STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265340	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Sullivan	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, facility staff failed to notify the physician and resident representative in a timely manner of a change in condition, when one resident (Resident #1) spilled coffee on his/her thigh and resulted in a significant burn injury. The facility's census was 67. 1. Review of the facility's policies showed the facility did not provide a policy for when to notify the Physician/Resident Representative of an injury, or change in a resident's condition. Review of the facility's interact Signs and Symptoms guide (an electronic quality improvement communication tool designed to improve the identification, evaluation, and communication about changes in resident status), dated 2014, showed staff are directed to document an immediate entry for any burn other than a minor first degree burn with no significant pain, or a non-immediate entry for minor first degree burn in the past twenty-four hours. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/23/25, showed staff assessed the resident as moderate cognitive impairment, independent with eating, bed mobility, and transfers. Review of the resident's progress notes, dated 06/02/25 at 5:04 P.M., showed Licensed Practical Nurse (LPN) C documented the resident spilled hot coffee on his/her right leg, no blistering observed but there is a red blotchy area, will continue to monitor for skin changes. Staff did not document they notified the physician or the resident's responsible party of the burn injury to the resident's right thigh. Review of the resident's progress notes, dated 06/04/25 at 12:20 P.M., showed staff documented the resident has reddened area to his/her right inner knee, and right thigh with two fluid-filled blisters, possibly from coffee spilled the day prior, physician and resident representative notified. During an interview on 06/30/25 at 8:43 A.M., the administrator said he/she would not have expected the nurse to contact the physician or the resident's responsible party after the burn occurred because it was a minor injury without significant pain. During an interview on 06/30/25 at 8:49 A.M., the Assistant Director of Nursing (ADON) said he/she would not have expected the nurse to contact the physician and the resident's responsible party after the burn occurred on 06/02/25 because it was a minor injury without significant pain. He/She said per LPN C's documentation on 06/02/25, he/she would not have expected LPN C to document an immediate interact entry either. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/30/25 at 11:33 A.M., the resident's physician said he/she would expect facility staff to notify him/her shortly after they became aware of the burn injury or within 24 hours. He/She said in this instance, he/she would have expected a notification from staff by the morning of 06/03/25. During an interview on 06/30/25 at 1:50 P.M., LPN C said he/she should have notified the resident's physician and resident representative of the burn on 06/02/25 but he/she got busy and forgot. He/She said he/she notified the resident's representative in-person the following day, and another nurse notified the physician. MO00255369

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to review and revise comprehensive care plans to include interventions for one resident (Resident #1) after he/she sustained burns to his/her thigh from hot liquids, and smoking interventions for one resident (Resident #2) out of three sampled residents. The facility's census was 67. 1. Review of the facility's policy titled, Comprehensive Care Plans and Revisions, dated 09/11/24, showed staff are directed as follows: -A Comprehensive Care Plan must be reviewed and revised by the interdisciplinary team (IDT) after each assessment, including both the comprehensive and quarterly review assessments; -The facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care; -When these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/23/25, showed staff assessed the resident as moderate cognitive impairment and independent with eating. Review of the resident's nurse's notes, dated 06/04/25, showed staff documented the resident has reddened area to his/her right inner knee, and right thigh with two fluid-filled blisters, from a coffee spill the day prior, physician and resident representative notified, Silvadene (a topical antimicrobial medication used to prevent and treat infection in second and third-degree burns) applied to his/her right thigh. Review of the resident's care plan, revised 06/03/25, showed the care plan did not contain interventions for hot liquids and/or treatment of the burn to the resident's right thigh. During an interview on 06/16/25 at 12:55 P.M., the Assistant Director of Nursing (ADON) said the nurse should have updated the resident's care plan after the documented coffee spill/burn to the resident's thigh and should have also documented the incident under risk management via the electronic record so the IDT could follow up and ensure interventions were implemented. During an interview on 06/16/25 at 2:19 P.M., the interim Director of Nursing (DON) said the nurse should have added interventions to the resident's care plan after the coffee spill and he/she did not know the care plan was not updated. During an interview on 06/25/25 at 3:12 P.M. the Care Plan Coordinator said he/she was not aware the resident had sustained burns from hot liquids, and the nurse who documented the treatment and notification to the physician was responsible to either add interventions to the care plan or inform the IDT during daily rounds so the team could discuss and implement interventions. He/She said he/she was not sure why that was not done. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as moderate cognitive impairment, and re-admitted to the facility on [DATE]. Review of the resident's nurse's notes, dated 05/21/25, showed staff documented the resident smokes and likes to attend all scheduled smoke breaks. Review of the resident's care plan, revised 06/06/25, showed the care plan did not contain interventions for smoking. Observation on 06/16/25 at 1:53 P.M., showed the resident outside smoking. During an interview on 06/16/25 at 12:55 P.M., the ADON said the resident smokes and his/her care plan should have interventions for smoking. During an interview on 06/25/25 at 3:12 P.M., the Care Plan Coordinator said the resident smokes, he/she was responsible to add interventions for smoking on the resident's quarterly care plan update but missed it. 4. During an interview on 06/16/25 at 12:55 P.M., the ADON said any nurse or other member of the IDT can update a resident's care plan with changes, and the Care Plan Coordinator is responsible to audit and update care plans at least quarterly or after an event. During an interview on 06/16/25 at 1:38 P.M., the administrator said any nurse or member of the IDT can update residents' care plan with changes. He/She said the Care Plan Coordinator is responsible to update care plans quarterly and in his/her absence, a regional nurse helps to ensure the care plans are up to date. He/She said direct care staff are expected to utilize residents' care plans to help with delivery of care. During an interview on 06/16/25 at 1:57 P.M., Certified Nursing Assistant (CNA) A said the nurses update residents' care plans, the CNAs access the care plans via the electronic point of care system and use the care plans to get information on a resident's specific care needs, how to transfer, and special precautions such as for smoking and hot liquids. During an interview on 06/25/25 at 3:12 P.M., the Care Plan Coordinator said he/she is responsible to update care plans at least quarterly and with changes when he/she is made aware. He/She said all nurses and members on the IDT can and are also responsible to update care plans with changes. MO00255369

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview and record review, facility staff failed to provide timely treatment to one resident (Resident #1) when he/she sustained a burn injury to his/her right thigh on 06/02/25 from hot coffee and staff did not document any treatment interventions for the burn until 06/04/25. The facility's census was 67. 1. Review of the facility's policies showed the facility did not provide a policy for how to address a change in a resident's condition after a burn injury. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/23/25, showed staff assessed the resident as moderate cognitive impairment, independent with eating, bed mobility, and transfers. Review of the resident's progress notes, dated 06/02/25 at 5:04 P.M., showed Licensed Practical Nurse (LPN) C documented the resident spilled hot coffee on his/her right leg, no blistering observed but there is a red blotchy area, will continue to monitor for skin changes. Staff did not document they administered any treatment to the resident's leg/thigh. Review of the resident's care plan, revised 06/03/25, showed the care plan did not contain interventions to direct staff on how to provide hot liquids to the resident or how to monitor the resident when hot liquids are provided. Review of the resident's progress notes, dated 06/03/25, did not contain documentation of the burn to the residents thigh. Review of the resident's progress notes, dated 06/04/25 at 12:20 P.M., showed staff documented the resident has reddened area to his/her right inner knee, and right thigh with two fluid-filled blisters, from a coffee spill two days prior, physician and resident representative notified, Silvadene (a topical antimicrobial medication used to prevent and treat infection in second and third-degree burns) applied to his/her right thigh. Review of the resident's shower sheet, dated 06/03/25, showed staff documented the resident refused his/her shower. Review of the resident's Physician's Order, dated 06/05/25, showed an order to apply Silvadene cream to right upper leg topically as needed for burn/blister twice daily. Review of the resident's Electronic Medical Record (EMR), dated 06/16/25, showed staff did not document they assessed the resident regarding his/her consumption of Hot Liquids. During an interview on 06/16/25 at 1:57 P.M., Certified Nursing Assistant (CNA) A said the resident drinks coffee all the time but he/she has not been assigned to him/her for a while. During an interview on 06/30/25 at 8:49 A.M., the Assistant Director of Nursing (ADON) said per LPN C's documentation on 06/02/25, he/she would not have expected LPN C to administer any treatment other than monitoring to the resident's skin after the burn. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 06/30/25 at 11:33 A.M., the resident's physician said after staff became aware of the burn, he/she would expect staff to apply a cool compress to the resident's thigh to cool the area down, monitor the area for any changes, and notify him/her by the next morning. He/She said he/she would have approved Silvadene treatment for use after the burn injury area had cooled. He/She said after staff notified him/her on 06/04/25, he/she approved treatment with Silvadene, directed NP F to assess the resident on 06/05/25, and the NP recommended to continue treatment with Silvadene and monitor. He/She said based on the NP's assessment and report on 06/05/25, the resident did not experience any ill-effects from the delay in treatment. During an interview on 06/30/25 at 1:44 P.M., CNA B said he/she served the resident coffee directly from the dining room as usual with his/her meal inside his/her room. He/She said he/she went to get milk and on his/her return to the room, he/she witnessed the resident pull the bedside table closer to him/her when the coffee spilled on his/her thigh and the resident yelled ow. The CNA said he/she immediately notified the nurse who assessed the resident. During an interview on 06/30/25 at 1:50 P.M., LPN C said one of the CNAs reported to him/her the resident spilled coffee on himself/herself, he/she assessed the resident's thigh with redness and the resident denied pain. He/She said he/she did not know how hot the coffee was. He/She said he/she did not initiate any treatment to the area and did not contact the physician for a treatment. MO00255369