review of the resident's Medication Administration Record (MAR), dated April 2025, showed staff did not document they administered the resident's medications as directed for:</p> <p>-Lantus Solostar Insulin (diabetes medication) on 4/12/25 and 4/13/25;</p> <p>-Novolog Insulin (diabetes medication) on 4/13/25, 4/20/25 and 4/27/25.</p> <p>Review of the resident's Medication Administration Record (MAR), dated May 2025, showed staff did not document they administered the resident's medications as directed for:</p> <p>-Novolog Insulin (diabetes medication) on 5/3/25 and 5/4/25.</p> <p>During an interview on 5/6/25 at 12:15 P.M., the resident said he/she is not getting his/her insulin, he/she said the weekends are especially bad at giving his/her insulin. He/She said every weekend he/she is missing doses of insulin and the doses he/she does get, he/she goes and asks the nurse for.</p> <p>4. Review of Resident #3's admission MDS, dated [DATE], showed staff assessed the resident as:</p> <p>-Cognitively intact;</p> <p>-Feeding tube;</p> <p>-Diagnoses of amyotrophic lateral sclerosis (ALS) (nervous system disease that weakens muscles).</p> <p>Review of the resident's Medication Administration Record (MAR), dated April 2025, showed staff did not document medications administered to the resident's as directed for:</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Isosource (calorically dense complete nutritional formula - sole source of nutrition through tube feeding) on 4/22/25 and 4/27/25.</p> <p>Review of the resident's Medication Administration Record (MAR), dated May 2025, showed staff did not document medications administered to the resident's as directed for:</p> <p>-Isosource (calorically dense complete nutritional formula - sole source of nutrition through tube feeding) on 5/3/25 and 5/4/25.</p> <p>During an interview on 5/6/25 at 12:22 P.M., the resident said he/she is not getting all of his/her feedings on the weekends.</p> <p>5. During an interview on 5/6/25 at 10:45 A.M., the Director of Nursing (DON) said he/she has gotten complaints about the weekend nurse not giving medications. He/She said he/she has spoken with administration about the issues with missing medication but he/she does not know if anything has been done. He/She said he/she expects all staff to follow physician orders.</p> <p>During an interview on 5/6/25 at 12:52 P.M., the administrator said his/her expectation is for staff to follow physician orders at all times and to document when medications are given. He/She said if it's not documented, it was not done. He/She said there have been some concerns with the weekend nurse, Registered Nurse (RN) A, but he/she has not been here very long and he/she needs more training.</p> <p>MO00253782</p>		