DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	C 03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF SULLIVAN	875 DUNSFORD DRIVE SULLIVAN, MO 63080

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: 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. 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. 2. Review of Resident #1's Minimum Data Set (MDS), a federally mandated assessment tool, dated 1/13/25, showed staff assessed the	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Suzanne Mayfield | TITLE: Exec Dir | (X6) DATE: 4/18/2025

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.

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F 600	Continued From page 1 resident as: -Cognitively intact; -Diagnoses of Alzheimer's and dementia; -No mood disorders or behaviors. 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. 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. 3. Review of Resident #2's MDS, dated 2/8/25, showed staff assessed the resident as: -Cognitively intact; -Diagnosis of Alzheimer's and unspecified mental disorder; -No mood disorders or behaviors. 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. 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	F 600		

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F 600	Continued From page 2 yelled at Resident #2, and Resident #2 hit Resident #1. Residents were separated. 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. 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. 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. 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	F 600		

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F 600	Continued From page 3 of any other interventions put in place at the time to keep Resident #1 safe from Resident #2. 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. 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. 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. 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. 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	F 600		

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F 600	Continued From page 4 Resident #2. 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. 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. MO00251423	F 600		

Missouri Department of Health and Senior Services

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	07744	A. BUILDING: _____ B. WING _____	C 03/24/2025

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A4074	19 CSR 30-85.042(65) Protective Oversight, Voluntary Leave Each resident shall receive twenty-four- (24-) hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II Refer to F600	A4074		

Missouri Department of Health and Senior Services
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Suzanne Mayfield — EXECUTIVE DIRECTOR — 4/8/25

PLAN OF CORRECTION

Provider/Supplier Name:	Life Care Center of Sullivan
Street Address, City, Zip:	875 Dunsford Drive, Sullivan, Mo 63080
Date of Survey:	03/24/2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This plan of correction is submitted as required under State and Federal law. The admission of the plan of correction does not constitute an admission on the part of Life Care Center of Cape Girardeau as to the accuracy of the surveyor's findings nor the conclusion drawn there from. **The facility's submission of this plan of correction does not constitute an admission on the part of the facility that the findings cited are accurate, that findings constitute a deficiency or that the scope and severity regarding any of the deficiencies cited are correctly applied.** **The plan of correction is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the plan of correction 4/18/25. Compliance will be maintained as provided in the plan of correction.**	4/18/25
	The following corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice	
	Resident #1 is currently residing in the facility and is free from abuse or neglect.	
	Resident #2 is currently residing in the facility and has had no further incidents. After the 3/20/25 incident res was admitted for pscyh eval & treatment. Facility was looking for more appropriate placement. Resident is on one-on-one. Resident was issued a 30-day discharge notice April 18, 2025. was accepted at another, more appropriate facility.	
	The facility has identified other residents having the potential to be affected by the same deficient practice.	

	All residents have the potential to be affected by the alleged deficient practice	
	The following measures or systemic changes will be put into place to ensure that the deficient practice does not recur.	
	ED will educate nursing admin on ensuring nursing staff are aware of interventions put into place following a resident to resident altercation DON/Designee will educate nursing staff on the Abuse Prevention policy & Aides will be educated on how to utilize the Kardex for resident specific care/interventions	4/18/25
	The facility will do the following to monitor the corrective action(s) and utilize the following quality assurance program to ensure the deficient practice will not recur.	
	DON/MDS/Designee will audit the care plan of resident with episodes of behaviors to ensure care plan/Kardex is updated with interventions weekly & during Resident at Risk meeting	4/18/25
	The results of the audits will be reviewed in the Quality Assurance Performance Improvement Committee (QAPI) monthly for three months or until substantial compliance is maintained. Re-education, frequency and/or duration of reviews will be increased as needed if any areas of noncompliance are identified during the auditing process until compliance has been reached	4/18/25

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.