STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265456	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abode Health and Wellness Center	17451 Medical Center Parkway Independence, MO 64057

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 interview and record review, the facility failed to prevent psychosocial abuse for two sampled residents (Residents #2 and #3) out of 12 sampled residents. On 4/15/16 Resident #1 was rubbing his/her hands on Resident #2's arm, shoulder and knee. On 5/5/26 Resident #1 touched Resident 2 on the breast and inner thigh. On 5/11/26 Resident #1 kissed Resident #3, resulting in Resident #3 crying. The facility census was 63 residents.Review of the facility's Abuse Prevention policy, dated 7/1/25, showed:-Abuse is willful infliction of injury, confinement, intimidation, or punishment with resulting physical harm, pain, mental anguish, or emotional distress and may be resident to resident, staff to resident, family to resident, or visitor to resident.-Sexual abuse is any touching of a resident directly or through clothing for sexual purpose or in a sexual manner, including but not limited to kissing, touching of genitals, buttocks, or breasts, or causing a resident to touch someone for sexual purposes.-Mental abuse was the use of verbal or non-verbal conduct which causes or has the potential to cause the resident to experience humiliation, fear, shame, agitation, or degradation. 1. Review of Resident #1's admission Record showed the resident was admitted to the facility on [DATE] with the following diagnoses:-Major depressive disorder (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living).-Anxiety disorder (a psychiatric disorder causing feelings of persistent anxiety).-Mild cognitive impairment (a stage of memory and thinking decline that is more pronounced than normal aging but not severe enough to disrupt daily life). Review of Resident #1's Pre-admission Screening and Resident Review, Level I (PASRR - Level I, a preliminary identification process used to determine if an individual has or is suspected of having a qualifying mental illness or intellectual/developmental disability (ID/DD). If the screening is negative the process is complete. If positive it flags for a Level II, an in-depth evaluation by the state's mental health or ID/DD authority to determine if nursing care and/or specialized services are needed.), dated 7/29/20, showed the resident had no diagnosis or signs or symptoms of a serious mental disorder, ID/DD, and had not required intensive psychiatric treatment within the past two years. Review of Resident #1's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 4/15/26, showed the resident was severely cognitively impaired (a significant deterioration in mental capacity, such as short or long-term memory loss and impaired reasoning that prevents an individual from living independently). Review of Resident #2's admission Record showed the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a slowly progressive disease of the brain that is characterized by impairment of memory and eventually by disturbances in reasoning, planning, language, and perception). Review of Resident #2's annual MDS, dated [DATE], showed he/she was severely cognitively impaired.Review of Resident #1's nursing Behavior note, dated 4/15/26 at 6:12 P.M. showed:-At supper time Resident #1 was rubbing his/her hands on a resident (Resident #2 according to interviews) from the A unit. -The resident was asked to stop and staff removed Resident #2 from the situation.-Resident #1 then started cussing at staff and Resident #6 stepped up to intervene. -Then Resident #1 started cussing (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	at Resident #6 and flipped him/her off. During an interview on 5/13/26 at 10:20 A.M., Licensed Practical Nurse (LPN) A said:-Certified Nursing Assistant (CNA) A reported to him/her that Resident #1 was touching Resident #2 on the arm, shoulder and knee in the dining room on 4/15/26. -When CNA A told Resident #1 to leave Resident #2 alone the resident started cussing at CNA A. Resident #6 got in the middle of it and told Resident #1 to leave CNA A alone. -Resident #1 then started cussing at Resident #6 and flipped him/her off. -He/She thought the incident happened around supper time at Resident #1's table.-He/She wrote a behavioral note on 4/15/26 and slid a note under the Assistant Director of Nursing (ADON) and Director of Nursing (DON)'s office door. -He/She was told by management there had been a past incident between Resident #1 and #2 and that Resident #1 wasn't supposed to be around Resident #2. -In a monthly meeting they talked about reportable incidents, but he/she couldn't recall if it was before or after the 4/15/26 incident. Review of Resident #6's quarterly MDS dated [DATE] showed he/she was cognitively intact. During an interview on 5/13/26 at 1:21 P.M., Resident #6 said:-About a month ago Resident #2 came over to the table where he/she and Resident #1 were sitting. -He/She saw Resident #1 touch Resident #2's breast(s). -Staff told Resident #1 to stop, but he/she couldn't say who the staff was.-Resident #1 yelled to the staff he/she wasn't bothering Resident #2 and had some loud, aggressive words to say to the staff.-He/She told Resident #1 to get away from Resident #2 and Resident #1 yelled he/she wasn't doing anything and told Resident #6 to shut up. -Staff told Resident #2 to get to his/her own table. During an interview on 5/13/26 at 1:35 P.M., Resident #2 said about a month ago Resident #1 touched him/her on the shoulder and might have touched him/her on the knee, but he/she wasn't sure. During an interview on 5/13/26 at 2:21 P.M. CNA A said:-He/She was told several months ago by the charge nurse that Resident #1 had touched Resident #2 or did something inappropriate. -Resident #2 wouldn't have been able to remember it by the next day.-When he/she walked into the dining room on 4/15/26 to bring a resident to a table he/she saw Residents #1 and #2 were close together near the back of the dining room and Resident #1 was holding Resident #2's hand on top of Resident #2's crotch. -He/She felt that Resident #1 knew he/she had his/her hand on Resident #2's crotch and was aware that no staff was in the dining room. -When Resident #1 was asked to let go of Resident #2's hand, he/she did, but then started cussing him/her out and grabbed the armrest of Resident #2's wheelchair. -Resident #6 was at the table and told Resident #1 he/she would fight him/her if Resident #1 kept trying to swing at him/her and didn't leave him/her alone. -Resident #1 flipped Resident #6 off, giving him/her the finger and called Resident #6 the b word.-He/She got between Residents #1 and #6 and told Resident #6 to just relax because he/she had the situation under control. Resident #1 left the area. During an interview on 5/14/26 at 11:42 A.M. Certified Medication Technician (CMT) A said:-A month ago, in the dining room before lunch was served Resident #1 had his/her hand on the inside of Resident #2's lower thigh. -He/She told the resident to keep his/her hands to himself/herself. During an interview on 5/14/26 at 5:00 P.M. the Administrator said:-Resident #6 reported that Resident #1 touched Resident #2's shoulder and inside of the resident's left knee on 4/15/26. -He/She didn't think the touching was of a sexual nature because Resident #1 had a history of grabbing and touching people to get their attention. -He/She also touched people when talking to them. -He/She knew the 5/5/26 was inappropriate touch but thought it was an impulsive behavior and didn't see it as abuse because they both actively seek each other out.-Resident #1 had no further behaviors after the 72 hours of 15-minute checks and he/she didn't see any reason to continue increased monitoring. Review of the facility's internal investigation, dated 5/5/26 showed:-On 5/5/26 at approximately 11:50 A.M., Resident #5 reported to the Activities Director that Resident #1 touched Resident #2 on the breast and inner thigh.-Findings: It was determined Residents #1 and #2 were actively seek one another. -Facility staff instructed to monitor and redirect as needed. Review of Resident #5's quarterly MDS, dated [DATE], showed he/she was cognitively intact. Review of Resident #5's undated statement showed he/she saw Resident #1 touch Resident #2 down below and on Resident #2's breast. During an interview on 5/14/26 at 1:15 P.M. Resident #5 said:-About a month (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ago he/she saw Residents #1 and #2 in the dining room. Resident #1 was feeling Resident #2 all over near the dining room doors and weren't at a table. -He/She saw Resident #1's hand all over both Resident #2's breasts, rubbing them and putting his/her hand on Resident #2's crotch and moving his/her hand around.-Resident #2 was kind of crying so he/she thought he/she was upset and Resident #2 also looked scared. Resident #2 was saying it hurts, it hurts.-He/She told the Activities Director and Social Services Director that the resident said it hurts thinking the resident meant it hurt when he/she was touched by Resident #1.-He/She was scared Resident #1 would do something like try to touch him/her or another resident. Review of the Activity Director's statement, dated 5/5/26, showed:-He/She was in the Activities office on 5/5/26 when Resident #5 came in and said Resident #1 was touching Resident #2 between his/her legs and breast in the cafeteria.-He/She went to the dining room and found Resident #1's hand was on the inside of Resident #2's leg.-He/She told Resident #1 to stop, and Resident #1 put his/her hand on Resident #2's knee.-He/She again told Resident #1 to stop, and Resident #1 said to mind his/her own business. During an interview on 5/12/26 at 12:55 P.M., the Activities Director said:-Resident #5 reported to him/her that someone was in the dining room touching someone else. The resident didn't mention names or body parts at the time.-He/She left his/her office and went immediately to the dining room. -When he/she got there Residents #1 and #2 were in the back of the dining room. -Resident #1 had his/her hand on the inside of Resident #2's thigh close to his/her knee. Resident #2 was wearing pants. During an interview on 5/12/26 at 3:16 P.M., the DON said:-When he/she first came to the facility he/she was told Resident #1 and #2 were to be kept separated as much as possible due to an incident of inappropriate sexual behavior in September of 2025 where Resident #1 touched Resident #2.-He/She thought the 4/27/26 incident was with Resident #2. -He/She read that on 5/9/26 Resident #1 tried to touch another resident, but he she didn't know who that resident was (Note: interview revealed it was Resident #3) and spat at and kicked a staff member. -On 5/5/26 Residents #1 and #2 both managed to wander down to the dining room a little before lunch was served where it was reported Resident #1 touched Resident #2 inappropriately. During an interview on 5/13/26 at 4:41 P.M. Resident #2's responsible party said:-He/She first became concerned about Resident #1 in Sept of 2025. -The facility had called and told him/her an incident happened. -They said Resident #1 either grabbed or attempted to grab Resident #2's breasts. -He/She was told Resident #1 tried to grab Resident #2 between his/her legs.-He/She filed a police report.-The facility had also called him/her about what happened 5/5/26. -For some reason Resident #1 would always come to Resident #2's table. -He/She could see on Resident #2's room monitor that Resident #1 went into Resident #2's room on 5/11/26. -He/She had started taking Resident #2 out of the facility after lunch and brought him/her back to the facility in the evening after supper and put him/her to bed to make sure Resident #2 was safe. -Resident #2 was a social bug and liked to roam, but because of Resident #1 staff often had Resident #2 behind the nurses' desk. -It felt like Resident #2 was being punished while Resident #1 roamed the hallways and did what he/she wanted. Review of Resident #7's annual MDS dated [DATE] showed he/she was cognitively intact. During an interview on 5/14/26 at 1:54 P.M. Resident #7 said:-A couple of weeks ago Resident #2 was looking out the dining room window and Resident #1's wheelchair was next to his/hers.-Resident #1 was touching Resident #2 at the crotch and at Resident #2's chest.-The residents in the dining room told Resident #1 to stop. During an interview on 5/12/26 at 2:14 P.M. the ADON said on 5/5/26 the Activity Director came to his/her office and said a resident notified him/her that Resident #1 touched Resident #2 on his/her upper arm and knee. No staff were in the dining room at the time. During an interview on 5/13/26 at 2:21 P.M. CNA A said:-When he/she walked into the dining room on 4/15/26 to bring a resident to a table he/she saw Residents #1 and #2 were close together near the back of the dining room and Resident #1 was holding Resident #2's hand on top of Resident #2's crotch. -He/She felt that Resident #1 knew he/she had his/her hand on Resident #2's crotch and knew no staff was in the dining room. -When Resident #1 was asked to let go of Resident #2's hand, he/she did, but then started cussing CNA A out and grabbed the armrest of Resident #2's (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair when he/she started to move Resident #2's wheelchair. During an interview on 5/14/26 at 11:42 A.M. CMT A said:-A month ago, in the dining room before lunch was served Resident #1 had his/her hand on the inside of Resident #2's lower thigh. -Resident #2 liked to look out the window and can wheel himself/herself there and that is where the incident happened. 2. Review of Resident #3's admission Record showed the resident was admitted to the facility on [DATE] with diagnoses that include dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). Review of Resident #3's annual MDS, dated [DATE], showed he/she:-Was sometimes understood simple, direct communication.-Was severely cognitively impaired.-Had no behaviors and did not wander.-Had upper body extremity impairments on both sides. Review of Resident #1's nursing progress note dated 5/9/26 at 12:31 P.M., showed Resident #1 tried to touch another resident. During an interview on 5/14/26 at 11:42 A.M. CMT A said:-He/She had seen Resident #1 try to go towards Residents #2 and #3 in the past. -Over the past weekend or two he/she saw Resident #1's hand on Resident #3's upper chest when they were in the dining room and told the resident he/she couldn't do that. The resident said, make me. It was the same incident where he/she got kicked. Resident #1 was at Resident #3's table. -He/She told Resident #1 he/she needed to move away from Resident #3's table. Again he said, make me and wasn't moving.-He/She told Resident #1 he/she needed to push him/her away from Resident #3. Review of the facility's internal investigation dated 5/11/26 showed:-On 5/11/26 at 1:40 P.M., Resident #1 approached Resident #3 in the hallway and kissed Resident #3. -After reviewing witness statements and residents' medical records it has been determined that Resident #1 should not be allowed to return to the facility for the safety of others. Review of CNA A's statement, dated 5/11/26, showed he/she observed Resident #1 kissing Resident #3 on the mouth. During an interview on 5/13/26 at 2:21 P.M. CNA A said:-He/she saw Resident #1 press his/her lips to Resident #3's. -He/She heard a smack and saw their lips together. Then he/she saw Resident #1 open his/her mouth and his/her tongue was a little out as if Resident #1 was going to put it in Resident #3's mouth. -He/She said something to the effect of what you are doing. -Resident #1 said Resident #3 asked him/her for a kiss. Review of the Maintenance Director's statement, dated 5/11/26, showed:-He/She was coming down the 50 hall to the corner of 80 hall across from the nurses station and saw Resident #3 sitting in his/her wheelchair crying near the linen closet door. -Resident #1 was beside Resident #3 in his/her wheelchair.-He/She asked the two CNAs what was going on and they said Resident #1 was trying to kiss Resident #3.-Resident #1 was calling Resident #3 a crybaby and telling Resident #3 to shut up. During an interview on 5/12/26 at 1:32 P.M., the Maintenance Director said:-He/She was coming down the 50 hall and heard Resident #1 using profanity at Resident #3. -Resident #1 told Resident #3 to shut the [expletive] up and kept calling him/her a crybaby. -Resident #3 was near the linen closet across from the nurses' station. -He/She could see immediately Resident #3 was crying. -Resident #1 was three feet or so away and was backing up away from Resident #3 when he/she came around the corner. -The CNAs said Resident #1 had kissed Resident #3. They didn't say where on the body Resident #3 was kissed. They never said if Resident #1 touched Resident #3 inappropriately in any other way. During an interview on 5/14/26 at 11:42 A.M. CMT A said:-Over the past weekend or two he/she saw Resident #1's hand on Resident #3's upper chest when they were in the dining room and told the resident he/she couldn't do that. The resident said, make me. -He/She told Resident #1 he/she needed to move away from Resident #3's table. Again he said, make me and wasn't moving.-He/She told Resident #1 he/she needed to push him/her away from Resident #3. During an interview on 5/14/26 at 12:16 P.M. CNA B said:-On 5/11/26 Resident was facing the nurses' station.-He/She and CNA A were walking toward the nurses' station, and he/she noticed Resident #1 was holding Resident #3's hands and then kissed Resident #3 on the lips.-Resident #3 started crying right after that happened and looked upset.-He/She told Resident #1 to let go of Resident #3's hands which he/she wouldn't do, and he/she had to physically separate Resident #1's (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hands from Resident #3. During an interview on 5/14/26 at 12:30 P.M. Resident #3's legal representative said:-The facility called him/her on 5/11/26 and said a resident kissed Resident #3 and the resident was pretty upset about it, but they didn't go into any details.-Resident #3 was an emotional person and the experience likely startled him/her at the time. -Once the resident becomes upset it can take a half hour for him/her to calm down although Resident #3 wouldn't be able to remember why he/she was upset. 3. During an interview on 5/14/26 at 5:00 P.M. the Administrator said:-Resident #1 inappropriately touched Resident #2 on 5/5/26.-With the 5/5/26 incident Resident #1's behaviors became more aggressive and hypersexual.-He/She thought the kissing incident on 5/11/26 was inappropriate.-The resident was given an immediate discharge because he/she had become so restless and impulsive, and it was determined he/she was no longer safe to be around other residents.

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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 self-report two instances of possible abuse of two sampled residents (Residents #2 and #3) out of 12 sampled residents. On 4/15/16 Resident #1 was rubbing his/her hands on Resident #2's arm, shoulder and knee. On 5/9/26 Resident #1 touched Resident #3's on the breast/upper chest area. The facility census was 63 residents.Review of the facility's Abuse Prevention policy, dated 7/1/25, showed:-Abuse is willful infliction of injury, confinement, intimidation, or punishment with resulting physical harm, pain, mental anguish, or emotional distress and may be resident to resident, staff to resident, family to resident, or visitor to resident.-Sexual abuse is any touching of a resident directly or through clothing for sexual purpose or in a sexual manner, including but not limited to kissing, touching of genitals, buttocks, or breasts, or causing a resident to touch someone for sexual purposes.-Mental abuse was the use of verbal or non-verbal conduct which causes or has the potential to cause the resident to experience humiliation, fear, shame, agitation, or degradation.-The Administrator and Director of Nursing (DON) must be promptly notified of suspected abuse or incidents of abuse. 1. Review of Resident #1's admission Record showed the resident was admitted to the facility 9/5/25 with the following diagnoses:-Major depressive disorder (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living).-Anxiety disorder (a psychiatric disorder causing feelings of persistent anxiety).-Mild cognitive impairment (a stage of memory and thinking decline that is more pronounced than normal aging but not severe enough to disrupt daily life). Review of Resident #1's Pre-admission Screening and Resident Review, Level I (PASRR - Level I, a preliminary identification process used to determine if an individual has or is suspected of having a qualifying mental illness or intellectual/developmental disability (ID/DD). If the screening is negative the process is complete. If positive it flags for a Level II, an in-depth evaluation by the state's mental health or ID/DD authority to determine if nursing care and/or specialized services are needed.), dated 7/29/20, showed the resident had no diagnosis or signs or symptoms of a serious mental disorder, ID/DD, and had not required intensive psychiatric treatment within the past two years. Review of Resident #1's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 4/15/26, showed the resident:-Was severely cognitively impaired (a significant deterioration in mental capacity, such as short or long-term memory loss and impaired reasoning that prevents an individual from living independently).-Had continuous inattention and disorganized thinking.-Had no verbal or physical behaviors that affected others during the review period.-Wandered daily. Review of Resident #2's admission Record showed the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease (a slowly progressive disease of the brain that is characterized by impairment of memory and eventually by disturbances in reasoning, planning, language, and perception). Review of Resident #2's annual MDS, dated [DATE] showed he/she:-Was admitted to the facility on [DATE].-Sometimes understood simple, direct communication.-Was severely cognitively impaired.-Had no behaviors and did not wander-Was diagnosed with Alzheimer's disease (a slowly progressive disease of the brain that is characterized by impairment of memory and eventually by disturbances in reasoning, planning, language, and perception). Review of Resident #1's nursing Behavior note, dated 4/15/26 at 6:12 P.M. showed:-At supper time Resident #1 was rubbing his/her hands on another resident (Resident #2 according to staff and resident interviews) from the unit. -The resident was asked to stop and staff removed Resident #2 from the situation.-Resident #1 then started cussing at staff and a third resident (Resident #6 according to staff and resident interviews) stepped up to intervene. -Then Resident #1 started cussing at Resident #6 and flipped him/her off.-Staff intervened, Resident #1 then turned around and went to his/her table to eat. During (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 5/12/26 at 3:16 P.M., the Director of Nursing (DON) said:-When he/she first came to the facility he/she was told Resident #1 and #2 were to be kept separated as much as possible due to an incident of inappropriate sexual behavior in September of 2025 where Resident #1inappropiately touched Resident #2.-He/She thought the 4/15/26 incident might have involved Resident #2, but he/she wasn't at the facility that day and wasn't sure. -He/She read that on 5/9/26 Resident #1 tried to touch another resident and spat at and kicked a staff member. -Staff have all been educated by the Administrator when to report incidents and the type of incidents to report, which include reporting any possible abuse or neglect.-The facility policy shows that all incidents with the potential for abuse should be reported.-Staff have all been educated so they can report directly to the Administrator. During an interview on 5/13/26 at 10:20 A.M., Licensed Practical Nurse (LPN) A said:-Certified Nursing Assistant (CNA) A reported to him/her that Resident #1 was touching Resident #2 on the arm, shoulder and knee in the dining room on 4/15/26. -When CNA A told Resident #1 to leave Resident #2 alone the resident started cussing at CNA A. -Resident #6 got in the middle of it and told Resident #1 to leave CNA A alone. -Resident #1 then started cussing at Resident #6 and flipped him/her off. -He/She thought the incident happened around supper time at Resident #1's table.-He/She wrote a behavioral note on 4/15/26 and slid a note under the ADON and DON's office door. -He/She did not immediately report the incident to anyone in management and hadn't asked CNA A, Resident #1, or Resident #6 for their statements to start an investigation because he/she had never been told there had been any inappropriate behaviors from Resident #1 in the past and thought it was just a behavior and didn't realize he/she needed to do an incident report at the time. -In a monthly meeting they talked about reportable incidents, but he/she couldn't recall if it was before or after the 4/15/26 incident. -About a week after the 4/15/26 incident he/she received education from the Administrator, DON, and ADON to report any incident whatsoever that was out of the ordinary and also was educated on Resident #1's behavioral history. They discussed the types of incidents that needed to be reported, such as anything that could rise to the level of abuse as well as any significant behaviors. The 4/15/26 incident should have been reported immediately to the Administrator and DON. Review of Resident #6's quarterly MDS dated [DATE] showed he/she:-Was admitted to the facility 7/9/24.-Clearly understood others.-Was cognitively intact.-Had no behaviors.-Was diagnosed with a stroke. During an interview on 5/13/26 at 1:21 P.M., Resident #6 said:-About a month ago Resident #2 came over to the table where he/she and Resident #1 were sitting. -He/She saw Resident #1 touch Resident #2's breast(s). -Staff was in the dining room when it happened and told Resident #1 to stop, but he/she couldn't say who the staff was. -Resident #1 yelled to the staff he/she wasn't bothering Resident #2 and had some loud, aggressive words to say to the staff.-He/She also told Resident #1 to get away from Resident #2 and Resident #1 yelled he/she wasn't doing anything and told him/her (Resident #6) to shut up. -Staff told Resident #2 to get to his/her own table. During an interview on 5/13/26 at 2:21 P.M. CNA A said:-He/She was told several months ago by the charge nurse that Resident #1 had touched Resident #2 or did something inappropriate. -Resident #2 wouldn't have been able to remember it by the next day.-When he/she walked into the dining room on 4/15/26 to bring a resident to a table he/she saw Residents #1 and #2 were close together near the back of the dining room and Resident #1 was holding Resident #2's hand on top of Resident #2's crotch. He/She didn't see Resident #1 touch Resident #2's breast(s).-When he/she asked Resident #1 to let go of Resident #2's hand, the resident did, but then Resident #1 started cussing CNA A out and grabbed the armrest of Resident #2's wheelchair and swung out at him/her. During an interview on 5/14/26 at 11:42 A.M. Certified Medication Technician (CMT) A said:-A month ago in the dining room before lunch was served Resident #1 had his/her hand on the inside of Resident #2's lower thigh. -He/She told the resident to keep his/her hands to himself/herself. -He/She reported it to the charge nurse and the other CNA who were working at the time, but he/she was not asked to write a statement and didn't know if any administrative staff had been informed. -He/She received education that all incidents that could be considered abuse or are out of the ordinary were to be reported to the charge nurse. During (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265456	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abode Health and Wellness Center	17451 Medical Center Parkway Independence, MO 64057

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 5/14/26 at 5:00 P.M. the Administrator said:-Resident #6 reported that Resident #1 touched Resident #2's shoulder and inside of the resident's left knee on 4/15/26. -He/She didn't report the incident to the state authority because he/she didn't think the touching was of a sexual nature. Resident #1 had a history of grabbing and touching people to get their attention and he/she thought that was what the resident was doing. -Staff have all been educated to report all incidents that are out of the ordinary immediately to their supervisor and any suspicion of possible abuse must be reported immediately to their supervisor, Administrator and DON. 2. Review of Resident #3's annual MDS, dated [DATE] showed he/she-Was admitted to the facility on [DATE].-Sometimes understood simple, direct communication.-Was severely cognitively impaired.-Had no behaviors and did not wander.-Had upper body extremity impairments on both sides.-Was diagnosed with dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). Review of a nursing progress note dated 5/9/26 at 12:31 P.M., showed:-Resident #1 tried to touch another resident (Resident #3, according to staff interviews). -When staff intervened Resident #1 spat at him/her and kicked the staff.-Resident #1 was redirected to his/her room. No injury to Resident #3. During an interview on 5/14/26 at 11:12 A.M., LPN B said:-After lunch on 5/9/26 Certified Medication Technician (CMT) A reported to him/her that Resident #1 was touching another resident but didn't say what part of the body was touched or mention who was touched. -He/She instructed CMT A to report it to the Administrator and CMT A said he/she would write a statement. During an interview on 5/14/26 at 11:42 A.M., CMT A said:-He/She had seen Resident #1 try to go towards Residents #2 and #3 in the past. -Over the past weekend or two he/she saw Resident #1's hand on Resident #3's upper chest when they were in the dining room and told the resident he/she couldn't do that. The resident said make me. It was the same incident where he/she got kicked. Resident #1 was at Resident #3's table. -He/She told Resident #1 he/she needed to move away from Resident #3's table. Again he said make me and wasn't moving.-He/She reported the incident to the charge nurse. -Staff have been educated to report all incidents that could be abuse or major behaviors to their supervisors. During an interview on 5/14/26 at 2:43 P.M., the Regional Nurse Consultant (RNC) said the Administrator was responsible for reporting all incidents of potential abuse to the State agency. Any incidents of crimes should also be reported to the police. During an interview on 5/14/26 at 5:00 P.M., the Administrator said:-He/She did not know about the 5/9/26 incident until 5/11/26 when he/she reviewed the resident's chart. Staff were educated at the time about reporting. -He/She reported the 5/11/26 incident because he/she knew that was inappropriate but didn't know that the touching on 5/9/26 was inappropriate.-He/She was responsible for reporting all incidents he/she thought were potentially abusive.

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	265456	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abode Health and Wellness Center	17451 Medical Center Parkway Independence, MO 64057

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate two instances of possible abuse for two residents (Residents #2 and #3) out of 12 sampled residents. On 4/15/16 Resident #1 was rubbing his/her hands on Resident #2 arm, shoulder and knee. On 5/9/26 Resident #1 touched Resident #3's on the breast/upper chest area. The facility census was 63 residents.Review of the facility's Abuse Prevention policy, dated 7/1/25, showed:-Abuse is willful infliction of injury, confinement, intimidation, or punishment with resulting physical harm, pain, mental anguish, or emotional distress and may be resident to resident, staff to resident, family to resident, or visitor to resident.-Sexual abuse is any touching of a resident directly or through clothing for sexual purpose or in a sexual manner, including but not limited to kissing, touching of genitals, buttocks, or breasts, or causing a resident to touch someone for sexual purposes.-Mental abuse was the use of verbal or non-verbal conduct which causes or has the potential to cause the resident to experience humiliation, fear, shame, agitation, or degradation.-The facility will initiate at the time of any findings of potential abuse or neglect an investigation to determine cause and effect and provide protection to any alleged victims to prevent harm during the continuance of the investigation.-Suspected or substantiated cases of resident abuse, neglect, misappropriation, or mistreatment shall be thoroughly investigated, documented, and reported to the physician, families, and/or representative, and as required by state guidelines. 1. Review of Resident #1's admission Record showed the resident was admitted to the facility 9/5/25 with the following diagnoses:-Major depressive disorder (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living).-Anxiety disorder (a psychiatric disorder causing feelings of persistent anxiety).-Mild cognitive impairment (a stage of memory and thinking decline that is more pronounced than normal aging but not severe enough to disrupt daily life). Review of Resident #1's Pre-admission Screening and Resident Review, Level I (PASRR - Level I, a preliminary identification process used to determine if an individual has or is suspected of having a qualifying mental illness or intellectual/developmental disability (ID/DD). If the screening is negative the process is complete. If positive it flags for a Level II, an in-depth evaluation by the state's mental health or ID/DD authority to determine if nursing care and/or specialized services are needed.), dated 7/29/20, showed the resident had no diagnosis or signs or symptoms of a serious mental disorder, ID/DD, and had not required intensive psychiatric treatment within the past two years Review of Resident #2's annual Minimum Data Set (MDS-xx , dated 4/15/26 showed he/she:-Was admitted to the facility on [DATE].-Sometimes understood simple, direct communication.-Was severely cognitively impaired.-Had no behaviors and did not wander-Was diagnosed with Alzheimer's disease (a slowly progressive disease of the brain that is characterized by impairment of memory and eventually by disturbances in reasoning, planning, language, and perception). Review of Resident #1's nursing Behavior note, dated 4/15/26 at 6:12 P.M. showed:-At supper time Resident #1 was rubbing his/her hands on another resident (Resident #2 according to staff and resident interviews) from the unit. -The resident was asked to stop and staff removed Resident #2 from the situation.-Resident #1 then started cussing at staff and a third resident (Resident #6 according to staff and resident interviews) stepped up to intervene. -Then Resident #1 started cussing at Resident #6 and flipped him/her off.-Staff intervened, Resident #1 then turned around and went to his/her table to eat. During an interview on 5/12/26 at 3:16 P.M., the Director of Nursing (DON) said:-When he/she first came to the facility he/she was told Resident #1 and #2 were to be kept separated as much as possible due to an incident of inappropriate sexual behavior in September of 2025 where Resident #1 touched Resident #2.-He/She thought the 4/15/26 incident might have involved Resident #2, but he/she wasn't at the facility that day and wasn't sure. -He/She wasn't sure if the Administrator investigated it or put any new interventions in place or if Resident #1 was placed on any increased monitoring. -There was staff (continued on next page)

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Abode Health and Wellness Center	17451 Medical Center Parkway Independence, MO 64057

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	training by the Administrator related to reporting incidents and to watch Residents #1 and #2 closely. -He/She read that on 5/9/26 Resident #1 tried to touch another resident and spat at and kicked a staff member, but he/she didn't know details about the incident. -The Administrator was responsible for investigating incidents of potential abuse. During an interview on 5/13/26 at 10:20 A.M., Licensed Practical Nurse (LPN) A said:-Certified Nursing Assistant (CNA) A reported to him/her that Resident #1 was touching Resident #2 on the arm, shoulder and knee in the dining room on 4/15/26. -When CNA A told Resident #1 to leave Resident #2 alone the resident started cussing at CNA A. -Resident #6 got in the middle of it and told Resident #1 to leave CNA A alone. -Resident #1 then started cussing at Resident #6 and flipped him/her off. -He/She thought the incident happened around supper time at Resident #1's table.-He/She wrote a behavioral note on 4/15/26 and slid a note under the Assistant Director of Nursing (ADON) and DON's office door. -He/She was educated after 4/15/26 that any behavioral or other incidents should be recorded by the charge nurse on an incident report and witness statements should be obtained.-Resident #1 was put on 15-min checks after the 4/15/26 incident. Review of Resident #6's quarterly MDS dated [DATE] showed he/she:-Was admitted to the facility 7/9/24.-Clearly understood others.-Was cognitively intact.-Had no behaviors.-Was diagnosed with a stroke. During an interview on 5/13/26 at 1:21 P.M., Resident #6 said:-About a month ago Resident #2 came over to the table he/she and Resident #1 were sitting. -He/She saw Resident #1 touch Resident #2's breast(s). -Staff told Resident #1 to stop, but he/she couldn't say who the staff was.-Resident #1 yelled to the staff he/she wasn't bothering Resident #2 and had some loud, aggressive words to say to the staff.-He/She also told Resident #1 to get away from Resident #2 and Resident #1 yelled he/she wasn't doing anything and told him/her (Resident #6) to shut up. -Staff told Resident #2 to get to his/her own table. During an interview on 5/13/26 at 1:35 P.M., Resident #2 said:-About a month ago Resident #1 touched him/her on the shoulder and might have touched him/her on the knee, but he/she wasn't sure. -He/She couldn't remember Resident #1 touching him/her inappropriately and thought of Resident #1 as a friend and never remembered feeling uncomfortable around him/her. During an interview on 5/13/26 at 2:21 P.M. CNA A said:-He/She was told several months ago by the charge nurse that Resident #1 had touched Resident #2 or did something inappropriate. -Resident #2 wouldn't have been able to remember it by the next day.-When he/she walked into the dining room on 4/15/26 to bring a resident to a table he/she saw Residents #1 and #2 were close together near the back of the dining room and Resident #1 was holding Resident #2's hand on top of Resident #2's crotch. -He/She felt that Resident #1 knew he/she had his/her hand on Resident #2's crotch and knew no staff was in the dining room. -When Resident #1 was asked to let go of Resident #2's hand, he/she did, but then started cussing CNA A out and grabbed the armrest of Resident #2's wheelchair. -Resident #1 was calling him/her the b word and saying the f word. Resident #1 was yelling and showing his/her fist and punching as if trying to hit CNA A, but he/she backed up out of Resident #1's way. -Resident #1 told CNA A to mind his/her own business and said Resident #2 didn't have to leave or do what CNA A said. -Resident #6 was at the table and told Resident #1 he/she would fight him/her if Resident #1 kept trying to swing at CNA A and didn't leave him/her alone. -Resident #1 flipped Resident #6 off, giving him/her the finger and called Resident #6 the b word. -He/She got between Residents #1 and #6 and told Resident #6 to just relax because he/she had the situation under control. Resident #1 left the area. -Resident #2 liked to look out the windows at the back of the dining room which was close to where Resident #1 sat for his/her meals. During an interview on 5/14/26 at 5:00 P.M. the Administrator said:-Resident #6 reported that Resident #1 touched Resident #2's shoulder and inside of the resident's left knee on 4/15/26. -He/She was responsible for investigating all incidents of possible abuse.-He/She didn't think the touching was of a sexual nature because Resident #1 had a history of grabbing and touching people to get their attention and when talking to them so he/she didn't investigate the incident as possible abuse. 2. Review of Resident #3's admission Record showed the resident was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive organic mental disorder (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). Review of the resident's annual MDS, dated [DATE] showed he/she-Was admitted to the facility on [DATE].-Sometimes understood simple, direct communication.-Was severely cognitively impaired.-Had no behaviors and did not wander.-Had upper body extremity impairments on both sides.-Was diagnosed with dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). Review of a nursing progress note dated 5/9/26 at 12:31 P.M., showed:-Resident #1 tried to touch another resident (Resident #3, according to staff interviews). -When staff intervened Resident #1 spat at him/her and kicked the staff. During an interview on 5/14/26 at 11:12 A.M., LPN B said:-After lunch on 5/9/26 Certified Medication Technician (CMT) A reported to him/her that Resident #1 was touching another resident but didn't say what part of the body was touched or mention who was touched. -He/She instructed CMT A to report it to the Administrator and CMT A said he/she would write a statement. -CMT A said he/she tried to intervene by separating Resident #1 from the other resident. -He/She could tell by CMT A's affect and tone of voice he/she was upset, probably because Resident #1 kicked CMT A in the leg, cussed at him/her, and called him/her names. CMT A said the resident also spat at him/her. -Immediately after separating the two residents Resident #1 went to the A unit and then came back to the B unit after about a half hour. -In April, 2026 he/she overheard other staff saying Resident #1 inappropriately touched another resident from the A unit. During an interview on 5/14/26 at 11:42 A.M., CMT A said:-He/She had seen Resident #1 try to go towards Residents #2 and #3 in the past. -Over the past weekend or two he/she saw Resident #1's hand on Resident #3's upper chest when they were in the dining room and told the resident he/she couldn't do that. The resident said make me. It was the same incident where he/she got kicked. Resident #1 was at Resident #3's table. -He/She told Resident #1 he/she needed to move away from Resident #3's table. Again he said make me and wasn't moving.-He/She told Resident #1 he/she needed to push him/her away from Resident #3. During an interview on 5/14/26 at 2:43 P.M., the Regional Nurse Consultant (RNC) said the Administrator was responsible for investigating any potential incidents of abuse. During an interview on 5/14/26 at 5:00 P.M., the Administrator said:-He/She did not know about the 5/9/26 incident until 5/11/26 when he/she reviewed the resident's chart. -He/She was responsible for reporting any potential instances of abuse. -The resident typically touched other residents to get their attention and often touched them when speaking to them. -He/She was not informed that anyone had been touched by Resident #1 in an inappropriate manner on 5/9/26 so he/she did not investigate the incident.