STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175522	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Great Bend	1401 Cherry Lane Great Bend, KS 67530

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 - 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. The facility identified a census of 43 residents, with six residents reviewed for abuse and neglect. Based on record review, observation, and interview, the facility failed to ensure six residents, Resident (R) 1, R2, R3, R4, R5, and R6, remained free from verbal and mental abuse when Certified Nurse's Aide (CNA) M exhibited aggressive behavior toward the residents. This failure resulted in R1, R2, R3, R4, R5, and R6 experiencing verbal/mental abuse, which likely caused embarrassment, humiliation, and a potential decreased quality of life using the reasonable person concept related to their psychosocial well-being. Findings included:- CNA N's Unnotarized Witness Statement, dated 12/11/25, documented CNA N and CNA M changed R1 in his room. CNA M looked at R1 and said, Ew, you smell like [expletive]. CNA N stated she tried to change the subject, and CNA M continued to speak about how R1 smelled. CNA M said, R1 smelled like he had a turd in his mouth. CNA M stated R1 probably smelled like that because of the chicken and dumplings he had last night, but R1 ate brown dumplings. CNA N said she did not know they even made brown dumplings. CNA M laughed at CNA N and said, That was sarcasm. I said it because his mouth smells like [expletive], [expletive] dumplings. CNA N stated she later saw CNA M wheel R2 in her wheelchair to eat breakfast, as R2 yelled. CNA M told R2 sternly to Stop it, people are sleeping right now, and you had better quit it. CNA N told Certified Medication Aide (CMA) R everything CNA M said, and CMA R instructed her to report what she had seen and heard. CNA N reported the incidents to administration later in the day.CMA R's Unnotarized Witness Statement, dated 12/11/25, documented sometime before 08:00 AM on 12/11/25, CMA R walked by R1's room and heard someone loudly talking and cussing. CNA N then waved CMA R into R1's room and told CMA R what happened. CMA R stated CNA M brought residents out to breakfast but was snappy and cold towards the residents. CMA R then stated earlier in the week R4 did not want to go to lunch, so CNA M wrapped her arms around R4's shoulders and tried to lift him up to the side of the bed. R4 pushed against CNA M and told her no, he did not want to go. CNA M tried several times to force R4 and manhandle him. CMA R told CNA M that was probably enough, and they could try later. CMA R's witness statement lacked evidence CMA R reported the incident to the administration.CNA O's Unnotarized Witness Statement, dated 12/11/25, documented earlier the same week CNA M and CNA O were getting residents up for supper, and CNA M worked in a rushed manner. She did not finish performing cares for residents, which included brushing hair, wiping hands or faces, and not changing soiled clothing. When the two CNAs got R5 up, CNA M made comments towards R5 about how nasty he was. CNA O stated she found CNA M's behavior unprofessional, hurtful to R5, and uncalled for. CNA O's witness statement lacked evidence CNA O reported the incident to the administration.Licensed Nurse (LN) G's Unnotarized Witness Statement, dated 12/11/25, documented on 12/11/25 at 06:30 AM, CNA M wheeled R6 to the nurse's station. R6 stated repeatedly she hurt and was in pain. CNA M said, Well, I don't know what to do for you. We are all in pain. LN G's witness statement lacked evidence LN G reported the incident to the administration.The Facility Incident Report, dated 12/17/25, documented an alleged (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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(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 - Actual harm Residents Affected - Few	cycle of abuse by CNA M. The initial incident occurred on 12/11/25 when CNA M and CNA N assisted residents up for breakfast. CNA M and CNA N were changing R1 when CNA M made repeated statements to and about R1 that he smelled. CNA M wheeled R2 to the dining room and yelled at R2. R2 was visibly upset in the dining room and kept repeating, I am not nice. Then CNA M and CNA N went to R3's room, where CNA M ranted and cussed about not being on the med cart. CNA N told CMA R what had happened, and CMA R told CNA N to report it. CMA R reported earlier in the week that she observed CNA M in R4's room. When R4 refused to go to the dining room, CNA M wrapped her arms around R4's shoulders to lift him to the side of the bed. R4 pushed against CNA M, and CNA M continued to try and force R4 to the side of the bed. CNA O stated earlier in the week she and CNA M were getting a resident up for supper, and CNA M was being aggressive and told R5 he was nasty. LN G witnessed CNA M tell R6, who was complaining of pain, I don't know what to do for you. We're all in pain.On 12/22/25 at 11:30 AM, observation revealed R1 sat in a wheelchair, watching other residents in the dining room while waiting for his lunch. R2 sat at an assisted table in the dining room, and people watched. Continued observation revealed R3 sat at a dining room table in his wheelchair, visiting with tablemates. R5 sat in his wheelchair at the assisted table at lunch time and was assisted with eating by staff. R6 sat in a wheelchair at the assisted resident dining room table, and staff assisted R6 to eat.On 12/22/25 at 01:30 PM, R4 laid in bed after lunch and waved his hands in the air.On 12/22/25 at 12:15 PM, CNA N stated she was just so overwhelmed with everything she witnessed from CNA M and trying to get everyone up for breakfast that when she finally got a chance to think, she told CMA R what had happened, and CMA R told her to go and tell the administrator. CNA N stated she was trained on ANE. On 12/22/25 at 12:30 PM, CNA O stated CNA M always seemed aggravated with residents while assisting with cares. CNA O stated she would tell CNA M to stop being rude to residents, but she did not want to start anything with someone she was working with, so she just let it go. CNA O stated R5 heard everything CNA M was saying about him, but he just let them continue to change him and get him ready for supper. CNA O stated she did not think R5 really understood what CNA M was saying.On 12/22/25 at 12:45 PM, CMA R stated when she saw CNA M trying to force R4 up and out of bed against his will, she did not report it because she thought it was an isolated incident. CNA M stated she realized she should have reported it. CMA R stated she was trained on ANE and knew she needed to report any suspected abuse.On 12/22/25 at 01:00 PM, LN G stated she did not suspect abuse at the time of the occurrence, but in retrospect, she should have notified someone CNA M was having a bad day. LN G stated she was trained in ANE and knew who to report suspected abuse to.On 12/22/25 at 01:15 PM, Administrative Nurse D stated she expected the staff to report any suspected incident of physical or verbal abuse to the administration when it occurred. Administrative Nurse D stated the good thing, if there was a good thing, was all of the residents this happened to were not alert and oriented, so even if they heard what CNA M said, they probably did not understand it.The facility's Abuse, Neglect, and Exploitation Policy, revised October 2022, documented the resident has the right to be free from verbal, sexual, physical, and mental abuse and involuntary seclusion. It is the policy of the facility to treat each resident with respect, kindness, dignity, and care, to keep them free from abuse and neglect, and to take swift and immediate action to investigate and adjudicate alleged resident abuse and neglect.The facility identified and implemented immediate corrective actions, which were completed on 12/12/25 and included: All nursing staff re-educated on Abuse, Neglect, and Exploitation Policy, an emergency Quality, Assurance, and Performance Improvement (QAPI) meeting was held with the facility's medical director. An emergency resident council meeting was conducted to discuss abuse and neglect. The local police department was contacted, and a report was filed. SSD will meet with each affected resident (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 0600 Level of Harm - Actual harm Residents Affected - Few	weekly for four weeks to check on any psychosocial impact. Due to the corrective action completed before the onsite survey, the citation was deemed past noncompliant at a G scope and severity to represent R1, R2, R3, R4, R5, and R6's potential psychosocial harm of embarrassment and/or humiliation.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. The facility identified a census of 43 residents, with six residents reviewed for abuse and neglect. Based on record review, observation, and interview, the facility failed to report suspected and observed abuse of Residents (R) 1, R2, R3, R4, R5, and R6 when Certified Nurse's Aide (CNA) M exhibited aggressive behavior toward the residents. Findings included:- CNA N's Unnotarized Witness Statement, dated 12/11/25, documented CNA N and CNA M changed R1 in his room. CNA M looked at R1 and said, Ew, you smell like [expletive]. CNA N stated she tried to change the subject, and CNA M continued to speak about how R1 smelled. CNA M said, R1 smelled like he had a turd in his mouth. CNA M stated R1 probably smelled like that because of the chicken and dumplings he had last night, but R1 ate brown dumplings. CNA N said she did not know they even made brown dumplings. CNA M laughed at CNA N and said, That was sarcasm. I said it because his mouth smells like [expletive], [expletive] dumplings. CNA N stated she later saw CNA M wheel R2 in her wheelchair to eat breakfast, as R2 yelled. CNA M told R2 sternly to Stop it, people are sleeping right now, and you had better quit it. CNA N told Certified Medication Aide (CMA) R everything CNA M said, and CMA R instructed her to report what she had seen and heard. CNA N reported the incidents to administration later in the day.CMA R's Unnotarized Witness Statement, dated 12/11/25, documented sometime before 08:00 AM on 12/11/25, CMA R walked by R1's room and heard someone loudly talking and cussing. CNA N then waved CMA R into R1's room and told CMA R what happened. CMA R stated CNA M brought residents out to breakfast but was snappy and cold towards the residents. CMA R then stated earlier in the week R4 did not want to go to lunch, so CNA M wrapped her arms around R4's shoulders and tried to lift him up to the side of the bed. R4 pushed against CNA M and told her no, he did not want to go. CNA M tried several times to force R4 and manhandle him. CMA R told CNA M that was probably enough, and they could try later. CMA R's witness statement lacked evidence CMA R reported the incident to the administration.CNA O's Unnotarized Witness Statement, dated 12/11/25, documented earlier the same week CNA M and CNA O were getting residents up for supper, and CNA M worked in a rushed manner. She did not finish performing cares for residents, which included brushing hair, wiping hands or faces, and not changing soiled clothing. When the two CNAs got R5 up, CNA M made comments towards R5 about how nasty he was. CNA O stated she found CNA M's behavior unprofessional, hurtful to R5, and uncalled for. CNA O's witness statement lacked evidence CNA O reported the incident to the administration.Licensed Nurse (LN) G's Unnotarized Witness Statement, dated 12/11/25, documented on 12/11/25 at 06:30 AM, CNA M wheeled R6 to the nurse's station. R6 stated repeatedly she hurt and was in pain. CNA M said, Well, I don't know what to do for you. We are all in pain. LN G's witness statement lacked evidence LN G reported the incident to the administration.The Facility Incident Report, dated 12/17/25, documented an alleged cycle of abuse by CNA M. The initial incident occurred on 12/11/25 when CNA M and CNA N assisted residents up for breakfast. CNA M and CNA N were changing R1 when CNA M made repeated statements to and about R1 that he smelled. CNA M wheeled R2 to the dining room and yelled at R2. R2 was visibly upset in the dining room and kept repeating, I am not nice. Then CNA M and CNA N went to R3's room, where CNA M ranted and cussed about not being on the med cart. CNA N told CMA R what had happened, and CMA R told CNA N to report it. CMA R reported earlier in the week that she observed CNA M in R4's room. When R4 refused to go to the dining room, CNA M wrapped her arms around R4's shoulders to lift him to the side of the bed. R4 pushed against CNA M, and CNA M continued to try and force R4 to the side of the bed. CNA O stated earlier in the week she and CNA M were getting a resident up for supper, and CNA M was being aggressive and told R5 he was nasty. LN G witnessed CNA M tell R6, who was complaining of pain, I don't know what to do for you. We're all in pain.On 12/22/25 at 11:30 AM, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observation revealed R1 sat in a wheelchair, watching other residents in the dining room while waiting for his lunch. R2 sat at an assisted table in the dining room, and people watched. Continued observation revealed R3 sat at a dining room table in his wheelchair, visiting with tablemates. R5 sat in his wheelchair at the assisted table at lunch time and was assisted with eating by staff. R6 sat in a wheelchair at the assisted resident dining room table, and staff assisted R6 to eat.On 12/22/25 at 01:30 PM, R4 laid in bed after lunch and waved his hands in the air.On 12/22/25 at 12:15 PM, CNA N stated she was just so overwhelmed with everything she witnessed from CNA M and trying to get everyone up for breakfast that when she finally got a chance to think, she told CMA R what had happened, and CMA R told her to go and tell the administrator. CNA N stated she was trained on ANE. On 12/22/25 at 12:30 PM, CNA O stated CNA M always seemed aggravated with residents while assisting with cares. CNA O stated she would tell CNA M to stop being rude to residents, but she did not want to start anything with someone she was working with, so she just let it go. CNA O stated R5 heard everything CNA M was saying about him, but he just let them continue to change him and get him ready for supper. CNA O stated she did not think R5 really understood what CNA M was saying.On 12/22/25 at 12:45 PM, CMA R stated when she saw CNA M trying to force R4 up and out of bed against his will, she did not report it because she thought it was an isolated incident. CNA M stated she realized she should have reported it. CMA R stated she was trained on ANE and knew she needed to report any suspected abuse.On 12/22/25 at 01:00 PM, LN G stated she did not suspect abuse at the time of the occurrence, but in retrospect, she should have notified someone CNA M was having a bad day. LN G stated she was trained in ANE and knew who to report suspected abuse to.On 12/22/25 at 01:15 PM, Administrative Nurse D stated she expected the staff to report any suspected incident of physical or verbal abuse to the administration when it occurred. Administrative Nurse D stated the good thing, if there was a good thing, was all of the residents this happened to were not alert and oriented, so even if they heard what CNA M said, they probably did not understand it.The facility's Abuse, Neglect, and Exploitation Policy, revised October 2022, documented the resident has the right to be free from verbal, sexual, physical, and mental abuse and involuntary seclusion. It is the policy of the facility to treat each resident with respect, kindness, dignity, and care, to keep them free from abuse and neglect, and to take swift and immediate action to investigate and adjudicate alleged resident abuse and neglect.The facility identified and implemented immediate corrective actions, which were completed on 12/12/25 and included: All nursing staff re-educated on Abuse, Neglect, and Exploitation Policy, an emergency Quality, Assurance, and Performance Improvement (QAPI) meeting was held with the facility's medical director. An emergency resident council meeting was conducted to discuss abuse and neglect. The local police department was contacted, and a report was filed. SSD will meet with each affected resident weekly for four weeks to check on any psychosocial impact. Due to the corrective actions completed before the onsite survey, the citation was deemed past noncompliance at an F scope and severity to represent R1, R2, R3, R4, R5, and R6's potential psychological harm of embarrassment and/or humiliation.