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	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Sullivan	875 Dunsford Drive Sullivan, MO 63080

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, facility staff failed to maintain professional standards of care, when staff failed to transcribe a wound treatment order from the hospital for one resident (Resident #1), and failed to document wound care and treatments as directed by the physician for three residents (Resident #1, #2, and #3) out of three sampled residents with wounds. The facility's census was 82.1. Review of the facility's Physician Orders policy, revised 02/11/26, showed the facility is to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines. Physician orders include medications and treatments. Review of the facility's Treatment Orders policy, revised 05/15/26, showed treatment orders are written per physician orders. 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. The physician order is followed, as are the manufacturer's instructions for use of each product ordered. 2. Review of Resident #1's Quarterly MDS, dated [DATE], showed staff assessed the resident as moderate cognitive impairment, and received applications of dressings to feet (with or without topical medications). Review of the resident's Physician Order Summary (POS), dated 06/01/26 through 06/15/26, showed a physician order directed staff to cleanse left heel with wound cleanser, pat dry, apply skin prep (a protective skin-protectant film) to peri wound, apply Santyl (medication to remove dead tissue from wounds) nickel thick to wound base, cut antibacterial foam dressing saturated in normal saline and apply to wound base, apply silicone foam bordered dressing daily and as needed if soiled or dislodged, stop date 06/16/26. Review of the resident's TAR, dated 06/01/26 through 06/15/26, showed the TAR did not contain documentation staff provided wound treatment as directed by the physician to the resident's left heel on 06/03/26, 06/05/26, 06/08/26, 06/12/26, and 06/14/26. During an interview on 06/24/26 at 2:02 P.M., Licensed Practical Nurse (LPN) A said he/she was new to the position, is now responsible to administer wound treatment to the resident's left leg Monday through Friday, and the charge nurse is responsible to do the treatment on the weekends. Review of the resident's Hospital Discharge Orders, dated 06/18/26, showed a physician order to change dressing to the resident's left leg daily, place 4x4's (gauze pads) over staples, place ABD padding (to absorb drainage and protect wounds) over the 4x4's, wrap with a sterile gauze, and wrap with ace bandage. Review of the resident's progress notes, dated 06/19/26 at 3:03 P.M., showed staff documented resident returned to facility yesterday evening, treatment not viewed due to no orders to change dressing noted or reported. Review of the resident's POS, dated 06/18/26 through 06/24/26, showed the POS did not contain orders for wound care to the resident's left leg. Review of the resident's TAR, dated 06/18/26 through 06/24/26, showed the TAR did not contain documentation of treatment orders or staff provided wound treatments to the resident's left leg. Observation on 06/25/26 at 1:22 P.M., showed staples to a wound on the resident's left leg. During an interview on 06/25/26 at 11:57 A.M., the administrator said the resident's wound treatment order was not transcribed to the POS or the TAR, but LPN A had documented the order in the wound assessment notes. He/She said if the order was not on the TAR, the nurses would not be prompted to administer the treatment. During an interview on 06/25/26 at 1:47 P.M., LPN A said the resident (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	re-admitted with wound care order from his/her surgeon, and he/she transcribed the order to the resident's TAR but somehow the order got deleted. LPN A said if the treatment was not listed on the TAR, the nurses would not be prompted to administer the treatment to the resident's leg. During an interview on 06/25/26 at 2:27 P.M., the Director of Nursing (DON) said he/she expects the admission nurse to ensure treatment orders are entered on the POS, the wound nurse to follow up the next day to ensure the treatment orders were on the TAR, and he/she audits after a few days after. The DON said he/she completed an audit the day before and realized the resident's wound care order did not get transcribed to the POS and was not on the TAR. During an interview on 06/25/26 at 3:17 P.M., the administrator said he/she expects the nurse who admits the resident to enter the physician's orders and LPN A to follow up and ensure correct wound care orders are entered on the resident's POS and TAR. 3. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, and received surgical wound care. Review of the resident's POS, dated 06/01/26 through 06/24/26, showed a physician order directed staff to administer the following wound treatment to cleanse left lateral foot with wound cleanser, pat dry, apply skin prep to peri wound, apply betadine moistened gauze to base of wound with foam dressing daily and as needed every Monday, Wednesday and Friday, stop date 06/18/26. Review of the resident's TAR, dated 06/01/26 through 06/24/26, showed the TAR did not contain documentation staff provided wound treatment as directed by the physician to the resident's left foot on 06/03/26, 06/08/26, and 06/15/26. Review of the resident's progress notes, dated 06/01/26 through 06/24/26, showed the record did not contain documentation regarding the missed treatments. Observation on 06/24/26 at 10:44 A.M., showed the resident with a wound to his/her left foot. During an interview on 06/24/26 at 1:47 P.M., LPN A said he/she or the charge nurse is responsible to administer the physician ordered treatment to the resident's foot and document on the TAR once completed. He/She said if the nurse did not document on the TAR, the treatment probably was not administered that day. 4. Review of Resident #3's Significant Change MDS, dated [DATE], showed staff assessed the resident as cognitively intact, and received surgical wound care. Review of the resident's POS, dated 06/01/26 through 06/24/26, showed a physician order directed staff to cleanse left below knee amputation with wound cleanser, apply skin prep to peri wound, cut specialized black foam to fit inside of wound bed, peel adhesive drape front and back, sealing wound, then cut hole in middle of drape, apply suction pad, then cover with adhesive drape to completely seal wound, connect to suction vacuum pump set at 125 millimeter of mercury (mmHG) continuously on Monday, Wednesday, Friday, and as needed if air leak or dislodged. Review of the resident's TAR, dated 06/01/26 through 06/24/26, showed the TAR did not contain documentation staff provided wound treatment as directed by the physician to the resident's left leg on 06/12/26 and 06/15/26. Review of the resident's progress notes, dated 06/01/26 through 06/24/26, showed the record did not contain documentation regarding the missed treatments. During an interview on 06/25/26 at 1:47 P.M., LPN A said he/she is responsible for administering the treatment to the resident's left leg on Monday, Wednesday and Friday, and if he/she is not available, the DON completes the treatment. LPN A said if the TAR was not signed, the treatment probably did not get done. During an interview on 06/25/26 at 1:53 P.M., the resident said staff are supposed to change the dressing to his/her leg every two to three days, but staff have missed changing the dressing a few times. During an interview on 06/25/26 at 2:27 P.M., the DON said LPN A is responsible for administering the treatment to the resident's left leg and he/she will assist LPN A when needed. The DON said he/she was not aware of any missed treatments to the resident's left leg. Complaint# 3047789

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, facility staff failed to provide care to meet the basic hygiene needs for five residents (Resident #2, #4, #5, #6, and #7) out of seven sampled residents who required assistance with Activities of Daily Living. The facility's census was 82. 1. Review of the facility's Activities of Daily Living (ADL) policy, revised 09/04/25, showed the residents will receive assistance as needed to complete ADLs. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the facility's shower schedule showed each resident is scheduled to be assisted with a bath/shower twice per week by facility staff. 2. Review of Resident #2"s Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Impairment to one side lower extremity (hip, knee, ankle, foot); -Required set-up assistance from staff for personal hygiene;-Required partial to moderate assistance from staff to shower/bathe. Review of the resident's care plan, dated 04/09/26, showed staff were directed to assist the resident with mobility and ADLs as needed. Review of the resident's electronic and paper shower records, dated 06/01/26 through 06/24/26, showed staff documented resident received a shower on 06/02/26, 06/04/26, 06/09/26, and 06/15/26. Observation on 06/24/26 at 10:44 A.M., showed the resident with long facial hair to his/her chin and upper lip. During an interview on 06/24/26 at 10:44 A.M., the resident said he/she is supposed to get two showers per week, but staff have only been offering one per week. He/She said he/she would like staff to shave his/her facial hair and has asked staff to shave him/her but they haven't, and if he/she had a razor he/she would shave the facial hairs him/herself. Observation on 06/24/26 at 1:47 P.M., showed the resident with long facial hair to his/her chin and upper lip. Observation on 06/25/26 at 10:04 A.M., showed the resident with long facial hair to his/her chin and upper lip During an interview on 06/25/26 at 10:04 A.M., the resident said staff assisted him/her with a shower the evening before but did not offer to shave or remove his/her facial hair. 3. Review of Resident #4"s admission MDS, dated [DATE], showed staff assessed the resident as follows: -Cognitively intact; -Required partial/moderate assistance from staff with transfers;-Required substantial to maximum assistance from staff to shower/bathe. Review of the resident's care plan, dated 05/26/26, showed staff were directed to assist the resident with mobility and ADLs as needed. Review of the resident's electronic and paper shower records, dated 05/01/26 through 05/31/26, showed staff documented the resident received a shower on 05/11/26, 05/27/26, and one resident refusal on 05/04/26. Review of the resident's electronic and paper shower records, dated 06/01/26 through 06/24/26, showed staff documented the resident received a shower on 06/11/26. Observation on 06/24/26 at 10:58 A.M., showed the resident in bed with long greasy hair. Observation on 06/25/26 at 10:17 A.M., showed the resident in his/her wheelchair with long greasy hair. During an interview on 06/24/26 at 10:58 A.M., the resident said he/she was told staff would offer him/her a shower twice a week, but he/she has never received two showers in a week, and his/her last shower was about two weeks ago. He/She said not having a shower makes him/her feel crappy and his/her hair feels greasy. 3. Review of Resident #5"s Quarterly MDS, dated [DATE], showed staff assessed the resident as moderate cognitive impairment, and dependent on staff for personal hygiene, transfers, and to shower/bathe. Review of the resident's care plan, dated 05/26/26, showed staff were directed to assist the resident with mobility and ADLs as needed. Review of the resident's electronic and paper shower records, dated 05/01/26 through 05/31/26, showed staff documented the resident received a shower on 05/12/26 and 05/26/26. Review of the resident's electronic and paper shower records, dated 06/01/26 through 06/24/26, showed staff documented the resident received a shower on 06/01/26 and 06/09/26. Observation on 06/24/26 at 11:36 A.M., showed the resident in his/her wheelchair with long greasy hair and long fingernails. Observation on 06/24/26 at 2:30 P.M., showed the resident in his/her wheelchair with long greasy (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hair and long fingernails. Observation on 06/25/26 at 10:24 A.M., showed the resident in his/her wheelchair with long greasy hair and long fingernails. 4. Review of Resident #6"s Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, and required substantial to maximum assistance from staff to shower/bathe. Review of the resident's care plan, dated 05/04/26, showed staff were directed the resident requires extensive/substantial assistance with bathing on shower days and as needed on request. Review of the resident's electronic and paper shower records, dated 05/01/26 through 05/31/26, showed staff documented the resident received a shower on 05/12/26, 05/29/26 and one resident refusal on 05/15/26. Review of the resident's electronic and paper shower records, dated 06/01/26 through 06/24/26, showed staff documented the resident received a shower on 06/09/26. Observation on 06/24/26 at 12:31 P.M., showed the resident in his/her wheelchair with greasy hair. During an interview on 06/24/26 at 12:34 P.M., the resident said he/she does not get a shower too often and he/she could use a shower. 5. Review of Resident #7"s Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively intact, and required substantial to maximum assistance from staff to shower/bathe. Review of the resident's care plan, dated 06/25/26, showed staff assessed the resident as totally dependent on one staff to provide bed bath, resident prefers Mondays and Thursdays. Review of the resident's electronic and paper shower records, dated 05/01/26 through 05/31/26, showed staff documented the resident received a shower on 05/09/26, 05/18/26 and 05/27/26. Review of the resident's electronic and paper shower records, dated 06/01/26 through 06/24/26, showed staff documented the resident received a shower on 06/02/26, 06/04/26 and 06/18/26. During an interview on 06/24/26 at 2:31 P.M., the resident said staff are supposed to assist him/her with a shower twice a week but have only been offering him/her a shower about once every two weeks and he/she had to beg staff a week ago to get a shower. He/She said he/she feels gross when he/she has to wait that long to get a shower. 6. During an interview on 06/24/26 at 1:12 P.M., Certified Nursing Assistant (CNA) D said the CNAs are supposed to offer each resident a shower twice per week or at least once a week per the shower schedule and document on the shower sheet and in the computer once completed. He/She said staff have been having difficulty keeping up with showers recently due to staffing. During an interview on 06/24/26 at 1:36 P.M., CNA E said the CNAs are supposed to offer the residents a shower twice a week per the shower schedule and chart on paper and the electronic chart once completed. He/She said the residents' showers are not getting done like they should because they've been busy, and the aides are just trying to keep the residents clean and dry. During an interview on 06/25/26 at 10:26 A.M., CNA F said the CNAs are supposed to offer the residents a shower twice a week per the shower schedule and as needed, and document on the shower sheet and in the computer once completed. He/She said staff are expected to wash hair, offer to shave facial hair and trim nails (if the resident is not diabetic). He/She said residents are not being assisted with showers because there are not enough staff at times to get it done. During an interview on 06/25/26 at 10:50 A.M., Registered Nurse (RN) C said staff are expected to offer the residents showers twice a week but staff don't always get them done due to low staffing. The RN said staff will try to complete the showers on the weekends when there is sometimes more help. During an interview on 06/25/26 at 2:27 P.M., the Director of Nursing (DON) said he/she expects the CNAs to offer residents a shower twice a week or at least once weekly, wash hair, trim nails, and shave shaved if needed, and document completed showers on paper and in the computer. The DON said the charge nurses are to provide oversight for the CNAs completing the showers, and he/she felt like showers not getting done had become more of an issue lately. During an interview on 06/25/26 at 3:17 P.M., the administrator said staff are expected to offer residents a shower twice a week, wash hair, trim nails, and shave females if needed. The administrator said he/she was not sure why staff were not offering showers to residents but he/she has had a few residents request a shower due to missed showers and ensured staff took care of it. Complaint# 3047789, 3047949, 3050202, 3052073