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	04/24/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement a complete abuse and neglect program that completed all screenings when staff failed to complete a Nurse Aide (NA) Registry (a registry which shows if someone has a Federal Indicator (indicates individuals who had a previous incident involving abuse, neglect, or misappropriation of property that would prevent the employee from working in a certified long-term care facility) for one (Registered Nurse (RN) H) of four sampled employees . The facility census was 55. Record review of the facility's Abuse, Neglect and Exploitation Policy, revised October 2022, showed the following:-The resident has the right to be free from verbal, sexual, physical and mental abuse and involuntary seclusion;-The appropriate certification and/or licensing agencies will be contacted for the current status of the employee's license or certification for employment. The person making the call will document registry verification, and the written response will be maintained in the employee's personnel file/verification of work eligibility notebook. 1. Record review of RN H's personnel record showed the following:-Hire/Start date of 12/23/25;-The facility did not document completion of NA registry check for the RN prior to or upon hire. During interviews on 04/24/26, at 11:25 A.M., 1:00 P.M., and 1:15 P.M., the Business Office Manager (BOM) said the following:-She ran the NA Registry check on all staff except for the RNs and the licensed practical nurses (LPN).-Corporate ran all the checks on all licensed nurses;-She talked with her corporate office, and they do not run the NA registry checks on any nurses. During an interview on 04/24/2,6 at 4:17 P.M., the Administrator said she did not know the facility should check the NA registry on all staff to include the nurses, before they start work.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain a complete infection control program when staff failed to use Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs - microorganism that has developed resistance to one or more classes of antibiotics, making infections caused by it more difficult to treat) in nursing homes) during wound care for two residents (Residents #29 and #48). The facility census was 55.Review of Centers for Disease Control and Prevention' (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of MDROs, dated 04/02/24, showed the following:-MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs;-EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities;-EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO;-Examples of high-contact resident care activities requiring gown and glove use for EBP include dressing, bathing/showering, transferring, providing hygiene, changing linens,changing briefs or assisting with toileting, device care or use of central line (a long, flexible tube inserted into a large vein in the chest, neck, or arm, with the tip ending close to the heart), urinary catheter (a thin, flexible, indwelling urinary tube inserted through the urethra into the bladder to drain urine continuously), feeding tube (a medical device used to deliver liquid food, fluids, and medications directly to the stomach or small intestine), tracheostomy (a surgical procedure that creates an opening, called a stoma, through the neck directly into the windpipe (trachea) /ventilator (a medical machine that helps a patient breathe or fully breathes for them)and wound care of any skin opening requiring a dressing. Review of the facility policy titled, Infection Management Process, revised 11/2023, showed the following:-CDC will be the resource for implementation of appropriate isolation procedures and immunization schedule;-EBP applies to all residents with wounds, indwelling devices regardless of MDRO colonization status. 1.Review of Resident #29 face sheet (a form that provides resident details) showed the following:-admission date 03/10/26;-Diagnoses included pressure ulcer of left heel stage 3 (a serious, full-thickness wound extending through the skin into the subcutaneous fat layer). Review of the residents' quarterly Minimum Data Set (MDS-federally mandated assessment tool administered by staff), dated 04/15/26, showed the resident had sever cognitive impairment. Review of the resident's care plan, revised 03/11/26, showed the following:-Stage 3 pressure ulcer to left heel;-Treatment in place;-Float heels while in bed.(Staff did not care plan related to EBP.) Observation on 04/22/26, at 2:01 P.M., showed the following:-Resident lying in bed with no EBP sign or supplies in room;-LPN A entered the resident's room, washed hands, donned gloves, and created a clean area for supplies. The LPN did not don gown;-LPN A completed wound care without donning gown;-LPN A Washed hands and exited room. 2. Review of Resident #49's face sheet showed the following information:-admission date of 10/01/25-Diagnoses include diabetic foot ulcer (wound primarily caused by complications of diabetes). Review of the residents' quarterly MDS, dated [DATE], showed the following:-No cognitive impairment related to daily living decision making;-At risk for developing pressure ulcers. Review of the resident's care plan, revised 03/11/26, showed the following:-Required staff assistance with all activities of daily living;-Diabetic ulcer to the right heel;-Current wound treatment in place.(Staff did not care plan related to EBP.) Observation on 04/22/26, at 2:45 P.M., showed the following:-No EBP signage or supplies in room;-LPN A entered room, washed hands, donned gloves, and created a clean area for supplies. LPN A did not don gown;-LPN A completed wound care without donning gown.-LPN A washed hands and exited room. 3. During an interview on 04/23/26. at 10:15 A.M., the Infection (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Preventionist said the following:-EBP is to protect vulnerable residents from staff members;-He/she thought EBP only applied to residents with current MDRO infections;-Signs should be posted on the doors of residents on EBP to alert staff. During an interview on 04/23/26, at 1:25 P.M., LPN A said the following:-EBP precautions apply to all residents with wounds;-Residents on EBP should have a sign on the door alerting staff. During an interview on 04/24/26, at 11:30 A.M., the Assistant Director of Nursing (ADON) said the following:-All residents on EBP precautions should have a sign on their door alerting staff;-EBP includes gowns and gloves and applies to all residents with wounds;-He/she expected all staff to follow EBP precautions when completing wound care. During an interview on 04/24/26, at 3:25 P.M., the Director of Nursing (DON) said the following:-He/she believed EBP only applied to residents with MDRO infections;-Facility policy was EBP applies to all residents with wounds. During an interview on 04/24/26, at 4:17 P.M., the Administrator said the following:-EBP included all wounds;-He/she expected staff to follow facility EBP policy.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure they maintained a medication administer error rate of less than 5% when staff failed to administer the correct medication to one resident (Resident #4) and failed to administer a medication to one resident (Residents #18), resulting in 2 errors out of 28 opportunities (a medication error rate of 7.1%). The facility census was 55.Review of the facility policy Medication Error Reporting and Adverse Drug Reaction Prevention, dated 01/23, showed the following:-The facility utilizes a system to assure that medication usage is evaluated on an ongoing basis;-Medication error shall be defined as any preventable event that may cause or lead to inappropriate medication use. 1.Review of Resident #18 face sheet showed the following information:-admission date of 03/26/26-Diagnoses included Parkinsons (a neurological disease), dementia (a progressive neurological disease), and hypertension (high blood pressure). Review of the residents' comprehensive Minimum Data Set (MDS-federally mandated assessment tool administered by staff), dated 03/26/26, showed the resident was cognitively intact Review of the resident's care plan, revised 04/14/26, showed the following:-Required staff assistance with activities of daily living due to physical impairments;-He/she required nursing observation for side effects of Plavix (a medication used to help prevent blood clots) such as bleeding or bruising. Review of the resident's April 2026 Physician Orders (POS) showed an active order for Plavix 75 milligrams (mg) once a day. Observation of medication pass on 04/23/26, at 10:00 A.M., showed Registered Nurse (G) did not administer the resident's Plavix. 2. Review of Resident #4 face sheet showed the following information:-admission date of 06/21/24;-Diagnoses include hypertension (high blood pressure), hyperlipidemia (high lipid values), and chronic kidney disease (CKD - the long-term, gradual loss of kidney function, preventing them from properly filtering blood and waste). Review of the residents' quarterly MDS, dated [DATE], showed the resident was cognitively intact. Review of the resident's care plan, revised 02/24/26, showed the following:-Requires staff assistance for activities of daily living due to physical limitations;-Takes medications to manage chronic pain;-Resident at risk for side effects due to taking multiple medications; Review of the resident's April 2025 POS showed an active order for ferrous gluconate (iron) 324 mg one time a day. Observation of medication pass on 04/23/26, at 10:15 A.M., showed RN G gave the resident ferrous sulfate 325 mg instead of ferrous gluconate 324 mg. 3. During an interview on 04/23/26, at 1:25 P.M., Licensed Practical Nurse (LPN) A said the following:-Giving the wrong medication would be a med error;-Staff should follow the three rights to ensure they are giving the proper medication. During an interview on 04/23/26, at 1:45 P.M., the MDS Coordinator said the following:-Staff should ensure the right medication, right person, right time, right dose, and verify resident with picture on the electronic medication administration record (eMAR) to help prevent medication errors;-Errors should be reported to the Director of Nursing (DON) right away. During an interview on 04/24/26, at 11:30 A.M., the Assistant Director of Nursing (ADON) said the following:-A medication error can be the wrong dose, wrong drug, wrong time, or medication not given;-He/she expected staff to be careful to help prevent medication errors;-He/she expected staff to administer medications without errors. During an interview on 04/24/26, at 3:25 P.M., the DON said the following:-He/she would consider it a medication error if a medication were not given, missed, wrong medication given, wrong time, or wrong dose;-He/she expected staff to follow the 5 rights to help prevent medication errors. During an interview on 04/24/26, at 4:17 P.M., the Administrator said the following:-Giving the wrong medication would be a medication error;-He/she expected staff members to follow the 5 rights of medication administration to help prevent medication errors.on to help prevent medication errors.