STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265294	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Carrollton	300 Life Care Lane Carrollton, MO 64633

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect two residents (Resident #2 and #3) right to be free from physical abuse when Resident #1 held Resident #2's arm down and squeezed Resident #2's jaw and when Resident #1 pushed Resident #3 against a wall. The facility census was 57.On 11/24/25 the Administrator was notified of the past noncompliance which occurred at the facility on 11/01/25 and 11/18/2025. On 11/1/25, the facility administrator was notified of the incident, an investigation immediately began, and corrective actions were implemented to include:- Resident #1 was initially placed on one on one watch, then sent to the emergency room for evaluation, and on 11/19/25 he/she was sent to the psychiatric hospital for further care;- On 11/18/25 an Ad Hoc Quality Assurance and Performance Improvement (QAPI)(refers to Quality Assurance and Performance Improvement (QAPI) activities that are impromptu, as-needed, and specific to a particular problem or initiative, rather than part of regular, scheduled meetings or programs) meeting was held reviewing the past non-compliance regarding the resident-to-resident altercation;- The Director of Nursing (DON) provided staff education for abuse, abuse prevention, resident to resident altercation, and the Elder Justice Act; - The actions to address the non-compliance were completed on 11/19/25.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;- The facility will identify, assess, and care plan for appropriate interventions, as well as monitor residents with needs and behaviors which might lead to conflict or neglect, including verbally aggressive behavior and physically aggressive behavior.Review of the facility Abuse Identification Policy dated 6/17/24, showed:- Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, causes physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse; - Willful is defined as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm;- Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking.Review of the facility Abuse Protection of Residents Policy, dated 6/17/24, showed:- The facility will ensure that all residents are protected from physical and psychosocial harm during and after the investigation;- Removal of access by the alleged perpetrator to the alleged victim and assurance that ongoing safety and protection is provided for the alleged victim and, as appropriate, other residents.1. Review of Resident #1's admission MDS (Minimum Data Set), a federally mandated assessment tool completed by facility staff, dated 10/9/25., showed:- Moderate cognitive impairment;- Diagnoses included: Alzheimer's disease (a brain condition that slowly damages memory, thinking, learning and organizing skills), anxiety, and insomnia (disorder that can make it hard to fall asleep or stay asleep);- Required supervision from staff for activities of daily (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	living (ADL's) to include showering, toileting, and transfers.Review of the resident's care plan, dated 11/19/25, showed:- The resident had the potential to be both verbally and physically aggressive and has been observed becoming agitated by residents who are non-verbal and yell at times;- The resident would remain one on one until cleared by psychology;- The resident when noted to be agitated would be removed from areas of other residents;- The staff would monitor the resident frequently and observe for any verbal aggression or threat of physical harm and intervene immediately.Review of the resident's nursing progress notes for the month of October 2025, documentation showed:- On 10/11/25 at 7:34 P.M., Resident #1 was seen in the hallway yelling at another resident and threatening to hit him/her with a rag if the other resident didn't stop yelling then knocked the hat off of the other resident's head;- On 10/16/25 at 7:30 P.M., Resident #1 kept trying to get out of the doors and was instructed a number of times not to. The last time Resident #1 attempted to, he/she got close to the nurse's face and said he/she was going to burn the place down with the nurse inside and started laughing as he/she walked away;- On 10/31/25 at 10:08 P.M., Resident #1 was tired and not acting like him/herself and hadn't slept well in a while.Review of the resident's nursing progress notes for the month of November 2025., showed:- On 11/1/25 at 4:13 P.M., Resident #1 was witnessed by staff leaning over Resident #2 holding their hands down on their abdomen while squeezing Resident #2's jaw with his/her other hand. The residents were separated with no injuries noted and frequent monitoring of Resident #1 had been initiated; - On 11/1/25 at 7:46 P.M., Received orders from the provider to send Resident #1 to a local hospital emergency room for evaluation and treatment.- On 11/1/25 at 11:29 P.M., Resident #1 returned from the hospital. Restless and walking up and down the hallways;- On 11/7/25 at 11:54 A.M., Received new orders from psychiatry to start Trazodone (medication used to treat depression) 50 milligrams (mg) twice daily, at noon and at night, changed Seroquel (anti-psychotic medication) from 150mg at night to 50mg twice daily and to discontinue the Thorazine (anti-psychotic medication). - On 11/14/25 at 1:22 P.M., Resident #1 had been up wandering the halls and staff had been continuously redirecting the resident out of other resident's rooms;- On 11/16/25 at 7:47 P.M., Resident #1 was upset that another resident was hollering, had his/her belt in hand and said he/she was going to hit the resident that was hollering. The belt was removed and the resident was redirected;- On 11/18/25 at 12:55 P.M., Nurse was attempting to give the resident medication, and the resident grabbed the medication cup and smashed it in his/her hand; - On 11/18/25 at 7:41 P.M., Resident #1 pushed Resident #3 up against the wall and was in his/her face talking. The two residents were separated and it was explained to Resident #1 that he/she couldn't do that. Resident #1 said he/she did that because all that resident does is complain. Resident #1 was given as needed Ativan 0.5mg, and placed on one on one watch, the Director of Nursing was notified who then notified the resident's family, provider, and the state agency. Orders received to send resident to a local emergency room (ER) to evaluate and treat the resident;- On 11/18/25 at 10:00 P.M., Resident #1 returned from the ER via ambulance with no new orders, all lab work normal, and resident is one on one with staff at this time;- On 11/19/25 at 11:42 A.M., Referral sent to psychiatric hospital was approved for a psychiatric evaluation and stay. Both family and provider made aware;- On 11/19/25 at 11:53 A.M., Resident #1 left with facility for psych evaluation.2. Review of Resident #2's Quarterly MDS, dated [DATE], showed;- Moderate cognitive impairment;- Diagnoses: stroke, dementia, and hemiplegia (severe or complete loss of strength leading to paralysis on one side of the body);- Required substantial assistance from staff for activities of daily living (ADL's) to include showering, toileting, and transfers.Review of the resident's care plan, dated 11/11/25, showed:- The resident was often observed talking to him/herself which can be upsetting to some residents;- Staff were to allow Resident #2 to wander (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as safely as able, monitor frequently, and promptly remove Resident #2 from areas of agitated residents;- The resident was at risk for falls related to confusion and balance problems and staff were to check on the resident frequently.Review of the resident's nursing progress notes for the month of November 2025, showed:- On 11/1/25 at 4:43 P.M., Resident #1 was leaning over Resident #2 holding Resident #2's hands down on his/her abdomen and squeezing Resident #2's jaw. The residents were separated, no injuries identified and the family, hospice and the provider were notified;- On 11/2/25 at 1:20 A.M., Resident #2 did not remember the incident yesterday and was not able to communicate needs.3. Review of Resident #3's Significant Change in Status MDS, dated [DATE], showed:- Severe cognitive impairment;- Diagnoses: traumatic brain injury, dementia, and arthritis;- Required substantial assistance from staff for activities of daily living (ADL's) to include showering, toileting, and transfers.Review of the resident's care plan, dated 11/11/25, showed:- The resident had potential to be physically aggressive, and staff would need intervene before agitation escalates;- Staff would guide the resident away from the source of distress and engage in calming conversation;- Staff would attempt to redirect the resident back to his/her room and if unable to do so, attempt to remove other residents away from him/her.Review of the resident's nursing progress notes for the month of November 2025, showed:- On 11/18/25 at 7:27 P.M., The facility notified the resident's spouse of the resident-to-resident altercation that occurred at 7:00 P.M. - On 11/18/25 at 11:11 P.M., Resident #3 seemed confused about the altercation with Resident #1 earlier in the day.- On 11/19/25 at 12:24 P.M., Resident #3 had been asked if he/she remembered the altercation with Resident #1 and he/she did not remember.During an interview on 11/24/25 at 10:04 A.M., Licensed Practical Nurse (LPN) A said:- He/she hadn't seen Resident #1 hurt anyone before and no one involved had prior issues with one another, but if loud noises happen, Resident #1 can get upset and staff will try to de-escalate and move Resident #1 to another area and remain one on one until Resident #1 calms down;- A resident-to-resident altercation could be abuse and residents had the right to be free from assault.During an interview on 11/24/25 at 10:20 A.M., Certified Medication Technician (CMT) A said:- Resident #1 had pushed Resident #2 back and held Resident #2's throat then both residents had been separated; - Resident #1 had been sent to the ER, but the ER sent Resident #1 right back and the facility continued to perform one on one watch until Resident #1 was sent out to the psychiatric hospital;- He/She had received training on abuse and neglect, de-escalation and redirecting of residents since the incidents.During an interview on 11/24/25 at 10:25 A.M., Certified Nursing Assistant (CNA) A said:- Resident #1 had pushed and grabbed Resident #2;- Resident #2 had one good arm and held Resident #1 back;- Both of the residents had been separated and had one on one watches until Resident #1 was sent out to the ER;- Staff had received training on abuse and neglect, de-escalating and redirecting residents after the incident.During an interview on 11/24/25 at 10:30 A.M., the Director of Nursing (DON) said:- Neither Resident #2 nor Resident #3 had been struck by Resident #1;- Resident #2 had his/her hands held down by Resident #1 and Resident #1 said he/she was going to hit Resident #2 then staff intervened;- Resident #3 had been pushed against a wall by Resident #1 and Resident #1 was being threatening to Resident #3. No marks had been left on the residents and staff had intervened immediately;- Resident #1 had been sent to the ER initially, and after testing and evaluation, Resident #1 was returned to the facility and placed on one-on-one watch;- The facility had sent a referral to the psychiatric hospital and Resident #1 remained one on one until transferred;- Training had been held with all staff on abuse and neglect policies, policy for prevention and for reporting after the incidents.During an interview on 11/24/25 at 10:40 A.M., the Social Services Director said:- Resident to resident incidents could be abuse and the residents definitely had the right to not be assaulted;- Resident #1 was (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	normally sweet but could get overstimulated at times;- He/She believed the facility was looking for placement for Resident #1 after he/she returned from the psychiatric hospital.During an interview on 11/24/25 at 1:25 P.M., the Senior Executive Director and acting Administrator said:- Resident to resident incidents could be considered abuse and residents had the right to not be assaulted or touched by another resident;- Resident #1 was at the psychiatric hospital and the facility was looking for another facility for Resident #1;- If the facility was unable to find placement for Resident #1 and he/she had improved then Resident #1 would be readmitted to this facility. Intakes 2672548, 2658037