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	05/20/2026

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 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** The facility failed to provide Resident (R) 1, who was a known wanderer, adequate supervision to prevent R1 from wandering down three long hallways and being pushed four to five feet in the air by another resident, R2, which resulted in an injury fall. R1 sustained a left femoral neck fracture (a serious type of hip fracture, a break in the upper part of the thigh bone just below the ball of the hip joint). Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), panic disorder, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia with behavioral disturbance (a progressive mental disorder characterized by failing memory and confusion), and fracture of the head of the left femur (thigh bone). R1's Quarterly Minimum Data Set, dated 01/12/26, documented R1 had a Brief Interview for Mental Status score of four, which indicated severely impaired cognition. The MDS documented R1 had physical behaviors directed towards others, verbal behaviors directed towards others, and wandering behaviors one to three days during the look-back period. The MDS documented R1 did not have any falls during the look-back period. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 10/24/25, documented R1's cognition was a challenge. R1 required staff to make safe decisions for him daily. Staff directed to anticipate R1's needs and wants. R1 had communication challenges related to his dementia. The Fall CAA, dated 10/24/26, documented R1 had one fall during the look-back period when R1 stumbled over another resident's wheelchair pedals, and the intervention was for staff to monitor R1 when he was wandering. The Behavioral CAA, dated 10/24/25, documented R1 had behaviors documented during the look-back period of rejection of care and wandering. The Care Plan, initiated 11/12/24, documented R1 may wander or attempt to leave the building. The care plan directed staff to ask R1 why he was wandering, ask if R1 needed anything, and redirect R1. The care plan directed staff to ensure that R1's room was close to a busy staff-oversight location in the building (11/19/24). The care plan documented R1 was at risk for falls and directed staff to monitor R1 when he wandered, as he did not have safety awareness and needed cueing and frequent reminders due to his dementia diagnosis (10/18/25). The Fall Risk Assessment, dated 01/12/26, documented R1 was a high fall risk. The Behavior Note, dated 04/01/26, documented R1 was exit-seeking this morning. R1 was aggressive with staff. R1 stated I can do whatever I want to do. I just want to do my time and get out of here. The Fall Note, dated 04/08/26 at 06:29 AM, documented a Certified Nurse's Aide (CNA) M notified Licensed Nurse (LN) G at approximately 09:15 PM, R1 had fallen on the 100 hall. When LN G arrived, she found R1 lying supine (on his back) with his knees bent and a folded blanket under his head. The Emergency Medical Services (EMS) arrived at 09:20 PM. EMS left the facility at 09:26 PM. LN G notified Administrative Nurse D, R1's family, and R1's primary care physician of the situation and called report to the hospital. LN G learned while caring for R1, R3 had witnessed R1's fall. R3 stated R1 had been touching items on R2's door. R2 came out of room [ROOM NUMBER] and shoved R1 to the floor. R3 reported to LN G she had not pushed R1 down. R3's husband, R4, was in room [ROOM NUMBER] on the computer, heard the commotion, R3 re-entered (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
	175522	A. Building B. Wing	05/20/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	room [ROOM NUMBER], and told R4 she had indeed pushed R1 down. R1 was scared and shaken and stated, She pushed and I fell. R1 had three skin tears on his left elbow. When R1's hips and legs were assessed, R1 complained of left leg and hip pain when he tried to move it. The Hospital Radiology Report, dated 04/08/26, documented R1 had sustained a comminuted (a fracture where a bone shatters into three or more pieces) transverse transcervical fracture (a break that runs horizontally across the middle, narrower portion of the femoral neck) with mild impaction (the broken ends are mildly driven into each other) and superior displacement (when the ball of the thigh bone shifts out of the hip socket) and moderate apex angulation and external rotation (when the bone has tilted and twisted out of its normal anatomical alignment). LN G's Notarized Witness Statement, dated 04/08/26, documented CNA M notified LN G at approximately 09:15 PM, R1 had fallen on the 100 hall. When LN G arrived, she observed R1 lying supine with his knees bent and a folded blanket under his head. R1 was scared and shaken. LN G asked R1 what had happened, and R1 stated, She pushed, and I fell to the floor. LN G assessed R1 and found no swelling to the back or sides of R1's head. R1 had three skin tears on his left elbow. LN G applied two Steri-strips (adhesive wound closures) to one of the skin tears. LN G assessed R1's range of motion, and R1 complained of left leg and hip pain when he tried to move it. LN G called LN H to assist. EMS came and took R1 to the hospital for further evaluation and treatment. During the care of R1, LN G learned R2 saw the fall. R2 told LN G R1 had touched items on R3 and R4's door, when R3 came out of their room and shoved R1 to the floor. LN G went to talk to R3, and R3 stated she did not push him. R4 then reported when he had been at his computer, R3 came into the room and told him she pushed him. CNA M's Notarized Witness Statement, dated 04/07/26, documented CNA M had been at the nurse's station up front when R2 walked towards her and waved her down the hall. CNA M walked towards R2 and then saw R1 lying on the ground at the end of 100 hall. CNA M ran to R1 and saw R1 on his left side. R1 was panicked. R2 said she witnessed R3 push R1, and he landed on the floor. On 05/20/26 at 10:30 AM, observation revealed R1 in his room and paced in a small triangle while a CNA tried to encourage him to go to the bathroom. Two other CNAs entered the room to assist. On 05/20/26 at 12:30 PM, Administrative Nurse D stated she did not know if there was anything the facility could have done to prevent the accident from happening besides making sure wheelchairs were not in the hall for R1 to stop and check out. Administrative Nurse D stated R1 ambulated all over the facility because he was one of those people who could not sit still. Administrative Nurse D stated when she watched the film of the accident, R1 had stopped in the hallway and was looking over R4's wheelchair that sat in the hall. R3 came out of her room, and Administrative Nurse D stated she could see R3 talking to R1. R1 turned to walk away when R3 shoved R1 four to five feet off the floor, and R1 landed in the hall. Administrative Nurse D stated R3 refused to admit she had pushed R1 and then finally did admit she had done it. Administrative Nurse D stated the police had waited to press charges against R3 to see if R1 made it through his surgery. On 05/20/26 at 01:30 PM, Administrative Staff A stated he did not know what the community could have done to prevent R1 from falling and breaking his hip. The facility's Fall Management policy, revised December 2017, documented the facility strives to minimize the risk for resident falls and to reduce injuries associated with resident falls. Residents are to be assessed in the first four hours of admission using a standardized fall risk assessment to identify individualized resident risk factors. Residents are to be reevaluated quarterly, with each fall and with any significant change. The facility interdisciplinary team is to review resident falls on a routine basis during Daily Clinical Excellence. The Director of Nursing or designee is responsible for reviewing falls on a routine basis to attempt to define the possible causes of the falls. Fall occurrences are to be documented in the clinical record, including environmental, situational, or psychological and situational factors, location, time found, position, adaptive equipment, actions taken, and new intervention implemented. The resident's plan of care is to be reviewed and revised with each fall occurrence and new interventions implemented. The facility completed corrective actions by 04/08/26, prior to the onsite survey. These actions included education with staff regarding keeping wheelchairs out of the halls, abuse, neglect, and exploitation, and behavioral management.