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	11/18/2025

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 - Immediate jeopardy to resident health or safety 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** The facility reported a census of 38 residents. The sample included three residents, reviewed for elopement/elopement risk. Based on observation, interview, and record review, the facility failed to ensure staff provided adequate supervision for cognitively impaired Resident (R) 1, who was at moderate risk for elopement. On 08/25/25 at approximately 12:50 PM, Administrative Staff B opened the facility door to allow R1 and R3 outside to sit on the patio. Administrative Staff B told Licensed Nurse (LN) G R1 was outside, seated in her electric wheelchair. At 02:10 PM, Emergency Medical Services (EMS) alerted the facility that they responded to a 911 call and found R1 on the ground approximately one-half mile from the facility. R1 hit a curb in her electric wheelchair, fell, and hit her head. The facility staff were unaware R1 had left the facility until they received the EMS call. The facility's failure to prevent a cognitively impaired resident from leaving the facility grounds without staff supervision placed R1 in immediate jeopardy.Findings included:- The electronic medical record (EMR), documented R1 admitted to the facility on [DATE]. The EMR documented R1's diagnoses included hepatic encephalopathy, (a serious condition that occurs when the liver is unable to filter toxins from the blood, and this buildup of toxins affects the brain's ability to function), cerebral vascular accident with residual effects (commonly known as a stroke when a blood vessel blockage or rupture disrupts blood flow to the brain), aphasia (an acquired communication disorder that results in loss of the ability to produce or understand language), and unspecified mood disorder symptoms (a mental health condition, often used when an individual experiences significant impairment or distress in daily functioning but does not neatly fit into other categories, such as depression, or bipolar disorder). The Annual Minimum Data Set (MDS) dated [DATE] documented R1 scored seven on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. R1 did not experience mood, wandering, or other behavior disorders during the assessment period and received antidepressant medications.The 05/09/25 Care Area Assessment (CAA) (an analysis of resident characteristics) documented R1 had a cognitive deficit but could make her needs known, R1 had diagnoses of hemiplegia and hemiparesis (paralysis on one side of the body), could stand with assist, required assistance of two staff with bed mobility, used a slide board for transfers, did not have a history of falls, and had bowel and bladder incontinence. The CAA recorded R1 used an electric wheelchair and chose not to use the toilet (check and change).A 08/08/25 Quarterly MDS documented a BIMS score of nine, which indicated moderately impaired cognition.The 09/10/25 Significant Change MDS documented a decrease in R1's BIMS score of six, indicating moderately impaired cognitive decline, from the assessments on 05/09/25 and 08/08/25. R1 scored an 11 on a mood screening tool, noting R1 had little interest or pleasure in doing things, felt tired or had little energy most days, and had a poor appetite. The 09/10/25 Communication CAA recorded R1's decreased cognition.R1's Care Plan dated 08/22/25 documented R1's inability to ambulate, required use of an electric wheelchair, and directed staff to provide assistance with (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	setup in the wheelchair and ensure its functional operation. R1 used a slide board for transfers. The care plan recorded R1 was a fall risk, had no recent falls, and outlined appropriate interventions. R1's care plan lacked documentation to identify R1 as an elopement risk and/or interventions to identify or prevent an elopement from the facility. R1's care plan did not address R1's ability to participate in unsupervised activities outside the facility. R1's revised Care Plan dated 08/25/25 recorded R1 used a regular wheelchair and required staff assistance with ambulation. A transfer method was not addressed on R1's revised care plan. The care plan, recorded R1 was identified at a high risk for wandering and directed staff to interpret behaviors from R1's viewpoint, coordinate information with the hospital for medical care, observe for triggers, assist R1 during increased times of wandering, assist with identifying and communicate to others, and upon return from hospital continue with oversight and referrals for physical, psychosocial, and medication evaluations. R1's revised Care Plan lacked documentation related to R1's outdoor privileges. A Nurses Progress Note dated 08/25/25 at 04:27 PM recorded the facility received a call from County EMS at approximately 02:05 PM, stating that the resident fell while out in the community. The nurse's note recorded there were witnesses, and EMS was told R1 had fell out of her chair and had a head injury and a laceration. EMS stated R1 was able to tell them that she lived in a facility. EMS also reported that they would be transporting the resident to the hospital for treatment of the head injury.A facility self-report #2600022 received on 08/25/25 recorded R1 eloped from the facility on 08/25/25. The report documented R1 was last seen around 12:45 PM or 12:50 PM, seated on the front porch/patio after a staff member assisted R1 outside with another resident (R3). The facility received a call from EMS at approximately 02:10 PM, stating they found a person (identified as R1) in the community, after community members called EMS, stating a person had hit the curb with her electric wheelchair and had fallen to the ground. EMS transported R1 to the hospital for evaluation and treatment. The report documented per the 08/02/25 assessment, R1 was not at risk for elopement, which contradicted the 08/02/25 Elopement Risk Assessment, which indicated R1 was at moderate risk for elopement. The report noted the other resident (R3) went back into the facility, leaving R1 alone. It is unknown how long R1 was alone. The weather was sunny and mild, with a temperature in the mid-70s. The Facility Investigation lacked documentation to address why R1 was outside unattended, who found the resident, what witnesses said, an interview with resident (R3) who was outside with R1, where and how specifically R1 was found, what route was taken by R1, how far R1 traveled from the facility, what environmental hazards were present, what R1 wore, and/or any ongoing communication with the hospital.A Skin Assessment dated 08/02/25, before R1's elopement and fall, recorded R1 had bruises on both breasts and around the breast. An Elopement Risk Assessment dated 08/02/25 recorded a score of 10, which placed R1 at moderate risk for elopement.A Skin Assessment done on R1's reentry, dated 09/03/25, recorded R1 had bruises all over due to her fall that resulted in her hospital admission. R1 had bruises to the right peri-orbital (eye socket), right cheek, shoulder, top of breast, forearm, upper arm, back of hand, knee, and forehead. This also included the left foot top, left forearm, scar on the 1st, 2nd, and 3rd fingers, and blanchable redness on the buttocks.The 09/03/25 reentry Elopement Risk Assessment recorded a score of 11, which continued R1's moderate risk for elopement status.The 08/25/25 Hospital emergency room Report documented R1 presented as trauma transfer from (another hospital), after a fall from her motorized wheelchair. The patient did not know why she is in the hospital and does not remember falling. R1 is only oriented to self and place and not to reason. A Computerized Tomography (CT) head scan was obtained at 04:25 PM on 08/25/25, which was significant for an acute right-sided subdural hematoma (bleeding near the brain that can happen after a head injury). The patient was also hypoxic (a deficiency (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in the amount of oxygen reaching the tissues).On 09/22/25 at approximately 08:00 AM observation of the area where R1 was found, approximately a half mile from the facility, revealed a main road in town, near a restaurant and bank, with changing slopes, cement curbing, and walkways, grassy and paved areas, varying speed limits and traffic patterns, stop signs, stop lights, lane changes, and other potential environmental hazards for a cognitively impaired dependent resident.According to Weather Underground (www.wunderground.com) on 08/25/25 at 12:53 PM, the temperature was 70 Degrees Fahrenheit with calm winds and fair skies.On 09/22/25 at 11:10 AM, observation revealed R1 in her room with a faded bruise and a pen-point puncture wound to her right temple.An undated Witness Statement documented Administrative Staff B opened the door for R1 to go outside along with another resident (R3). R1 stated she did not inform the nurse she was going outside. Administrative Staff B stated she would inform the nurse, and informed LN G, R1 was on the front porch, and LN G said, Ok. Administrative Staff B then told another staff member that the issue of the resident signing out needed to be addressed in the resident council. This was approximately 12:50 PM. LN G's undated Witness Statement documented at 01:00 PM, Administrative Staff B notified her that R1 was outside. At 02:05 PM or 02:10 PM, the front hall nurse, LN H, received a call from the county EMS stating R1 fell outside the facility, sustained a head injury, and was being transported for emergency treatment. LN H's statement documented notifications made to the facility's Administrative Staff A, interim, Administrative Nurse D, residents' responsible party, and R1's physician and or nurse practitioner. An undated Witness Statement documented LN H received a phone call from county EMS at 02:02 PM inquiring if R1 resided at the facility. LN H questioned the inquiry, and after EMS explained the resident fell and sustained a head injury, LN H provided information regarding R1's cognition and medications. EMS reported R1 would be transported to the hospital or a head trauma unit. On 09/22/25 at 11:10 AM, R1 stated she remembered using her electric wheelchair to travel from the facility, but did not know where she was going or why. R1 did not remember falling from her electric wheelchair. R1 stated she remembered being hungry at the time, but did not remember hitting a curb or being in the hospital. R1 did not remember hurting herself (pointing to a bruise on her right temple). R1 denied any mistreatment by staff or other residents.On 09/23/25 at 11:06 AM, CNA N stated R1 did not go outside often.During a phone interview on 09/23/25 at 11:15 AM, Administrative Staff B stated R1 would go outside on occasion (usually with other residents). She wanted to purchase some potato chips from the vending machine, but then saw other residents going out and said, Oh, I'm gonna go outside, instead. She seemed ok, there was nothing out of the ordinary. R1 did not seem agitated or anxious.On 09/23/25 at 11:28 AM, CNA O stated she worked that day but on a different hall. CNA O stated she knew R1 would like to sit in the front of the building occasionally, but it was not frequent. The resident would ride around in her electric wheelchair, but CNA O never saw her leave the facility grounds.On 09/22/25 at 04:39 PM, LN G stated Administrative Staff B reported R1 was out on the patio. At around 02:00 PM, EMS called and stated the resident was located away from the facility.On 09/22/25 at 04:59 PM, LN G stated she did not know how R1 was found away from the facility, on the ground. LN G stated R1's bruise and puncture-like wound was likely from the fall, noting it was much larger when R1 first returned from the hospital but has decreased a lot.On 09/22/25 at 12:54 PM, Administrative Staff A stated R1 would go in and out of the building depending on her mood. Administrative Staff A stated she did not know of R1 ever exiting the building without staff knowledge before. She confirmed R1 was found lying on the ground, near a restaurant. Administrative Staff A stated she was unaware of where R1 was going or why. R1 returned from the hospital with a puncture-like wound to her upper right temple. Administrative Staff A noted all residents were assessed for elopement risk after this incident, and an (continued on next page)

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