STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175502	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Eudora	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure Certified Nurse Aide (CNA) M used a gait belt and two-person assist during toileting and toileting hygiene for Resident (R) 1 to prevent accidents. On 04/17/2026 at approximately 01:15 PM, CNA M assisted R1 with toileting. When R1 stood up in front of the toilet for CNA M to clean bowel movement off of her, R1 stated she needed to sit down and proceeded to sit back down onto the edge of the toilet. R1 slipped off the toilet edge and onto the floor. R1's right leg bent backwards at the knee with her ankle positioned at the height of her upper body. CNA M called for help, and Licensed Nurse (LN) G responded. The facility called for assistance from Emergency Medical Services (EMS) to assist R1 off the floor, which they were able to do after they provided medication. EMS partially reset R1's right leg, then transported her to the hospital, where she was found to have an acute comminuted (break or splinter of the bone into more than two fragments) distal (away from the farthest point of origin or attachment) femoral (thigh bone) fracture and required surgical intervention. Findings included:- R1 admitted to the facility on [DATE], discharged to the hospital on [DATE], and readmitted to the facility on [DATE]. R1's Electronic Medical Record (EMR) documented diagnoses of need for assistance with personal care, generalized muscle weakness, and age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). R1's Quarterly Minimum Data Set (MDS) dated [DATE] documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 had impairment on both sides of her lower extremities. R1 required substantial/maximal assistance with toileting hygiene and partial/moderate assistance to stand. R1 had no falls since the last assessment. R1's Significant Change MDS dated [DATE] documented R1 had a BIMS score of 13, which indicated intact cognition. R1 had impairment on both sides of her lower extremities. R1 was dependent on staff for toileting hygiene, and standing was not attempted due to a medical condition or safety concerns. R1 had no falls since her re-entry to the facility. The Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 05/14/2026 documented R1 required substantial assistance with ADL completion and directed caregivers of her wants and needs. R1's 06/23/2021 Care Plan documented she needed staff assistance with ADL related to physical limitations. The Care Plan documented an intervention, dated 09/11/2024, that R1 was incontinent and could not take herself to the bathroom and perform her own hygiene. R1 needed two-staff assistance with her toileting needs, such as using a bedpan, toileting hygiene, or changing her brief. The facility's Investigation dated 04/20/2026, documented on 04/17/2026 at approximately 01:15 PM, CNA N reported to Administrative Nurse D that R1 fell. Administrative Nurse D entered R1's room to discover LN G and CNA M in R1's bathroom. Feces covered the floor and the toilet riser. R1 laid on the floor while CNA M supported her head, and LN G left to call EMS. R1's left ankle bled, and Administrative Nurse D applied pressure with gauze. While Administrative Nurse D applied pressure to R1's left ankle, she observed R1's right leg was deformed with her right knee twisted and bent backwards. R1 transferred to the hospital and was admitted for a right leg femur fracture. The facility's investigation documented CNA M failed to utilize a gait belt during the transfer. CNA M (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	self-terminated her employment, and the facility completed nursing staff education regarding gait-belt usage. The facility concluded the root cause analysis of R1's fall was her deconditioning and weakness from her recent hospital stay with an environmental contributing factor of feces covering the floor and toilet riser. R1's EMR documented the following: A Nurse's Note on 04/17/2026 at 06:30 AM documented at approximately 06:30 AM, the CNA called the nurse for help. The nurse entered R1's room and observed R1 sitting upright on the floor with her back supported by the bed and her legs straight in front of her. R1 stated she did not fall, she tried to go to the bathroom, and while the CNA helped transfer her from the bed to the wheelchair, her legs gave up, and she slipped onto the floor. A Fall Note on 04/17/2026 at 02:37 PM documented the CNA assisted R1 in the bathroom, and she stood up for the CNA to clean her then stated to the CNA that she had to sit down. R1 sat down on the edge of the toilet, then proceeded to fall from the toilet to the floor. When the nurse arrived, R1 sat on the floor directly in front of her toilet and leaned to her right side. The CNA helped keep R1's head from resting on the toilet. R1 had stool on the floor, and she continued to defecate. R1's right leg appeared deformed as it was bent completely backwards at the knee and she sat on that leg. The nurse called for EMS to transport R1 to the hospital. A Computed Tomography (CT scan- a test that uses X-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) of the right lower extremity without intravenous (IV-administered directly into the bloodstream via a vein) contrast results on 04/17/2026 at 09:47 PM, documented diffuse osseous demineralization (progressive loss of minerals from bone tissue which reduced bone density and strength) and an acute, comminuted distal femoral fracture that had intra-articular extension (extends to the joint) to the knee. CNA M's notarized Witness Statement dated 05/01/2026 revealed on 04/17/2026 at around 01:15 PM, she toileted R1 in her bathroom. Once she finished cleaning feces on R1's legs and stomach, CNA M asked R1 to stand up so she could wipe her bottom. R1 stood up, and CNA M wiped her a few times before R1 stated she needed to sit down. CNA M stated R1 sat down on the edge of the toilet, and her bottom slipped off the edge and R1 slid onto the floor with her back to the toilet. R1's right leg was bent behind her with her right ankle positioned up to her right armpit. CNA M stated she immediately yelled for help and LN G entered with CNA N. LN G's Witness Statement, not dated, revealed on 04/17/2026, CNA M called her to R1's room. LN G entered R1's room and saw R1 sat on the floor directly in front of her toilet and leaned to her right side while CNA M helped keep R1's head from resting on the toilet. R1 had stool on the floor and continued to defecate. LN G stated R1's right leg appeared deformed as it was bent completely backwards at the knee and R1 sat on her right leg. LN G called EMS to transport R1 to the hospital. Administrative Nurse D's Witness Statement, not dated, revealed on 04/17/2026, CNA N approached her and said LN G needed her in R1's room. Administrative Nurse D entered R1's room and found R1 on the floor while CNA M held her head for support. R1 laid on her right side against the toilet and noted feces on the floor. R1's left ankle bled, and Administrative Nurse D applied pressure to her left ankle then noticed R1's right leg was deformed with her right knee twisted and bent backwards. EMS arrived and gave R1 IV pain and sedation medications, then relocated R1's knee and leg. EMS transported R1 to the hospital. On 06/04/2026 at 11:39 AM, R1 laid in bed with her eyes closed. On 06/04/2026 at 12:27 PM, CNA O stated she had access to the Kardex (nursing tool that gives a brief overview of the care needs of each resident) that directed a resident's care. She confirmed R1's Care Plan directed R1 needed two staff assistance with toileting hygiene. CNA O stated she knew R1's fall occurred in her bathroom with one CNA and no gait belt usage. She stated she kept residents safe during transfers by using two staff, if their care plan directed they needed two staff, and she always used a gait belt, even with stand-by assist transfers. On 06/04/2026 at 12:46 PM, LN H stated staff knew how much assistance a resident needed by their care plan or Kardex. She confirmed R1's Care Plan directed she needed two staff assistance with toileting hygiene. LN H stated she worked on 04/17/2026 and went to R1's room to assist. She said R1 was on the floor in front of the toilet while CNA M sat on the floor and cradled her head in her lap. LN H stated R1 laid to her right with the toilet to her left, and LN H did not (continued on next page)

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