

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265340	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/24/2025
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Sullivan		STREET ADDRESS, CITY, STATE, ZIP CODE  875 Dunsford Drive Sullivan, MO 63080	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43010</p> <p>Based on interview and record review, facility staff failed to ensure one resident (Resident #1) remained free from physical abuse when Resident #2 struck Resident #1 in the face. The facility census was 66.</p> <p>1. 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. Identify, assess, and care plan for appropriate interventions and monitor residents with needs and behaviors which might lead to conflict or neglect such as verbally aggressive behaviors and physically aggressive behaviors.</p> <p>2. Review of Resident #1's Minimum Data Set (MDS), a federally mandated assessment tool, dated 1/13/25, showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Diagnoses of Alzheimer's and dementia;</li> <li>-No mood disorders or behaviors.</li> </ul> <p>Review of the resident's care plan, reviewed 3/16/25, showed staff assessed the resident at risk for changes in mood or behavior due to medical condition. Staff were directed to separate the resident from other residents if yelling occurs to avoid resident altercation.</p> <p>Review of the nurse's notes, dated 3/16/25 at 8:50 A.M., showed Registered Nurse (RN) A documented staff reported the resident in the hallway and Resident #2 approached him/her yelling. Resident #1 yelled back and Resident #2 slapped him/her.</p> <p>3. Review of Resident #2's MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Cognitively intact;</li> <li>-Diagnosis of Alzheimer's and unspecified mental disorder;</li> <li>-No mood disorders or behaviors.</li> </ul> <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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's care plan, dated 3/16/25, showed staff assessed the resident experienced behaviors. Staff are directed to separate resident from other residents if yelling occurs to avoid resident altercations and minimize potential for the resident's disruptive behaviors by offering tasks which divert attention.</p> <p>Review of the nurse's notes, dated 3/16/25 at 9:15 A.M., showed RN A charted the resident in the middle of the hallway yelling. Resident #1 yelled at Resident #2, and Resident #2 hit Resident #1. Residents were separated.</p> <p>Review of the nurse's notes, dated 3/20/25 at 8:21 A.M., showed LPN J charted he/she heard yelling at the nurses station. When he/she arrived at the nurses's station, Nurses Aide (NA) D saw Resident #2 slap Resident #1 twice in the face.</p> <p>4. During an interview on 3/24/25 at 12:18 P.M., the administrator said the incident on 3/16/25 happened at the nurse's station between 200 hall and 400 hall when Resident #2 slapped Resident #1. He/She said staff separated the residents after the altercation but is unsure of what other interventions were put in place to keep Resident #1 safe from Resident #2.</p> <p>During an interview on 3/24/25 at 12:38 P.M., LPN B said the interventions put in place for the residents for their first altercation which occurred on 3/16/25 was to separate them. This was an isolated incident and staff were aware if Resident #2 became agitated he/she was to be redirected. He/She said the care plans were updated to reflect the behaviors.</p> <p>During an interview on 3/24/25 at 12:56 P.M., RN A said Resident #2 is always loud and shouts about smoking time. He/She said on 3/16/25 Resident #2 came up to the nurses station yelling When is it time to smoke and Resident #1 told Resident #2 to shut up. Resident #2 then slapped Resident #1 with an open hand to the face. He/She said staff immediately separated the residents and took Resident #2 to his room. RN A said he/she updated their care plan to move the residents away from each other if they started yelling to avoid an altercation. He/She is unaware of any other interventions put in place at the time to keep Resident #1 safe from Resident #2.</p> <p>During an interview on 3/24/25 at 1:13 P.M., NA D said he/she was present for the second altercation on 3/20/25 and saw Resident #2 as he/she went to hit Resident #1 in the face. NA D said Resident #2 struck Resident#1 twice in the face. He/She said the resident's were immediately separated and staff took Resident and placed him/her one on one until the ambulance arrived.</p> <p>During an interview on 3/24/25 at 1:28 P.M., Certified Nurse Aide (CNA) E said he/she was in a room providing care when the altercation occurred on 3/16/25. CNA E said he/she was not instructed to do anything following the incident to keep Resident #1 safe from Resident #2.</p> <p>During an interview on 3/24/25 at 1:38 P.M., RN C said he/she was not here for the incident but said staff were told to keep Resident #2 away from the nurse's station.</p> <p>During an interview on 3/24/25 at 1:46 P.M., CNA F said he/she was coming back from break on 3/16/25 and heard Resident #2 yelling and moving toward Resident #1. Resident #2 slapped Resident #1 in the face. CNA F said he/she immediately removed Resident #2 and took him/her back to his/her room to deescalate him/her. He/She is unaware of any interventions put in place to keep Resident #1 safe from Resident #2.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/24/25 at 2:09 P.M., CNA G said he/she was not aware of any interventions put in to place to keep Resident #1 safe from Resident #2.</p> <p>During an interview on 3/25/25 at 2:14 P.M., the Director of Nursing (DON) said he/she was made aware of the first altercation on 3/17/25 after the investigation had been started. He/She said staff separated the residents and were instructed to keep them apart to keep from having any more altercations. The DON said he/she is unsure of how the second altercation happened.</p> <p>During an interview on 3/27/25 at 3:30 P.M., LPN J said he/she was present for the altercation on 3/20/25. He/She did not witness it, but came up after Resident #2 had already made contact with Resident #1. He/She said staff separated the residents immediately and he/she took Resident #2 to the activity room. LPN J said he/she did not know of any interventions in place to keep Resident #1 safe from Resident #2.</p> <p>MO00251423</p>