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	04/22/2026

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 0658 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review facility staff failed to obtain orders and complete assessments for one resident (Resident #1's) surgical wound which resulted in amputation of the right trans metatarsal (a partial foot amputation) The facility census was 67.1. Review of the facility's treatment order policy, reviewed 6/12/25, showed treatment orders are written per physician orders. If a resident has multiple wound sites, a complete and separate treatment order must be written for each site. The physician writes an order that includes the following: site of wound, name of cleanser, name of ointment, type of dressing and number of times to perform the treatment/duration of treatment.Review of the facility's Physician Orders, revised 2/11/26, showed a physician, physician assistant or nurse practitioner must provide orders for the resident's immediate care and ongoing care of the resident.2. Review of the resident's face sheet showed the resident admitted to the facility on [DATE].Review of the resident's hospital Discharge summary, dated [DATE], showed a diagnosis of gangrene (a serious, often life-threatening condition caused by tissue death). Review showed the summary did not contain orders for surgical wound care or for a follow up appointment.Review of the resident's physician order sheets, dated 4/10/26, showed the physician orders directed staff to have wound care provider evaluate and treat. Review showed the orders did not contain orders for surgical wound care or for follow up post operative appointment.Review of the residents Treatment Administration Record (TAR), dated 4/8/26 to 4/14/26, did not contain documentation of treatment orders or that staff provided treatments to the residents' surgical site.Review of the resident's nurses notes from 4/8/26 to 4/13/26 did not contain documentation staff assessed the residents dressing or surgical site. Review of the residents nurses notes, dated 4/14/26, showed staff documented family at bedside and concerned regarding resident's toe amputation site. Surgeon gave orders for residents to be sent to emergency room for further evaluation.Review of the resident's hospital discharge information, dated 4/22/26, showed podiatry consulted for worsened chronic right foot wound with tissue necrosis (he premature, irreversible death of cells and living tissue caused by external factors like infection, toxins, or trauma, often resulting from blocked blood flow) and a right trans metatarsal amputation was performed on 4/18/26.During an interview on 4/22/26 at 9:48 A.M., the administrator said the resident was admitted with an amputation of his/her toes and thought the order was to not change the dressing. He/She said the resident's family was at bedside on 4/14/26 and took the dressing off and sent a picture to the surgeon and he/she wrote an order for the resident to be sent to the emergency room. The administrator said the resident had more toes amputated at the hospital.During an interview on 4/22/26 at 10:26 A.M., the Director of Nursing (DON) said the resident admitted with amputation of the toes and the resident said the dressing was not to be removed until his/her follow up appointment. He/She said the family removed the dressing and the resident was sent to the hospital. He/She said the hospital had to take more toes or more of the foot and probably will end up taking more due to gangrene.During an interview on 4/22/26 at 12:12 P.M., Licensed Practical Nurse (LPN) C said he/she worked with the resident the day he/she was sent to the hospital, and he/she recommended the resident be sent because his/her foot looked like it was dying. He/She said he/she looked in the chart and there were no wounds or treatment orders. He/She said (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 0658 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the admitting nurse documented the resident said not to touch the surgical site until he/she had a follow up with the surgeon.During an interview on 4/22/26 at 1:01 P.M., the DON said he/she could not find an order for the resident's treatment or an order to say the dressing should stay in place. He/She said her recollection was that is what the resident told the admitting nurse. During an interview on 4/22/26 at 1:06 P.M., LPN D said he/she documented the resident's bandage was to stay intact until he/she saw the surgeon for his/her follow up appointment because that was what he/she was told by the resident. He/She said the resident's hospital discharge paperwork did not contain treatment orders for the surgical site. He/She said the resident admitted on a Tuesday or Wednesday and said Thursday was the follow up, but the resident could not say if that was a day or two from then or a week. He/She said He/She passed the concern of the lack of wound orders to the oncoming nurse to get clarification and does not know what happened from there. LPN D said he/she did not notify the physician because he/she had passed everything on in report to the day charge and thought he/she would notify the physician to get direction.During an interview on 4/22/26 at 1:20 P.M., LPN C said he/she does not recall being asked to call to clarify the treatment orders for the resident, but he/she did not call the hospital, the original surgeon, or the wound care company to receive orders for the resident.During an interview 4/23/26 at 10:21 A.M., the Physician said the resident was a tough case because he/she and the facility had limited access to the resident's chart. He/She said the resident's amputation was completed by a private surgeon and then the resident was admitted to the facility from the local emergency room. He/She said he/she saw the resident on 4/10/26 and placed the order for wound care to evaluate and treat because there were no orders. He/She said he/she told the facility staff leaving the bandage for the weekend was acceptable because that is common for surgeons to request, depending on how long until the follow up. He/She said the facility should have followed up with wound care or tried to get in touch with the private surgeon to receive orders, He/She said in an ideal world, the facility would have orders by Monday 4/12/26 at the latest. He/She does not know why there was a lapse in wound care assessing the resident for that week.During an interview on 5/7/26 at 8:54 A.M., the DON said the resident was on the list to see the wound care plus nurse practitioner, but her case load had almost tripled because of the influx in new admits with wounds. He/She said wound care prioritized stage four wounds and wound vacs over surgical because the resident should have had a follow up with the surgeon.#2986607