STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265813	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morningside Center	1700 Morningside Drive 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 protect one resident's (Resident #2) right to be free from physical abuse when Resident #1 slapped Resident #2 on the cheek. The facility census was 52. Review of the facility's Abuse and Neglect Policy undated., showed:- The purpose is to ensure that the residents of Morningside Center are protected from any mistreatment, neglect or all types of abuse;- Alleged violation is defined as a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse;- Abusers may include facility staff, other residents;- Abuse is defined as any verbal, mental, sexual, physical mistreatment of a resident whether or not an actual injury occurs;- Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish;- The facility will identify, correct, and intervene in situations where abuse is more likely to occur.Review of the facility's Resident Rights policy, undated., showed:- Residents have a right to be free from abuse and restraint;- You shall not be subjected to physical, sexual, or emotional injury or harm. The Administrator was notified on 1/14/2026 of the past noncompliance which began on 12/21/2025. The facility administration immediately separated and protected the resident from further abuse by Resident #1. Residents #1 and #2 were assessed and resident representatives and physicians were notified. All staff were In-serviced on how to have a positive impact and redirect residents with wandering and behaviors including physical, emotional, and verbal abuse by 12/23/25. Each resident's plan of care was updated by 12/24/25. The noncompliance was corrected on 12/24/2025. Review of Resident #1's Annual MDS (Minimum Data Set), a federally mandated assessment tool completed by facility staff, dated 12/23/25., showed:- Cognition not intact;- He/she was dependent on nursing staff for showers, toileting, and transfers;- Diagnoses urinary tract infection, diabetes, and respiratory failure.Review of the resident's care plan, dated 1/9/26, showed:- The resident could be a threat to others and at times become physically and verbally aggressive had been added to the care plan on 12/24/25, after the incident;- The resident was to be moved to a quiet and calm place had been added to the care plan on 12/24/25, after the incident;- The resident had impaired cognition and safety awareness, and staff had been required to calm the resident if signs of distress developed.Review of the resident's nursing progress notes for the month of December 2025 showed:- On 12/17/25 at 11:01 P.M., Resident #1 refusing care while hitting, kicking and cursing at staff;- On 12/18/25 at 2:04 A.M., Resident #1 refusing cares and incontinence checks/changes at this time. Yelling get out of my house while swinging at staff;- On 12/20/25 at 3:25 A.M., Resident #1 yelling at staff and swinging at them when they get close to him/her;- On 12/21/25 at 6:02 P.M., Resident #1 sitting in common area, in wheelchair, when another resident approached him/her, began touching him/her, the resident became angry and slapped Resident #2 across the face. (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	Review of Resident #2's Quarterly MDS, dated [DATE], showed;- Cognition was not intact;- The Resident required moderate assistance with Activities of Daily Living (ADL's) to include showering, toileting, and transfers;- Diagnoses included: dementia, bipolar disorder, insomnia.Review of the resident's care plan, dated 1/9/26, showed:- The staff were required to do regular one on ones with the resident;- The resident had socially inappropriate/disruptive behavioral symptoms as evidenced by removing clothing in common areas;- The resident has impaired decision making and disorganized thinking related diagnosis of dementia.Review of the resident's nursing progress notes for the month of December 2025, showed:- On 12/21/25 at 6:05 P.M., the residents had been witnessed next to one another by the television in the hallway. The resident was picking on another resident's chair and clothes. Resident #1 said go away and before the staff member and resident #2 could go, Resident #1 slapped Resident #2 across the left side of their face.- On 12/21/25 at 8:25 A.M.; The Director of Nursing (DON) documented the resident had no obvious signs of distress or pain and was at the beauty shop that day smiling and talking.Review of the facility's self-report, dated 12/22/25., showed:- Resident #2 had been picking at Resident #1's clothing and wheelchair;- Resident #1 had yelled get away and Licensed Practical Nurse (LPN) A had been nearby, heard the raised voice, but did not arrive in time to separate the residents;- Resident #1 slapped Resident #2 in the face area and grabbed Resident #2's face;- Upon examination, Resident #2's face was red and he/she could not communicate pain but did not appear to be in great distress;- The residents were separated and the Administrator, DON, and family member had been notified;- Staff had been educated to be aware of Resident #2's wandering, educated about Resident #1's aggressive behavior, and the facility began to look into a stay at a psychiatric hospital for Resident #1.During an interview on 1/14/26 at 8:24 A.M., Resident #1 said:- He/she had got mad; it was his/her fault;- He/She was just trying to get Resident #2 to leave him/her alone. Trying to get Resident #2 away from others. During an interview on 1/14/26 at 8:35 A.M., Housekeeper A said: - He/She had training regarding resident-to-resident incidents, and he/she might try to intervene but would definitely get help;- He/she believed a resident should be free from abuse or assault.During an interview on 1/14/26 at 9:00 A.M., LPN A said:- He/she had observed the residents by the nurses station;- Resident #2 was picking and touching at Resident #1s clothes and wheelchair;- Resident #2's right hand went up, and before LPN A could do anything, contacted Resident #1's left cheek;- Both residents were assessed and separated then notifications made to the family, the physician, and the Administrator;- Resident #2 wanted Resident #1 out of his/her space, to leave him/her alone.During an interview on 1/14/26 at 10:10 A.M., Registered Nurse (RN) A said:- All of the staff keep track of Resident #2 who liked to wander. Resident #1 is immobile and can't get around and get to other residents;- A resident should definitely be free from abuse or assault.During an interview on 1/14/26 at 11:33 A.M., the Assistant Administrator said:- Resident #1 didn't have care planned interventions for aggressive behaviors towards others at the time of the incident because Resident #1 was kind of new and the facility was not aware of the Resident's history;- He/she acknowledged the resident had been aggressive many times towards staff and no interventions had been care planned prior to the incident;- During one of Resident #1's hospital visits, the hospital had decreased some of the resident's medications and that may have caused some aggression;- Going forward Resident #1 had been monitored more often and had undergone another hospitalization;- The staff from Resident #1's previous nursing home had said there had been no behaviors;- The staff were monitoring Resident #2 more often and were trying to develop an activity program including making rummage boxes, playing more music, and dancing;- Resident #2 had a red area for a bit, but no bruising afterwards;- Residents have the right to not be assaulted or abused;- The staff abuse/neglect training had been in November. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Intake 2699220