

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  11/24/2025
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)
F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to protect two residents (Resident #2 and #3) right to be free from physical abuse when Resident #1 held Resident #2's arm down and squeezed Resident #2's jaw and when Resident #1 pushed Resident #3 against a wall. The facility census was 57. On 11/24/25 the Administrator was notified of the past noncompliance which occurred at the facility on 11/01/25 and 11/18/2025. On 11/1/25, the facility administrator was notified of the incident, an investigation immediately began, and corrective actions were implemented to include:- Resident #1 was initially placed on one on one watch, then sent to the emergency room for evaluation, and on 11/19/25 he/she was sent to the psychiatric hospital for further care;- On 11/18/25 an Ad Hoc Quality Assurance and Performance Improvement (QAPI)(refers to Quality Assurance and Performance Improvement (QAPI) activities that are impromptu, as-needed, and specific to a particular problem or initiative, rather than part of regular, scheduled meetings or programs) meeting was held reviewing the past non-compliance regarding the resident-to-resident altercation;- The Director of Nursing (DON) provided staff education for abuse, abuse prevention, resident to resident altercation, and the Elder Justice Act; - The actions to address the non-compliance were completed on 11/19/25. Review of the facility's Abuse Prevention Policy dated 6/17/24, showed:- It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation;- The facility will identify, assess, and care plan for appropriate interventions, as well as monitor residents with needs and behaviors which might lead to conflict or neglect, including verbally aggressive behavior and physically aggressive behavior. Review of the facility Abuse Identification Policy dated 6/17/24, showed:- Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, causes physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse; - Willful is defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm;- Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Review of the facility Abuse Protection of Residents Policy, dated 6/17/24, showed:- The facility will ensure that all residents are protected from physical and psychosocial harm during and after the investigation;- Removal of access by the alleged perpetrator to the alleged victim and assurance that ongoing safety and protection is provided for the alleged victim and, as appropriate, other residents. 1. Review of Resident #1's admission MDS (Minimum Data Set), a federally mandated assessment tool completed by facility staff, dated 10/9/25., showed:- Moderate cognitive impairment;- Diagnoses included: Alzheimer's disease (a brain condition that slowly damages memory, thinking, learning and organizing skills), anxiety, and insomnia (disorder that can make it hard to fall asleep or stay asleep);- Required supervision from staff for activities of daily living (ADL's) to include showering, toileting, and transfers. Review of the resident's care plan, dated 11/19/25, showed:- The resident had the potential to be both verbally and physically aggressive and has been observed becoming agitated by residents who are non-verbal and yell at times;- The resident would remain one on one until cleared by psychology;- The resident when noted to be agitated would be removed from areas of other residents;- The staff would monitor the resident frequently and observe for any verbal aggression or threat of physical harm and intervene immediately. Review of the resident's nursing progress notes for the month of October 2025, documentation showed:- On 10/11/25 at 7:34 P.M., Resident #1 was seen in the hallway yelling at another resident and threatening to hit him/her with a rag if the other resident didn't stop yelling then knocked the hat off of the other resident's head;- On 10/16/25 at 7:30 P.M., Resident #1 kept trying to get out of the doors and was instructed a number of times not to. The last time Resident #1 attempted to, he/she got close to the nurse's face and said he/she was going to burn the place down with the nurse inside and started laughing as he/she walked away;- On 10/31/25 at 10:08 P.M., Resident #1 was tired and not acting like him/herself and hadn't slept well in a while. Review of the resident's nursing progress notes for the month of November 2025., showed:- On 11/1/25 at 4:13 P.M., Resident #1 was witnessed by staff leaning over Resident #2 holding their hands down on their abdomen while squeezing Resident #2's jaw with his/her other hand. The residents were separated with no injuries noted and frequent monitoring of Resident #1 had been initiated; - On 11/1/25 at 7:46 P.M., Received orders from the provider to send Resident #1 to a local hospital emergency room for evaluation and treatment - On 11/1/25 at 11:29 P.M Resident #1 returned from</p>		