

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175502	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2025
NAME OF PROVIDER OR SUPPLIER Medicalodges Eudora		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 Maple Street Eudora, KS 66025	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 45 residents, with three residents reviewed for abuse. Based on record review, observations, and interviews, the facility failed to prevent the mental abuse of cognitively impaired and dependent residents, Residents (R) 2, R3, and R4. In May 2025, Hospitality Aide P took demeaning and humiliating photos of the residents in compromising positions, without their consent, knowledge, or permission. Hospitality Aide P kept the images on her personal cell phone and later texted them to at least one other staff member. It is unknown if Hospitality Aide P distributed the images beyond this incident. This deficient practice violated the rights of R2, R3, and R4 and placed the residents in immediate jeopardy, based on reasonable person concept, for the negative psychosocial impact of fear, humiliation, privacy violation, and dehumanization. Findings included:- R2's Annual Minimum Data Set (MDS) dated [DATE] did not record a Brief Interview for Mental Status (BIMS) score. However, the facility indicated in a facility incident (FRI #6430) that the resident had a BIMS of 7, which indicated R2 had severely impaired cognition. The MDS documented R2 was 5 feet 3 inches in height and weighed 118 pounds (Lbs.). R2 was assessed to be incontinent of bowel and bladder, had functional impairment on one side, ambulated with the use of a wheelchair, and was dependent on staff for all activities of daily living (ADL) except for eating, which required cueing and encouragement. Facility Reported Incident number 6430 documented Administrative Staff A received three separate emailed photographic images on 07/04/25 at 08:15 AM from Certified Nurse Aide (CNA) M, a former employee. Administrative Staff A identified R2, R3, and R4 as residents in the photos. The images depicted R2 lying in bed on the left side and unclothed from the waist down. The image of R3 depicted the resident lying in bed, with her head tilted to the side. The image of R4 revealed the resident lying on her back while CNA O stood on and at the head of R4s bed, using a draw sheet to assist the resident up in bed. The report documented the facility notified law enforcement, began an investigation, and implemented an immediate plan of correction. The facility investigation documented substantiated abuse, based on the photographs received, the reports provided, and the involved residents' inability to give consent. On 07/16/25, a review of the photographs depicted the following:R2 lying in bed on her left side, seemingly sleeping, wearing a flannel-type nightgown, to the waist. R2's legs were retracted in a fetal-like position, and R2's right hip and legs were exposed and visible. R2's face was evident in the photo.R3 lying in bed on her right side, from the mid chest up, head tilted to the side, dressed and seemingly sleeping. The resident's face was evident in the photo.R4 lying on her back while CNA O stood on and at the head of R4's bed, using a draw sheet to assist the resident up bed. The photograph showed the resident from the waist up, wearing a blouse, and the lower left leg was exposed. The residents' alertness could not be determined; however, R4's face was visible, as well as CNA O's entire body. The facility investigation did not contain CNA M's Witness Statement (former employee). The 07/04/25 unnotarized Witness Statement from Hospitality Aide P documented, Hospitality Aide P sent pictures to CNA M (her relative) after she received the photos of residents from CNA M. Hospitality Aide P stated she did not know photographs were not allowed at that time. Hospitality Aide P stated she would not have taken a picture of a resident's face. The 07/04/25 unnotarized Witness Statement from CNA/Certified Medication Aide (CMA) O documented the pictures were taken. CNA/CMA O asked for the photographs to be deleted and thought it was taken care of. CNA/CMA O further stated she should have reported. Review of the Electronic Medical Record revealed all three residents were cognitively impaired and dependent on staff for cares.R2's Annual Minimum Data Set (MDS) dated [DATE] did not record a Brief Interview for Mental Status (BIMS) score. [However, the facility indicated in a facility incident (FRI #6430) that the resident had a BIMS of 7, which indicated R2 had severely impaired cognition]. The MDS documented R2 was five feet three inches tall, weighed 118 pounds lbs., was incontinent of bowel and bladder, had functional impairment on one side, ambulated with the use of a wheelchair, and was dependent on staff for all activities of daily living (ADL) except for eating.R3's Quarterly Minimum Data Set (MDS) dated [DATE] recorded a BIMS score of zero, which indicated severely impaired cognition. The MDS documented R3 was five feet tall, weighed 109 pounds (lbs.), was incontinent of bowel and bladder, had functional impairment on both sides, ambulated with the use of a wheelchair, and was dependent on staff for all activities of daily living (ADL).R4's Quarterly Minimum Data Set (MDS) dated [DATE] recorded a BIMS score of zero, which indicated severely impaired cognition. The MDS documented R4 was five feet six inches tall, weighed 174 lbs., was frequently incontinent of bowel and bladder, had</p>		