STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265482	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Living Community	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)
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 protect one Resident (Resident #1's) right to be free from inappropriate touching when one resident (Resident #2), was found with his/her mouth on Resident #1's chest. The facility census was 47.1. Review of the facility's abuse policy, undated, showed it is the policy of the facility that each resident will be free from abuse. The residents will be protected from abuse, neglect and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for Protection.2. Review of Resident #'1's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/22/26, showed staff assessed the resident as cognitively impaired, wandered daily, and with a diagnosis of dementia with behaviors.Review of the resident's care plan, dated 03/10/26, showed the resident wandered on the secure unit, could be difficult to understand due to cognition, and staff must anticipate his/her needs. Review of the resident's progress notes, dated 4/17/26, showed Licensed Practical Nurse (LPN) A documented he/she was informed Resident #1 was in Resident #2's room with the door shut. Upon entering the room, it was observed that Resident #1 had their shirt up and Resident #2 was sucking on Resident #1's chest. The residents were separated and neither recalled the incident. 3. Review of Resident #2's admission MDS, dated [DATE], showed staff assessed resident as cognitively impaired, without behaviors, and diagnoses of dementia and depression. Review of the resident's plan of care, dated 04/08/26, showed resident was at risk for inability to meet his/her own needs related to his/her cognition. Review of the resident's progress notes, dated 4/17/26, showed Licensed Practical Nurse (LPN) A documented he/she was informed Resident #1 was in Resident #2's room with the door shut. Upon entering the room, it was observed that Resident #1 had their shirt up and Resident #2 was sucking on Resident #1's chest. The residents were separated and neither recalled the incident. 4. Review of facility investigation, dated 04/17/26, showed a visitor knocked on Resident #2's door. When there was no answer, the visitor opened the door and observed Resident #1 with his/her shirt up and Resident #2 mouth on Resident #1's chest. Review showed the residents were startled and Resident #2 went into the bathroom and Resident #1 exited the room. The visitor reported to the charge nurse then the administrator. During an interview on 04/18/26 at 3:20 P.M., LPN A said Resident #1 was a tag-a-long type personality and Resident #2 was a stronger personality. Resident #2 will say come along and Resident #1 will follow. Both residents are very confused. LPN A said he/she was informed of the inappropriate touching and then notified the physician and family. He/She also completed a head-to-toe assessment and did not observe any visible injuries. Neither resident recalled the incident. During an interview on 04/20/26 at 11:36 A.M., CNA C said Resident #1 and Resident #2 are attached at the hip and best friends. Resident #2 could be intrusive and overbearing with Resident #1, but he/she was unaware of any inappropriate interactions before the one on 4/17/26. During an interview on 04/20/26 at 11:42 A.M., Certified Medication Technician (CMT) D said he/she was informed by the visitor they witnessed Resident #2's mouth on Resident #1's chest and instructed the visitor to report to the administrator. The CMT said he/she also informed the administrator of the concern. He/She said Resident #1 and Resident #2 are (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
	265482	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Living Community	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	always together. Resident #2 can be overprotective of Resident #1. CMT D said when the visitor informed him/her of the incident, Resident #1 was in the dining room away from Resident #2. He/She said the staff kept the residents apart after that. During an interview on 04/20/26 at 10:46 A.M., the administrator said he/she was informed about the interaction that occurred on 04/17/26 at 1:30 P.M. between Resident #1 and Resident #2 and immediately began an investigation. The administrator said both residents have dementia and live on the secured unit. He/She said the visitor reported Resident #2's mouth was on Resident #1's chest in Resident #2's room. He/She said Resident #2 can be flirtatious with others, but he/she has not seen behaviors of this type before. He/She said Resident #1 was unable to recall inappropriate touching between the two residents before. The administrator said Resident #2 was unable to recall the incident but told him/her that Resident #1 was his/her friend and when asked if they were alone in a room together, Resident #2 said, not today. He/She said staff did not construe anything sexual had occurred, so it was not reported. During an interview on 04/20/26 at 12:28 P.M., the Director of Nursing (DON) said he/she is unaware of inappropriate touching between Resident #1 and Resident #2. He/She said if staff observed inappropriate touching between residents he/she would expect staff to separate the residents and report to the charge nurse and/or the DON. During an interview on 04/19/26 at 9:02 A.M., Resident #1's family member said he/she did not think his/her loved one would have consented to this before he/she became sick. He/She said he/she couldn't say for sure how he/she would have felt when that occurred. #2987293

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265482	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Living Community	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to develop and implement a person-centered comprehensive care plan for three residents (Resident #1, #2, and #3) out of three sampled residents. The facility census was 47.1. Review of the facility's Care Plan Comprehensive policy, undated, showed assessment of each resident is ongoing process and the care plan will be revised as the resident's condition changes. A well-developed care plan will be oriented to: involving resident, resident's family and other resident representatives as appropriate, assessing and planning for care to meet the residents medical, nursing, mental and psychosocial needs, involve the direct care staff with the care planning process relating to the resident's expected outcomes and addressing additional care planning areas that are relevant to meeting the resident's needs in the long term care setting.2. Review of Resident #1's admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 02/22/26, showed staff assessed the residents with cognitive impairment, wanders daily, and has a diagnosis of dementia with behaviors.Review of the resident care plan, dated 03/10/26, showed staff assessed the resident as wanders, difficult to understand due to cognition, and staff must anticipate his/her needs. The care plan did not contain documentation for the interventions implemented after the inappropriate touching of his/her peer.Review of the resident's nurse notes, dated 04/17/26, showed staff documented the resident was in another resident's room with the door shut. The physician was notified and ordered 15-minute surveillance. During an interview on 04/20/26 at 11:36 A.M., Certified Nurse Aide (CNA) C said Resident #1 wanders daily and follows others around. He/She said he/she does not know what the care plan says for the resident's behaviors, and he/she does not have access to care plans. During an interview on 04/20/26 at 11:52 A.M., Licensed Practical Nurse (LPN) E said he/she does not update the care plans but believes the aides are able to access them. During an interview on 04/20/26 at 12:12 P.M., the MDS nurse said the resident follows other people around but did not have it in the care plan. He/She said he/she is responsible for updating the care plans. The MDS nurse said he/she is still new to the position and trying to get them updated as best as he/she can. 3. Review of Resident #2's MDS, dated [DATE], showed staff assessed the resident with cognitive impairment, does not exhibit behaviors, and has diagnoses of dementia and depression. Review of the residents' history and physical form in his/her referral packet, dated 2/13/26, showed staff documented a diagnosis of severe dementia with agitation, mood swings and recent altercation with a peer. Review of the resident's plan of care, dated 04/08/26, showed staff assessed the resident as at risk of inability to meet his/her needs due to his/her cognition. The plan of care did not contain documentation the resident required a secure unit, or staff direction for when resident exhibits behaviors.During an interview on 04/20/26 at 11:36 A.M., CNA C said the resident can get agitated and verbally aggressive. CNA C said he/she did not know what the care plan directed staff regarding the resident's behaviors. He/She said he/she does not have access to the care plans.During an interview on 04/20/26 at 11:42 A.M., Certified Medication Technician (CMT) D said he/she does not know what the care plan said regarding the resident's behaviors. During an interview on 04/20/26 at 12:12 P.M., the MDS nurse said the resident is exit seeking but it is not included in the care plan and should be. He/She said he/she is trying to get the care plans updated. 4. Review of Resident #3's admission MDS, dated [DATE], showed staff assessed the resident with cognitive impairment, did not exhibit behaviors. Review of the nurse notes showed staff documented: -On 04/04/26, agitation and confusion with stated intent to leave with restlessness and anxiety, exit seeking, going into peer rooms and applying the peers clothing, due to ongoing exit-seeking behaviors and safety concerns, resident relocated to secured memory care unit for increased supervision;Review of the residents plan of care, dated 04/13/26, showed staff assessed the resident is at risk for inability to meet his/her own needs related to his/her cognition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265482	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Living Community	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan did not contain documentation the residents required a secure unit or direction for staff when residents exhibits behaviors.During an interview on 04/20/26 at 11:36 A.M., CNA C said Resident #3 wanders, gets fidgety, and disrobes after he/she is dressed for the day. CNA C said he/she did not know what the care plan directed staff regarding the resident's behaviors. He/She said he/she does not have access to care plans.During an interview on 04/20/26 at 12:12 P.M., the MDS nurse said the resident goes in and out of other resident rooms and he/she should have documented that in the resident's plan of care. He/She said he/she is trying to get the facility's care plans updated. 5. During an interview on 04/20/26 at 11:42 A.M., CMT D said behaviors specific to residents should be in their plan of care. He/She said he/she has access to the care plans but did not know what it said regarding the residents or their behaviors. He/She said he/she relies on verbal reports from the off going shift or the nurses. During an interview on 04/20/26 at 11:52 A.M., LPN E said he/she does not have the ability to modify the care plans but has access to them. He/She said behaviors should be included in the care plans, so staff know how to care for the residents when they have behaviors.During an interview on 04/20/26 at 12:12 P.M., the MDS nurse said he/she is responsible for updating the care plans and to assure they are accurate. He/She said he/she has been in the role for five months and is trying to make sure they are updated when they come due. Staff are informed of care plan changes as they are updated. He/She said he/she learns of resident changes by word of mouth, weekly risk meetings, and weekly review of the event notes. He/She said behaviors should be a part of the care plans and include elopement, cognition, and any interventions specific to the residents. He/She said he/she believes the aides have access to the care plans but isn't sure. During an interview on 04/20/26 at 12:28 P.M., the Director of Nursing (DON) said he/she has been in the role for three weeks and is still trying to put new plans into place. He/She expects care plans to include behaviors and interventions for resident specific behaviors. He/She said the MDS nurse is responsible for updating the care plans. During an interview on 04/20/26 at 12:32 A.M., the Administrator said resident specific behaviors should be a part of the care plan. He/She said the aides have access to the care plans and they are updated by the MDS nurse. #2987293