STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265530	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capitol River Wellness & Rehabilitation	1221 Southgate Lane Jefferson City, MO 65110

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to maintain a comfortable and homelike environment. The facility census was 84. 1. Review of the facility policy titled, Maintenance Services, dated August 2020, showed the Maintenance Department is responsible for maintaining the building in compliance with current federal, state, and local, regulations, and guidelines. The Director of Maintenance is responsible for conducting regular inspections of hallways and activity areas. 2. Observation on 05/19/26 at 8:36 A.M., showed the memory care unit walls below the handrails, unpainted, and missing baseboard with exposed screws. 3. Observation on 05/19/26 at 10:56 A.M., showed the main dining walls with missing base trim, exposed unfinished and unpainted drywall. 4. Observation on 05/19/26 at 10:59 A.M., showed the 100 and 300 hallway walls with missing base trim and a large hole in the drywall between rooms [ROOM NUMBERS]. 5. Observation on 05/19/26 at 12:29 P.M., showed kitchenette in the main dining rooms wall with exposed drywall, untaped and not mudded, with exposed two by four lumber, unpainted and unfinished. 6. Observation on 05/21/26 at 9:20 A.M., showed the 100 and 300 hallway walls with exposed screws and unpainted drywall at the base. Observation showed gaps between the floor and walls where the base trim had been. 7. Observation on 05/21/26 at 9:22 A.M., showed the Therapy Department short hall outside with missing base trim, exposed screws, and unpainted and unfinished drywall. 8. Observation on 05/21/26 at 9:25 A.M., showed by the nurse's station area between 100 and 300 halls with missing base trim and exposed screws. Observation showed the drywall unpainted and unfinished at base of walls and unpainted drywall patches. 9. Observation on 05/21/26 9:51 A.M., front halls with missing base trim, exposed screws and unpainted and unfinished drywall. During an interview on 05/21/26 at 9:11 A.M., Resident #50 said the baseboards haven't been fixed for over a year, they look dirty and should be cleaned up. The resident said we live here. (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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. During an interview on 05/21/26 at 1:02 P.M., Certified Nurse Aide (CNA) N said he/she has been at the facility since June of 2025 and the walls have had missing base trim. The CNA said it looks bad and does not look homelike. During an interview on 05/21/26 at 1:04 P.M., Licensed Practical Nurse (LPN) L said the missing trim, unpainted drywall and exposed screws is not homelike. During an interview on 05/21/26 at 1:08 P.M., the Maintenance Director said the facility hired a company and is a relative of the last administrator and they quit, so it has been like that for over a year. During an interview on 05/21/26 at 2:16 P.M., Director of Nursing (DON) said the missing baseboards happened a long time ago, at least a year ago. The DON said he/she thinks it looks terrible. The memory care has been unpainted like that for about a month. During an interview on 05/21/26 at 2:41 P.M., the administrator said the baseboards have been gone for six months. The administrator said contractors started and then they had to leave, and they have never come back. The administrator said he/she would not consider it homelike and ultimately it is his/her responsible.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to provide written information to the residents and/or the residents' representative of the bed hold policy at the time of transfer to the hospital for eight residents (Resident #8, #12, #28, #47, #67, #71, and #86) out of 23 residents sampled. The facility census was 84. 1. Review of the facility policy titled, Bed Hold, dated June 2020, showed the facility notifies the resident or his/her representative, in writing, of the bed hold policy any time the resident is transferred to general acute care hospital. 2. Review of Resident #8's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and had not returned. The medical record did not contain documentation staff provided the bed hold policy upon discharge to the resident or the resident's responsible party. 3. Review of Resident #12's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and returned on 12/24/25. Review showed the resident discharged from the facility to the hospital on [DATE] and returned on 01/27/26. The medical record did not contain documentation staff provided the bed hold policy upon discharge to the resident or the resident's responsible party. 4. Review of Resident #20's medical record showed staff documented the resident discharged to the hospital on [DATE] and returned to the facility on [DATE]. Review showed the resident discharged to the hospital on [DATE] and returned to the facility on [DATE]. The medical record did not contain documentation staff provided the bed hold policy upon discharge to the resident or the resident's responsible party. 5. Review of Resident #28's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and returned on 03/22/26. The medical record did not contain documentation staff provided the bed hold policy upon discharge to the resident or the resident's responsible party. 6. Review of Resident #47's medical record showed staff documented the resident discharged to the hospital on [DATE] and returned on 04/16/26. Review showed the resident discharged to the hospital on [DATE] and returned on 05/19/26. The medical record did not contain documentation staff provided the bed hold policy upon discharge to the resident or the resident's responsible party. 7. Review of Resident #67's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and returned on 05/05/26. The medical record did not contain documentation staff provided the bed hold policy upon discharge to the resident or the resident's responsible party. 8. Review of Resident #71's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and returned on 05/15/26. The medical record did not contain documentation staff provided the bed hold policy upon discharge to the resident or the resident's responsible party. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. Review of Resident #86's medical record showed staff documented the resident discharged from the facility to the hospital on [DATE] and did not return to facility. The medical record did not contain documentation staff provided the bed hold policy upon discharge to the resident or the resident's responsible party. 10. During an interview on 05/20/2026 at 2:47 P.M., the administrator said he/she knows the facility is deficient with bed holds. The administrator could not provide any requested bed holds. During an interview on 05/21/26 at 11:15 A.M., Licensed Practical Nurse (LPN) H said there is an admissions staff that has the resident sign a bed hold upon admission and when they get sent out to hospital. He/She said the charge nurse changes the status in the computer when they go to hospital. He/She said the nurse does not do anything with bed holds. During an interview on 05/21/26 at 11:38 A.M., the Assistant Director of Nursing (ADON) A said as far as he/she knows the nurse should be giving the bed hold to the resident upon discharge. During an interview on 05/21/26 at 2:25 P.M., the Director of Nursing (DON) said he/she had been told once a bed hold is signed on admission another one does not need to be provided upon transfers. During an interview on 05/21/26 at 2:50 P.M., the administrator said the nurse is responsible for ensuring bed holds are obtained when a resident is sent to the hospital. He/She said the nurses have not been properly educated since he/she has been at facility.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, facility staff failed to complete a baseline care plan within 48 hours of admission for six residents (Resident #8, #35, #62, #67, #71, and #86) out 23 sampled residents. The facility census was 84.1. Review of the facility's policy titled Care Planning, dated 06/2020, showed the Facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission and will include at least the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. 2. Review of Resident #8's medical record showed staff documented the resident admitted to the facility on [DATE]. Review of the record showed a baseline care plan was not completed.3. Review of Resident #35's medical record showed staff documented the resident admitted to the facility on [DATE]. Review of the record showed a baseline care plan completed on 03/04/26.4. Review of Resident #62's medical record showed staff documented the resident admitted to the facility on [DATE]. Review of the record showed a baseline care plan completed on 04/23/26.5. Review of Resident #67's medical record showed staff documented the resident admitted to the facility on [DATE]. Review of the record showed a baseline care plan was not completed.6. Review of Resident #71's medical record showed staff documented the resident admitted to the facility on [DATE]. Review of the record showed a baseline care plan was not completed.7. Review of Resident #86's medical record showed staff documented the resident admitted to the facility on [DATE]. Review of the record showed a baseline care plan completed on 04/27/26. 8. During an interview on 05/21/26 at 11:15 A.M., Licensed Practical Nurse (LPN) H said baseline care plans are completed by the charge nurse and social services designee (SSD). He/She said upon admission the care plan will be in the resident chart to complete. He/She said staff try and complete the care plan before the end of admission day or within two days. He/She baseline care plans are important, so staff know what goals the resident has and how to care for them. During an interview on 05/21/26 at 11:29 A.M., the Assistant Director of nursing (ADON) A said baseline care plans should be completed by the admitting charge nurse and SSD. He/She said he/she is supposed to ensure baseline care plans are completed. He/She said baseline care plans should be completed within 24-48 hours of admission, but he/she would rather have them completed within 24 hours. He/She said he/she could not give a reason why the baseline care plans are not completed. He/She said the importance of baseline care plans is to have the initial plan of care and build a plan of care based on initial assessment.During an interview on 05/21/26 at 11:46 A.M., the SSD said he/she tries to have the social services section completed within the first 24 hours of admission. He/She said the importance of baseline care plans is to have an idea of the resident care and what needs are needed. He/She said if he/she is gone, there is no one else to complete the social services sections of baseline care plans. During an interview on 05/21/26 at 2:30 P.M., the Director of Nursing (DON) said baseline care plans are completed by nursing and social services. He/She said baseline care plans should be completed within 48 hours of admission. He/She said the importance of baseline care plans is to establish resident care and goals. He/She said the ADON should review the health records every day to ensure they are completed. He/She said he/she was aware that some were not getting done, but they are working on it.During an interview on 05/21/26 at 2:50 P.M., the administrator said he/she expects baseline care plans to be completed within the first 24 hours of admission. He/She said the importance is so every staff knows how to care for that resident. He/She was not aware they were not getting done. He/She said the DON and himself/herself are responsible for ensuring they are being completed.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to complete entrapment assessments for four residents (Resident #5, #9, #71, and #83) who used bed rails out of 23 sampled residents. The facility census was 84. 1. Review of the facility's policy titled Bed Rails, dated 06/2020, showed: -Before installing a bed rail, the facility must assess the resident for risk of entrapment from bed rails and ensure the beds dimensions are appropriate for the resident's size and weight; -Maintenance/Designee will assess the bed dimensions no less than quarterly; -Maintenance will also check bed rails regularly to ensure they are still installed correctly, as rails may shift or become loose over time. The facility policy did not address zone measurements for risk of entrapment. 2. Review of Resident #5's Annual Minimum Data Set (MDS), a federally mandated assessment tool, dated 03/06/26, showed staff documented bed rails not used. Review of the resident's care plan, dated 03/08/26, showed staff documented dependent on two aides for bed mobility. Observation on 05/19/26 at 9:37 A.M., showed the resident in bed with grab bars in fixed upright position, on both sides of the bed. Observation on 05/20/26 at 9:57 A.M., showed the resident in bed with grab bars in fixed upright position on both sides of the bed. Review of the resident's medical record showed the record did not contain an entrapment assessment. 3. Review of Resident #9's Quarterly MDS, dated [DATE], showed bed rails not used. Review of the resident's care plan, dated 05/20/26, showed assist rails for help in bed mobility, turning and repositioning. Observation on 05/18/26 at 12:15 P.M., showed the resident in bed with grab bars in fixed upright position on both sides of the bed. Observation on 05/19/26 at 8:49 A.M., showed the resident's grab bars had approximately six inches of space between the bar and the mattress. At this same time, the resident said he/she had issues with the space between the grab bar and the mattress before. Observation on 05/20/26 at 10:33 A.M., showed resident in bed with fixed grab bars on both sides of (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the bed. There is an approximate six inch gap between the grab bar and mattress. Review of the resident's medical record showed the record did not contain an entrapment assessment. 4. Review of Resident #71's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact and did not use bed rails. Review of the resident's care plan, revised 05/02/26, showed staff documented resident may have enabler bars to aid in bed mobility. Observation on 05/18/26 at 2:23 P.M., showed resident in bed with bilateral grab bars in upright position on the bed. Observation on 05/19/26 at 5:51 P.M., showed resident in bed with bilateral grab bars in upright position on the bed. Observation on 05/20/26 at 09:48 A.M., showed resident in bed with bilateral grab bars in upright position on the bed. Observation on 05/21/26 at 09:45 A.M., showed resident in bed with bilateral grab bars in upright position on the bed. Review of the resident's medical record showed the record did not contain an entrapment assessment. 5. Review of Resident #83's Quarterly MDS, dated [DATE], showed bed rails not used. Review of the resident's care plan, dated 05/02/26, showed staff documented the resident, may use U shaped enablers to bed to improve independence and bed mobility. Observation on 05/18/26 at 11:59 A.M., showed the resident in bed with grab bars on both sides. There is an approximate three inch gap between the mattress and grab bars. Observation on 05/19/26 at 9:29 A.M., showed the resident in bed with grab bars on both sides of the bed. Observation on 05/20/26 at 10:51 A.M., showed the resident in bed with grab bars on both sides of the bed. Review of the resident's medical record showed the record did not contain an entrapment assessment. 6. During an interview on 05/21/26 at 9:46 A.M., the Maintenance Director said he/she has worked at the facility for a month and has not been asked to complete any assessments for bed rails. He/She said he/she is unaware of any entrapment assessments and unsure what the facility policy is. He/She said he/she has not been asked to complete any bed rail measurements. During an interview on 05/21/26 at 11:15 A.M., Licensed Practical Nurse (LPN) H said if a resident (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	requests bed rails, therapy assesses the resident and lets the nurses know what kind of rail is needed, bed rail assessments are completed by the nurses, and maintenance puts the rails on the bed. He/She is unsure who is responsible for entrapment measurements, as the charge nurse does not do anything with bed rail measurements. He/She said entrapment assessments are important for safety and ensuring nothing slides between the rails like feet or arms. During an interview on 05/21/26 at 11:40 A.M., the Assistant Director of Nursing (ADON) A said therapy assesses the resident and informs nursing what type of rail is needed, and the nurse will obtain an order and let maintenance know so the rail can be applied. He/She said maintenance should complete the entrapment measurements. During an interview on 05/21/26 at 1:05 P.M., the maintenance assistant said he/she has worked at the facility for three years. He/She said the nurses will let him/her know when a bed rail is needed and he/she will find the correct rail for the bed and will install it. He/She said he/she never knew that entrapment measurements needed to be done. He/She said not measuring for entrapment with bed rails put the residents at risk for injury if they come stuck in the rail. During an interview on 05/21/26 at 2:16 P.M., the Director of Nursing (DON) said maintenance is responsible for completing entrapment assessments, the nurses do the siderail assessments then maintenance completes the measurements. The DON said he/she doesn't know how often entrapment assessments are to be done. The DON said it is important to measure gaps for safety and positioning, to prevent the residents from getting injured or caught in the rails. During an interview on 05/21/26 at 2:41 P.M., the administrator said maintenance and nursing is responsible for entrapments assessments. The administrator said he/she knew entrapments assessments not getting done was an issue, just so many other priorities. The administrator said staff are supposed to measure gaps for safety. The administrator said ultimately, he/she is responsible to make sure the entrapment assessments get done.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to ensure sanitary conditions for a urinary drainage bag (a bag attached to a tube that holds urine) when staff failed to keep the drainage bag off the floor for three residents (Resident #5, #58 and #34) out of three sampled residents. The Facility census was 84. 1. Review of the facility policy titled, Catheter-Care of, dated June 2020, showed catheter collection bags should always be kept below the level of the bladder, including during transport, avoiding contact with the floor. Take care to ensure the collection bag does not touch the floor at any time. 2. Review of Resident #5's Annual Minimum Data Set Assessment (MDS), a federally mandated assessment tool, dated 03/06/26, showed staff assessed the resident with an indwelling urinary catheter. Review of the resident's care plan, dated 04/09/26, showed the resident required a Foley Catheter (a flexible, sterile tube inserted into the bladder to continuously drain urine) and directed staff to keep urinary collection bags off floor. Observation on 05/18/26 at 11:27 A.M., showed the resident in a tilt in space wheelchair, by the nurse's station. The resident's catheter bag rested on the floor. Six staff walked past the resident with his/her catheter bag on the floor, to include the Director of Nursing (DON), Assistant Director of Nursing (ADON), Restorative Aide (RA) M, Certified Nurse Aide (CNA) K and Licensed Practical Nurse (LPN) L. The RA stopped and talked to the resident and did not identify or adjust catheter bag on the floor. Observation on 05/18/26 at 12:20 P.M., showed the resident in his/her wheelchair at the dining room table with his/her catheter bag on the floor under the resident's wheelchair. Observation on 05/19/26 at 9:37 A.M., showed CNA K and CNA N performed a bed to wheelchair mechanical lift transfer for the resident. CNA N laid the resident's catheter bag on the floor and left the room to find a dignity bag for the resident's catheter bag to go in, CNA K remained in the room with the resident and left the catheter bag on floor. At 9:49 A.M. CNA N returned to the resident's room with a dignity bag. CNA N picked the resident's catheter bag up off the floor and placed it in the dignity bag, hooked the bag under the wheelchair, and left the room. 3. Review of Resident #58's Quarterly MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired and had an indwelling catheter. Review of the resident's care plan, dated 05/08/26, showed the resident required a suprapubic catheter (a flexible tube inserted through the abdomen directly into the bladder to drain urine). Observation on 05/18/26 at 11:30 A.M., showed the resident in bed, with his/her catheter bag hung on the bedframe. The bag touched the floor mat on the floor. Observation on 05/19/26 at 9:08 A.M., showed the resident in bed with his/her catheter hung from the bedframe. The bag touched the floor mat on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/19/26 at 2:55 P.M., showed the resident in bed with his/her catheter hung from the bedframe. The bag touched the floor mat on the floor. During an interview on 05/21/26 at 10:25 A.M., LPN H said the resident's catheter bag should not touch the floor, germs could travel up and into the bladder, it is an infection control issue. 4. Review of Resident #34's Quarterly MDS, dated [DATE], showed staff assessed the resident with an indwelling urinary catheter. Review of the resident's care plan, dated 04/09/26, showed the resident required a catheter and directed staff to keep urinary collection bags off floor. Observation on 05/20/26 at 10:21 A.M., showed the resident in his/her wheelchair by the nurse's station with his/her catheter bag hung under his/her wheelchair with part of the bag on the floor. LPN L, LPN H, CNA K and CMT Q at the nurse's station and within sight of the catheter bag on the floor. Observation on 05/20/26 at 11:51 A.M., showed the resident remained at the nurse's station. An unknown staff member placed a blanket over the resident; the catheter bag continued to touch the floor. Observation on 05/20/26 at 2:17 P.M., showed the resident in his/her wheelchair at the nurse's station, with his/her catheter bag on the floor under the wheelchair. CMT Q, LPN H and CMT P were near the resident and did not pick the catheter bag up off the floor. During an interview on 05/20/26 at 2:51 P.M., LPN H said the resident's catheter bag on the floor is not appropriate, and he/she was not aware it had been left on the floor. The LPN said it's a hygiene issue, because it was dragging on the floor which can cause infections. Observation on 05/21/26 at 12:58 P.M., showed the resident in his/her wheelchair, at the dining room table. CNA N sat beside the resident to assist the resident at mealtime. The resident's catheter bag rested on the dining room floor, partially under the left wheel of the resident's wheelchair. During an interview on 05/21/26 at 12:59 P.M., CNA N said the resident's catheter bag should be hung up on the wheelchair, it should not be on the floor, because it could drag on floor and bust open, it's not safe. The CNA said he/she can see the resident's catheter bag on the floor. During an interview on 05/21/26 at 1:04 P.M., LPN L said a resident's catheter bag should never be on the floor, because of germs, it could cause infection. During an interview on 05/21/26 at 12:47 P.M., the Medical Director said catheter bags should not be on floor due to contamination issues and infection issues. 5. During an interview on 05/21/26 at 2:21 P.M., the DON said if a resident is in bed the catheter bag should be on the floor or touching the floor. He/she said staff should use a basin or bag, something to keep it from touching the floor. The DON said a resident's catheter bag should never be on the floor for infection reasons. The DON said he/she would hope staff would notice a resident's catheter bag that has been on the floor for hours. The DON said all nursing staff are responsible to make sure catheter bags are off the floor, from the aides to the nurses. The DON said he/she is responsible for making sure the nursing staff are doing that. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265530	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capitol River Wellness & Rehabilitation	1221 Southgate Lane Jefferson City, MO 65110

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/26 at 2:41 P.M., the administrator said residents' catheter bags should never be on the floor, because of infection control concerns. The administrator said nursing staff are responsible for ensuring the catheter bags are not on the floor. The administrator said he/she doesn't know if the facility has given the training, or expectation on how often staff should check placement of the resident's catheter bag.