

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265294	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Carrollton		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Life Care Lane Carrollton, MO 64633	

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interviews and record review the facility failed to protect a resident's right to be free from misappropriation of resident property when a staff member, CNA B requested and accepted money from Resident #1. The facility census was 57. Review of the facility's Abuse Prevention Policy, updated on 06/17/24, showed:- It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, as well as exploitation;- Identify, correct and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur to include trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms, if any. Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's property or money without the resident's consent;- Residents' property includes all residents' possessions, regardless of their apparent value to others since they may hold intrinsic value to the resident;- Examples of resident property include jewelry, clothing, furniture, money, and electronic devices;- Examples of misappropriation of resident property include but are not limited to: * Unauthorized or coerced use by staff of resident's personal property; * Unauthorized or coerced purchases on a resident's credit card; * Unauthorized or coerced purchases from resident's funds; * a resident who provides a gift to staff in order to receive ongoing care, based on staff's persuasion and; * staff who accept money from a resident for any reason including when staff have made the resident believe that staff was in a financial crisis or the resident believes that he/she is in a relationship with the staff person., and through intimidation, threats, or coercion; - Exploitation is defined as taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats or coercion. 1. Review of Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 7/21/25, showed:- The resident was cognitively intact; - The resident was independent with all activities of daily living (ADL's);- Diagnoses included: right leg above the knee amputation, end stage renal disease (a permanent loss of kidney function where kidneys no longer work well enough to sustain life, requiring dialysis or a kidney transplant for survival), depression, schizophrenia, and anxiety. Review of the resident's nursing progress notes for the month of August 2025., showed:- On 8/20/25 at 6:15 P.M., the Administrator documented she had spoken with the resident's representative to alert and update them of an incident concerning the resident being financially exploited by an employed certified nursing assistant (CNA).- On 8/20/25 at 6:20 P.M., the Administrator documented she alerted the primary care provider that the facility reported an incident regarding alleged financial abuse of Resident #1 by CNA B to the Department of Health and Senior Services. Review of the facility investigation that included staff interviews and statements, dated 8/17/25, showed the following:- On 8/16/25 CNA C said, Resident #1 came to the desk and said he/she had been giving CNA B money to help out. -On 8/16/25 LPN A documented the resident was at the nurse's station telling the nurse and CNA C that he/she had been financially helping CNA B because CNA B said he/she was going to lose his/her home and was not able to pay the bills. LPN A notified the Administrator of the situation. -On 8/17/25 CNA C reported he/she heard the resident tell the charge nurse he/she gave CNA B \$300 this morning to go to Walmart. Review of the police report #2025-002449, dated 8/19/25, showed:- The Officer spoke with the Administrator who stated she had begun investigating CNA B receiving money from Resident #1 on 8/17/25;- The Administrator's investigation showed CNA B had been attempting to coheres the resident into moving in with him/her;- CNA B was advised he/she could not move the Resident out of the building per facility policy;- The Administrator stated CNA B borrowed approximately \$220 from Resident #1 and had told her it would be paid back to Resident #1;- The Administrator informed the officer that CNA B was suspended, and Resident #1 was their own person;- The Officer documented he/she reported to the Administrator that the incident was surely a policy violation for an employee to accept money from a resident and the Administrator informed the Officer she was going to hotline the information. Review of the Resident's care plan, updated 8/19/25, showed the resident identified as someone who would offer staff and other residents' money or would buy things for them and was at risk for financial abuse and exploitation due to being so free with his/her money. During an interview on 9/25/25 at 10:04 A.M., the Regional Director of Clinical Services said he was only familiar with what the investigation showed. He was not aware CNA B attempted to move the resident out of the facility. He knew CNA B had been terminated and thought the resident had been giving CNA B money off and on for</p>		