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	05/01/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one resident (Resident #1) was free from abuse when Resident #1 was pushed onto the floor by Resident #2 which caused two skin tears on Resident #1's left arm after Resident #1 went into Resident #2's room due to confusion. This affected one of four sampled residents. The facility census was 28.Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, showed residents had the right to be free from abuse. This included by was not limited to freedom from corporal punishment, verbal, mental, or physical abuse. The facility would protect residents from abuse by anyone including other residents.Review of the facility policy titled, Resident-to-Resident Altercations, dated 2001, showed facility staff were supposed monitor residents for aggressive/inappropriate behaviors towards other residents. Behaviors that may provoke a reaction by residents to others included wandering into others' rooms/space. 1.Review of Resident #1's Quarterly Minimum Data Set (MDS) a federally required assessment tool completed by facility staff, dated 03/19/26, showed:-The resident was not cognitively intact;-The resident required assistance from staff to perform activities of daily living;-The resident's diagnoses included: Insomnia (a sleep disorder causing difficulty falling asleep or staying asleep), Alzheimer's Disease (an irreversible brain disorder that affects memory and the ability to carry out activities of daily living), and muscle weakness.Review of Resident #1's care plan, dated 03/19/26, showed the resident had impaired cognitive function due to Alzheimer's disease. Review of Resident #1's progress note, dated 04/22/2026, showed the facility staff noticed Resident #1 was not in his/her room and went to look for him/her. When facility staff found Resident #1 he/she had been thrown out of another resident's room which caused a skin tear to the resident's left elbow and left wrist.Review of Resident #2's Comprehensive MDS, dated [DATE], showed:-The resident was not cognitively intact;-The resident was able to perform activities of daily living without assistance from staff;-The resident diagnoses included: Dementia and repeated falls. The resident's #2's care plan, dated 04/30/26, showed:-The resident was independent for meeting emotional, intellectual, physical, and social needs;-The resident had the potential for impaired cognitive function or impaired thought process related to dementia;-The resident had a potential psychosocial wellbeing problem related to social isolation.Review of Resident #2's progress note, dated 4/22/26, showed resident #2 was interviewed by the Administrator. Resident #2 told the Administrator that a big ole son of a bitch came into my room and turned on all the lights and shut my door. That's all I'm saying. Review of the facility investigation, dated 04/28/26, showed:-Review of video surveillance showed that Resident #1 fell out of Resident #2's room;-Resident #1 acquired two small skin abrasions from making contact with the floor when he/she fell;-Resident #2 was interview able and had said that someone had come into his/her room, turned the lights off and shut the door;-Resident #2 told Resident #1 to get out and Resident #1 did not move so Resident #2 pushed Resident #1 out of his/her room. Observation on 05/01/26 at 11:47 A.M., showed resident #1 had a quarter sized skin tear on his/her left elbow that was scabbed over and a dime sized skin tear to his/her left wrist that was scabbed over. During an interview on 05/01/26 at (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	10:58 A.M., Resident #1's responsible party said the resident gets confused sometimes, which was probably why he/she went into the wrong room. He/She wished that the facility had more staff to keep a closer eye on all the resident's, especially the resident's that have memory problems. During an Interview on 05/01/26 at 11:23 A.M., the Administrator said:-She watched the camera footage and it showed Resident #1 going into Resident #2's room, then showed Resident #2 pushed Resident #1 out of his/her room, Resident #1 fell on his/her side and obtained two skin tears to his/her arm;-Resident #2 was woken up from his/her sleep by Resident #1 going into his/her room and was startled by someone being in his/her room;-She did not believe that Resident #2 intended to hurt Resident #1. During an interview on 05/01/26 at 11:09 A.M., Resident #2 said:-Some big son of a bitch came into my room early in the morning and woke me up;-Resident #2 told Resident #1 to get out of his/her room three times and Resident #1 did not move so Resident #2 pushed Resident #1 out of his/her room and Resident #1 fell down on the floor;During an interview on 05/01/26 at 1:09 P.M., Certified Nursing Assistant (CNA) A said:-He/She noticed that Resident #1 was not in his/her room around 5:00 A.M. on 04/22/26 and he/she went to looking for the resident when another resident had asked CNA A assist him/her;-While CNA A was assisting another resident he/she heard another room door open;-He/She stepped out of the other resident's room and saw Resident #1 on the floor outside of Resident #2's room;-He/She got Registered Nurse (RN) A to assess the resident for any injuries. During an interview on 05/01/26 at 1:57 P.M., RN A said:-He/She did not witness Resident #2 push Resident #1 onto the floor, he/she was notified by CNA A;-Resident #1 had two skin tears to his/her arm;-Resident #1 abused Resident #2 when he/she pushed Resident #1 to the floor. During an interview on 05/01/26 at 3:25 P.M., the Director of Nursing (DON) said:-She had spoken with Resident #2 who said that he/she understood he/she couldn't physically push another resident out of his/her room;-Resident #2 pushing Resident #1 onto the floor was considered abuse. During a follow up interview on 05/01/26 at 4:08 P.M., the Administrator said:-She did not believe that Resident #2 pushing Resident #1 onto the floor was abuse since Resident #2 did not intend to harm Resident #1, Resident #2 just wanted Resident #1 out of his/her room;-Abuse was if a resident intended to deliberately harm another resident. Intake 2990685.