STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265266	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Neosho	400 Lyon Drive Neosho, MO 64850

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 - 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 observation, interview, and record review, the facility failed to protect the resident's right to be free from sexual abuse by other residents when one resident (Resident #1) exhibited abusive behaviors including touching breasts of one resident (Resident #2) after the facility placed the resident (Resident #1) on one-on-one with a staff The facility census was 54.Review of the facility's policy titled Abuse, Neglect and Exploitation, revised 10/2022, showed the following:-The resident has the right to be free from verbal, sexual, physical and mental abuse and involuntary seclusion. It is the policy of Medicalodges, Inc., to treat each resident with respect, kindness, dignity and care, to keep them free from abuse and neglect and to take swift and immediate action to investigate and adjudicate alleged resident abuse and neglect;-Abuse is the willful infliction of injury; the unreasonable confinement, neglect, intimidation or punishment resulting physical harm, pain or mental anguish or deprivation by an individual (including a caretaker) of goods or services necessary to attain or maintain physical, mental and psychosocial well-being;-Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault;-The facility shall ensure sufficient staffing on all shifts to meet the needs of the residents;-All staff assigned shall be knowledgeable of the individual care needs of the residents to whom they are assigned;-The facility will identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur;-Resident care plans shall include problems observed and/or a history of previous problems such as signs of self-injurious behavior, wandering into other resident rooms, communication disorders, etc. which might result in aggressive behavior, agitation and/or conflict. Interventions shall be part of the care plan, and all staff shall be knowledgeable and have ready access to this information. 1. Review of Resident #1's face sheet (a document that gives a patient's information at a quick glance) showed the following:-admission date of 09/27/24;-Diagnoses included anoxic (lack of oxygen) brain damage, paraphilia (unusual sexual desires, typically involving extreme or dangerous activities), and sexual dysfunction. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 04/07/26, showed the following:-Moderate cognitive impairment;-Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) occurred four to six days but less than daily;-The resident was independent with activities of daily living (ADL - dressing, eating, bathing, etc.) with the exception of set-up assistance from staff to shower. Review of the resident's care plan, revised 04/27/26, showed the following:-He/she had occasional behaviors;-He/she had behaviors of sexual nature such as exposing his/her genitals;-He/she touched hands of residents of the opposite gender;-Monitor his/her behaviors and redirect his/her as needed. He/she needed reminders regarding appropriate group behaviors at times;-Please encourage him/her to participate in activities of his/her choice;-He/she had a deficit in cognitive functioning characterized by deficit in memory, judgement, decision making and thought process related to cognitive changes;-Administer his/her medication as (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 - Few	ordered;-Please report to his/her nurse and/or physician of any noted changes in his/her behavior or cognitive status. 2. Review of Resident #2's face sheet showed the following:-admission date of 12/12/22;-Diagnoses included dementia and high blood pressure. Review of the resident's quarterly MDS, dated [DATE], showed the following:-Severe cognitive impairment;-Wandered four to six days but less than daily;-Independent for eating and putting on and taking off footwear, required supervision of staff for oral hygiene and maximum assistance of staff for toilet hygiene, bathing, upper and lower body dressing and personal hygiene. Review of the resident's care plan, revised 10/06/25, showed the following:-Resident had increased behaviors;-At times, the resident may wander into other rooms and bring items in or out of other rooms. Due to this, at times my items may get misplaced. Please help to monitor this and assist him/her as needed with locating items;-Encourage him/her to participate in activities of his/her choice;-Resident had a stop sign on his/her door to keep other residents from entering his/her room and taking his/her personal items. Please ensure that it is up;-Resident had a deficit in cognitive functioning affecting his/her speech, memory and complex decision making related to dementia;-Cognitive loss that affected his/her memory;-Please observe and report any changes in his/her cognitive status. 3. Review of the facility's investigation, dated 04/24/26, showed the facility placed Resident #1 on one-on-one on 04/24/26 and placed an alert to continue one-on-ones with the resident. Review of the facility's investigation, received 04/28/26, showed the following:-Resident #1 went up to Resident #2 and grabbed his/her breast;-Resident #1 was one-on-one at the time, however Certified Medication Technician (CMT) B did not personally intervene;-CMT B summoned the Certified Nursing Assistant (CNA) A, however Resident #1 grabbed Resident #2's breast before the CNA could intervene;-Action plan initiated and notification to residents chart to continue one-on-one until Resident #1 went out to the hospital;-The allegation was verified by evidence collected during the investigation based on the witness statement from the occurrence. Resident #1 was one-on-one with staff due to seeking out sexual attention and staff failed to intervene and redirect Resident #1 prior to him/her grabbing Resident #2's breast. Review of the Resident #1's risk assessment dated [DATE], at 3:20 P.M. showed the following:-CNA came to this nurses' office to report an incident where the resident touched another resident's breast in the dining room;-The CNA was alerted by med tech that the resident stopped and stood by the other resident, after getting a cup of coffee;-CNA entered the dining room to redirect him/her away from the other resident and the resident reached out and touched the other resident's right breast before she could stop him/her;-The resident remained on 1:1 observation and taken to his room by CNA. 4. During an interview on 04/29/26, at 1:14 P.M., CNA C said the following:-The facility implemented interventions of increased monitoring and redirection with the Resident #1;-He/she believed the resident was placed one-on-one after an incident on 04/21/26 but Administrator had not assigned a specific staff member to the resident;-Resident #1's behaviors had gradually gotten worse since he/she started in 09/2025. The administration told the CNAs to keep the resident separated from the residents of the opposite gender;-He/she believed Resident #1 had behaviors daily;-The CNAs charted the resident's behaviors in their chart;-If he/she witnessed resident to resident abuse, he/she separated the residents and then immediately reported to the Director of Nursing (DON), Assistant Director of Nursing (ADON), or charge nurse;-If a resident was placed one-on-one, the resident should have a staff member with them at all times and the staff should only be assigned that duty;-If a resident touched another resident's breast, he/she considered that sexual abuse. During interviews on 04/29/26, at 9:50 A.M. and 1:23 P.M., CNA D said the following:-He/she was not told Resident #1 was one-on-one. He/she was told to keep a close eye on the resident due to sexual behaviors of the resident. Resident #1 exposed self and touched chest and private areas of other residents;-The resident was on medication due to his/her behaviors;-The resident's behaviors were better until this last week when something suddenly changed with the resident;-Interventions for the resident's behaviors included redirection, increased monitoring, and medication;-He/she did not know Resident #1 was placed one-on-one;-If Administration did not assign (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a specific staff member to Resident #1;-If he/she witnessed resident to resident abuse, he/she separated the residents and immediately reported to the DON or charge nurse;-If a resident was one-on-one, Administration should assign a staff member specifically to stay with that resident;-The facility did not always staff two CNAs on the locked unit, but if he/she was the only staff member, he/she asked for assistance if he/she needed it. During an interview on 04/29/26, at 12:29 P.M., CNA A said the following:-On 04/25/26, at approximately 4:00 P.M., Resident #1 was in his/her bed, and the CNA was beside the resident's room watching the resident;-The resident got up and walked to the dining room to get a cup of coffee;-When the resident walked into the dining room, the CNA could not see the resident because there was a wall between where the CNA was positioned and the resident was in the dining room;-CMT B passed medications in the dining room and told the CNA to go check on the resident because the resident was close to Resident #2;-When the CNA entered the dining room, he/she saw Resident #1 touch Resident #2's breast;-He/she removed Resident #1 from the dining room away from Resident #2;-The locked unit had two staff assigned to the hall that day;-He/she was not assigned to be one-on-one with Resident #1 that day and still had other duties with other residents to perform;-The resident was placed one-on-one on 04/24/26, but Administration did not specifically assign a specific staff member to watch the resident on 04/25/26;-Interventions for the resident's behaviors included giving the resident a snack or activity, redirect and separated from other residents and the resident received medications from his/her sexual behaviors;-The resident knew what he/she was doing and when staff watched him/her;-If he/she witnessed resident to resident abuse, he/she separated the residents and reported to the charge nurse immediately;-If Administration placed a resident one-on-one, staff should stay with the resident everywhere the resident went and should only be assigned to that resident;-Administration did not assign specific staff when a resident was placed one-on-one to his/her knowledge. During an interview on 04/29/26, at 1:30 P.M., Licensed Practical Nurse (LPN) F said the following:-On 04/25/26, CNA A reported to the MDS Coordinator that Resident #1 got up to get coffee and touched Resident #2's breast;-Administration placed Resident #1 on 15-minute checks and then placed the resident one-on-one, but the LPN did not know when this happened;-Staff separated Resident #1 from Resident #2, notified the residents' responsible parties, physician and the police department;-The physician sent Resident #1 out for psychiatric evaluation;-He/she considered Resident #1 touching Resident #2's breast sexual abuse;-Interventions for the resident's behaviors included staff closely watching the resident and redirecting the resident away from residents of the opposite gender and medication;-If Administration placed the resident one-on-one, they should assign a specific staff member to the resident;-If a CNA or CMT witnessed resident to resident abuse, they separated the residents and reported it to the charge nurse immediately. During an interview on 04/29/26, at 2:08 P.M., CMT B said the following:-On 04/25/26, he/she passed medications in the dining room of the locked unit. When he/she did this he/she had to watch closely while they took their medications;-He/she saw Resident #1 stand by Resident #2 and told CNA A and the CNA responded;-He/she did not respond to the residents because he/she did not see any touching;-CNA A notified the MDS Coordinator immediately;-He/she was not given any direction related to Resident #1 being one-on-one, and administration did not assign a specific staff member to the resident that day to his/her knowledge;-He/she did not know the resident was one-on-one on 04/25/26;-If he/she witnessed resident to resident abuse, he/she separated the residents and reported it to the charge nurse immediately. During an interview on 04/29/26, at 2:24 P.M., CNA G said the following:-He/she worked the locked unit on 04/25/26;-He/she knew staff were to watch Resident #1 closely but did not know the resident was one-on-one;-Administration did not specifically assign a staff member in the locked unit one-on-one with the resident on 04/25/26;-Interventions for the resident's behaviors included redirection and give the resident an activity;-He/she considered Resident #1 touching Resident #2's breast sexual abuse'-If he/she witnessed resident to resident abuse, he/she separated the residents then reported to the charge nurse immediately. During an interview on 04/29/26, at 3:42 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P.M., LPN H said the following:-If a CNA or CMT witnessed resident to resident abuse, they separated and protected the residents and then reported to the charge nurse immediately;-The charge nurse reported to the DON immediately, assessed the residents and notified the residents' responsible parties and physician;-If a resident was one-on-one, a specific staff member was assigned to always keep eyes on that resident. During an interview on 04/29/26, at 2:37 P.M., the MDS Coordinator said the following:-Interventions for Resident #1 behaviors included increased monitoring, medication and offering the resident activities;-On 04/25/26, Resident #1 stood by Resident #2 and CNA A saw Resident #1 grab Resident #2's breast;-CNA A reported the incident to him/her;-Resident #1 was on one-on-one supervision at the time;-CNA A was assigned to be the one-on-one staff member with the resident;-He/she knew the resident was one-on-one because the Administrator informed him/her;-On 04/25/26, two staff were assigned during the day to the locked unit;-The resident was placed one-on-one on 04/24/26;-The night of 04/24/26, only one staff was assigned to the locked unit and that overnight CNA was to call for assistance if they needed a break or to assist another resident;-The Administrator said the resident was one-on-one during waking hours;-During the overnight hours from 04/24/26 to 04/25/26 no staff member was assigned one-on-one with the resident;-If a CNA or CMT witnessed resident to resident abuse, they should separate the residents and report to their charge nurse immediately;-If a resident was one-on-one, a specific staff member was assigned to that resident and that staff member always kept eyes on the resident within close vicinity of the resident;-He/she did not know who was responsible for assigning a staff member to one-on-one duties;-The staff member assigned to the resident filled out a form every 15 minutes related to where the resident was and what the resident was doing. During an interview on 04/29/26, at 4:13 P.M., the ADON said the following:-Interventions for Resident #1's behaviors included education, increased monitoring and medication;-The Administrator placed the Resident #1 one-on-one on 04/24/26 during waking hours;-He/she understood CNA A knew Resident #1 was one-on-one and that the CNA was assigned to the resident;-The Administrator said CNA A sat outside the resident's door and CMT B witnessed the incident between Resident #1 and Resident #2;-He/she did not know if Resident #1 had a specific staff member assigned to the resident on 04/25/26;He/she considered Resident #1 grabbing Resident #2's breast sexual abuse that was preventable;-If a resident was one-on-one, the charge nurse assigned a specific staff member to that resident;-The charge nurses knew who was one-on-one through report from the administrative staff;-The administrative team was responsible for ensuring the charge nurses knew to assign a specific staff member to a resident that was one-on-one and the charge nurse was responsible for ensuring staff followed through with their one-on-one duties. During an interview on 04/29/26, at 4:49 P.M., the Administrator said the following:-Interventions for the resident's behaviors included redirection, increased monitoring and medication;-The physician increased the resident's medication dose on 04/24/26 with the residents first increased dose given on 04/25/26;-He/she placed the resident one-on-one on 04/24/26 for the waking hours because the resident typically slept through the night;-He/she informed night staff to request assistance to sit with the resident if they needed a break or to assist with another resident as could not guarantee the resident would sleep all night;-On 04/25/26, CNA A was assigned one-on-one with the resident;-CNA A should have followed the resident into the dining room;-If a resident was one-on-one, the nursing administration team assigned a specific staff member to always stay with them;-The staff knew what residents were one-on-one by an alert that was placed in the electronic documentation system for CNAs to see and staff were notified by the nursing administration team. Complaint #2994354