STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265621	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Manor Care Center	939 East Birch Chillicothe, MO 64601

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review the facility failed to protect the resident's right to be free from physical abuse when C.N.A. A slapped Resident #1 on the hand with his/her open hand and forced the residents' hands down into his/her lap twice while in the dining room for a meal. This effected one of three sampled residents. The facility census was 25. Review of the facilities Abuse, Neglect, and Exploitation policy, dated 1/31/24, showed:-Abuse means the willful infliction injury, intimidation, or punishment resulting in physical harm, pain or mental anguish, which can include staff to resident abuse;-New employees will be educated on abuse during initial orientation and existing staff will receive annual education through planned in-services and as needed;-Training topics will include: prohibiting and preventing all forms of abuse, understanding behavioral symptoms of residents that may increase the risk of abuse such as aggressive reactions of resident's, resistance to care, outbursts or yelling, and difficulty in adjusting to new routines or staff;-The facility will implement policies and procedures to prevent and prohibit all types of abuse;-Report all alleged violations to the Administrator. Review of CNA A's employee file, dated 1/26/26, showed:-CNA A was hired on 1/26/26;-CNA A did not complete the quiz that was provided after watching the Hand-In-Hand- Module two: What is Abuse video;-CNA A did not complete the quiz that was provided after watching the Hand-In-Hand- Module three: Being with a person with Dementia: Listening and Speaking video;-CNA A did not complete the quiz that was provided after watching the Hand-In-Hand- Module five: Preventing Abuse video;-CNA A did not complete the quiz that was provided after watching the Hand-In-Hand- Module six: Being with a Person with Dementia video. Review of the resident's care plan, dated 2/16/26, showed: -The resident had the potential to be verbally aggressive related to dementia, staff were to analyze triggers and what de-escalated the behavior and anticipate the resident's needs;-The resident had the potential to be physically aggressive hitting/swatting related to dementia, staff were to engage calmly in conversation or walk away calmly if resident became agitated. Review of Resident #1's Comprehensive Minimum Data Set (MDS) a federally required assessment tool completed by facility staff, dated 2/17/26, showed:-The resident was not cognitively intact; -The resident was dependent on staff for carrying out activities of daily living;-The resident used a wheelchair for mobility;-The resident had diagnoses of lack of coordination, generalized muscle weakness, and dementia (a decline in mental ability severe enough to interfere with daily life).Review of the security camera footage provided by the Administrator, dated 4/14/26, showed the resident was sitting at a table in the dining room. CNA A delivered Resident #1's meal tray and the resident reached up and slapped CNA A on the arm. CNA A hit the resident with an open hand on the back of the resident's right hand. Resident #1 then reached up towards CNA A and CNA A grabbed the resident's hand and forcibly shoved his/her hand towards the resident's lap. Resident #1 reached up towards CNA A again, and CNA A grabbed the resident's hand again and forcibly shoved the resident's hand towards the resident's lap. CNA A then threw a bowl of food from the resident's tray onto the table in front of the resident. During an interview on 04/16/2026 at 10:44 A.M. Nurse's Aide (NA) A said:-On 4/14/26 NA A was on the opposite side of the dining room from where Resident #1 was sitting when NA A heard a slapping sound coming from the area Resident #1 was sitting at. NA (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 - Actual harm Residents Affected - Few	A turned around and observed CNA A standing near Resident #1 -NA A did not witness CNA A slap the resident;-NA A had a suspicion that CNA A had hit Resident #1 but was unsure since he/she did not actually witness what had occurred;-The next morning on 4/15/26, NA A overheard some of the dietary staff say that they had heard CNA A say that he/she would defend him/herself if necessary, overhearing this remark made NA A feel like he/she should report his/her suspicion that CNA A hit Resident #1 to the Administrator. During an interview on 04/16/2026 at 11:41 A.M. Registered Nurse (RN) A said:-He/she was working on 4/14/26 at 6:08 P.M. -He/she did not witness CNA A hit Resident #1;-He/she was not notified by NA A or dietary staff that CNA A had hit Resident #1;-He/she would expect staff to notify him/her or the Administrator or Director of Nursing (DON) of any suspicion of abuse immediately. During an interview on 04/16/2026 at 11:46 A.M. CNA B said:-He/she was in the dining room assisting another resident with their meal when he/she had heard two slapping sounds;-He/she did not see CNA A hit Resident #1;-He/she had just assumed the sound was Resident #1 hitting CNA A since Resident #1 did do that occasionally;-He/she should have went to check on Resident #1 when he/she heard the slapping sounds;-He/she had heard CNA A make the comment that CNA A would defend him/herself if necessary multiple times before while working. -CNA B thought that CNA A was joking when saying this and that CNA A liked to joke around often. During an interview on 04/16/2026 at 2:44 P.M. NA B said:-He/she should have reported suspicion of abuse to the charge nurse immediately;-Resident #1 could become agitated and the best way to handle Resident #1 when agitated was to ensure the environment around him/her was calm and determine what could have been triggering him/her and remove that trigger if possible.CNA A did not return a call to the state survey agency as requested. During an interview on 04/16/2026 at 3:28 P.M. the Administrator said CNA A hitting Resident #1 is physical abuse. Residents have the right to be free from abuse. During an interview on 04/16/2026 at 3:46 P.M. the DON said CNA A hitting Resident #1 is physical abuse. Residents have the right to be free from abuse. Review of the facility investigation dated 4/20/26 showed: -On 04/15/2026 at ap 1230, NA A reported an allegation of suspicion of physical abuse to the administrator. NA A reported that during supper on 04/14/26 she overheard a slap sound that made her and another employee turn around and look in the direction of Resident#1s table.-Due to NA As location across the room she did not see what had occurred.-An investigation was immediately initiated and included review of the video surveillance of area at approximately 6:08P.M. -It was confirmed that Resident #1 slapped at CNA A and CNA A slapped Resident #1 on the hand and forcefully subdued her hand twice. -A second employee, CNA B also heard the slap and was witnessed walking by the incident and looking at Resident#1 within seconds of the action. CNA B that she had heard two slaps, did not know if it was the resident slapping at staff (which is a common occurrence with this resident), and walked by to see that everything was ok. CNA B did not see what had occurred. - It was confirmed through review of the video that Resident #1 grimaced, but no confirmation of (physical) injury was found upon assessment. -Resident#1 is nonverbal and not able to provide information.-Based on the findings from the video CNA A was suspended pending notification of termination due to substantiated abuse. -On 4/16/26 the administrator terminated CNA A. Intake 2984683

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow facility policy to notify law enforcement of an allegation of staff to resident physical abuse. This affected one of four sampled residents. The facility census was 25.Review of the facilities Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy, dated 2001, showed:-If resident abuse was suspected the suspicion must be reported immediately to the administrator and to other officials according to state law;-The administrator or the individual making the allegation immediately reports his or her suspicion to law enforcement officials.Review of Resident #1's Comprehensive Minimum Data Set (MDS) a federally required assessment tool completed by facility staff, dated 2/17/26, showed:-The resident was not cognitively intact; -The resident was dependent on staff for carrying out activities of daily living;-The resident used a wheelchair for mobility;-The resident had diagnoses of lack of coordination, generalized muscle weakness, and dementia (a decline in mental ability severe enough to interfere with daily life)Review of the facilities security camera footage of the dining room, dated 4/14/26, showed:-The resident sat at a table in the diningroom;-The CNA A delivered Resident #1 his/her meal tray. The resident reached up and slapped CNA A on the arm, CNA A then hit the resident with an open hand on the back of his/her right hand, Resident #1 reached up towards CNA A again and CNA A then grabbed the resident's hand and forcibly shoved his/her hand towards the resident's lap. Resident #1 reached up towards CNA A again and CNA A again grabbed the resident's hand and forcibly shoved his/her hand towards the resident's lap.-CNA A then threw a bowl of food from the resident's tray onto the table in front of the resident.During an interview on 04/16/2026 at 10:44 A.M. Nurse's Aide (NA) A said:-On 4/14/26 NA A was on the opposite side of the dining room from where Resident #1 was sitting and NA A heard a slapping sound coming from the area where Resident #1 was sitting. When NA A turned around to see what happened, CNA A was standing near Resident #1. -NA A did not witness CNA A slap the resident;-NA A had a suspicion that CNA A had hit Resident #1 but was unsure since he/she did not witness CNA A hit Resident #1;-The next morning on 4/15/26, NA A had overheard some of the dietary staff say that they had heard CNA A say that he/she would defend him/herself from residents if necessary and overhearing this remark, made NA A feel like he/she should report her suspicion that CNA A hit Resident #1 to the Administrator so he/she did.During an interview on 4/13/2026 at 3:28 P.M. the Administrator said she did not notify law enforcement of the situation. She thought she should have notified law enforcement when the allegation of abuse was brought to her attention however, she did not because the facilities [NAME] administrator had told her she did not need to because the resident did not have injury after CNA A hit the resident. Review of the facility investigation dated 4/20/26 showed: -On 04/15/2026 at ap 1230, NA A reported an allegation of suspicion of physical abuse to the administrator. NA A reported that during supper on 04/14/26 she overheard a slap sound that made her and another employee turn around and look in the direction of Resident#1s table.-Due to NA As location across the room she did not see what had occurred.-An investigation was immediately initiated and included review of the video surveillance of area at approximately 6:08P.M. -It was confirmed that Resident #1 slapped at CNA A and CNA A slapped Resident #1 on the hand and forcefully subdued her hand twice. -A second employee, CNA B also heard the slap and was witnessed walking by the incident and looking at Resident#1 within seconds of the action. CNA B that she had heard two slaps, did not know if it was the resident slapping at staff (which is a common occurrence with this resident), and walked by to see that everything was ok. CNA B did not see what had occurred. - It was confirmed through review of the video that Resident #1 grimaced but no confirmation of injury was found upon assessment. -Resident#1 is nonverbal and not able to provide information. -The investigation showed the administrator contacted law enforcement on 4/16 for presence at the facility for the termination notification to CNA A for physical abuse of a resident. Intake 2984683