

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Medicalodges Great Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, record review, and interview, the facility failed to ensure there was sufficient nursing staff to the facility failed to ensure there was a sufficient number of staff as outlined in the Facility Assessment, when the full-time Director of Nursing (DON) also served as the facility's required part-time Infection Preventionist as well performing Minimum Data Set (MDS) duties. Findings included:- The Facility Assessment Tool, last updated on 12/02/2025, documented the facility was licensed to provide care for 51 residents. The current census was 46. The Assessment Tool's staffing plan documented staffing was based on the resident population and their needs for care and support and the general approach to staffing to meet the needs of the residents. The assessment tool documented the facility would have the following Administrative Nursing Staff: one DON, one Assistant Director of Nursing, and one MDS registered nurse. On 07/15/2026 at 10:15 AM, Administrative Nurse D stated for the past six or seven months she has been doing the job of the DON, assistant director of nursing (ADON), and MDS duties as well as being the facility's Infection Preventionist. Administrative Nurse D stated since the beginning of the year, the facility has gone through a lot of staff turnover, including administration, so it had been hard to always keep up with things. Administrative Nurse D stated the facility had hired a MDS person who started last week and had just hired an ADON this week so she should be able to focus more on her DON duties. The facility's Facility Assessment policy dated August 2024 documented the facility's intent was to evaluate the facility resident population and identify the resources needed to provide the necessary person-centered care and services the residents require during both day-to-day operations (including nights and weekends) and emergencies. The assessment tool was organized with three areas including: Resident profile including numbers, diseases/conditions, physical and cognitive disabilities, acuity, and ethnic/cultural/religious factors that impact care; Services and care offered based on resident needs (includes types of care the resident population needs using evidence-based, data driven methods which consider types of diseases, conditions, physical and behavioral needs, cognitive disabilities, overall acuity consistent with resident assessments; Facility resources needed to provide competent care for residents, including facility staff, staffing plan, emergency and contingency staffing plan, staff training/education and competencies, policies and procedures for provision of care, medical providers, physical environment and building needs, and other resources, including agreements with third parties, health information technology resources and systems, a facility-based and community-based risk assessment, and other resources.		

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: 175522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Medicalodges Great Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review, and interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment. Findings included:- On 07/13/2026 at 09:00 AM, observation revealed the following issues with the facility hallway carpet:1. Three pink stains in the carpet (one approximately 3 inches(in) by 4 inches, one approximately 4 by 4 in, and one approximately 3 in x 6 in) located by the entrance to the 100 halls.2. Numerous different-sized grayish stains in the carpet located by the entrance to the facility, where the 100 and 200 halls meet.3. Numerous white stains in front of the oxygen storage room located by the conference room.4. Numerous different-sized grey and pink stains throughout the 100, 200, 300, and 400 halls.5. Six, approximately 18 inches (in) by 18 in carpet squares, had numerous different-sized frayed carpets located by the 300-400 nurse's station. One of the carpet squares had a missing piece of carpet in the left-hand corner, approximately 3 in by 4 in. On 07/14/2026 at 08:53 AM, Administrative Staff verified the above findings and agreed that the above areas needed new carpet. She stated it was on her list of tasks to complete, but she had not contacted carpet installation businesses to get a bid on replacing the carpet yet. Upon request, the facility did not provide a policy regarding the environment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Medicalodges Great Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews and record review, the facility failed to conduct a criminal background check as required for one facility employee. The employee was allowed access to residents without knowing if they had been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law., or mistreatment. Findings included:- On 07/13/2026 at 02:30 PM, a review of staffing for background checks was completed for facility Staff. Upon request and review, the facility was unable to provide evidence that a criminal background check had been completed for Social Service Staff X, who had worked at the facility since 01/10/2022. On 07/13/2026 at 03:00 PM, Administrative Staff A stated the business manager would obtain criminal background/record checks on all employees prior to the employee working at the facility. Administrative Staff A verified she could not find a criminal record check for Social Service Staff X, and the business office manager who was at the facility when she was initially hired no longer worked at the facility. The facility's Background Screening Investigation dated October 2022 documented all new employees would be investigated prior to employment for a previous history of abuse, neglect, or exploitation. The appropriate certification and/or licensing agencies would be contacted for the current status of the employee's license or certification for employment. The person making the calls would document registry verification, and the written response would be maintained in the employee's personnel file/verification of work eligibility notebook. All non-licensed employees shall have a criminal background check as required by law and may be periodically checked. Results of background checks would be maintained in the employee's personnel file. All employees are hired on a probationary basis pending the result of their background check. Any employees who have passed their probationary status and who have a negative background check (when such are periodically checked) shall be subject to termination.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Medicalodges Great Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to discard expired stock medication from the 300 and 400 Hall medication cart. Findings included:- On 07/13/2026 at 08:30 AM, observation of the 300 and 400 Hall medication cart revealed the following:Famotidine (acid reducer) 10 milligrams (mg), 60 count, expiration 4/2026. On 07/13/26 at 08:35 AM, Certified Medication Aide (CMA) R verified the medication was expired, and the medication aides or nurses were to discard expired medications. On 07/13/26 at 2:45 PM, Administrative Nurse D verified the pharmacy consultant would check the medication carts monthly and verified the medication aides or nurses were to check the medication cart and discard expired medications. The facility's Storage of Medication policy, dated 01/2024, documented medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Outdated, contaminated, discontinued, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and recorded from the pharmacy, if a current order exists. Medication storage conditions are monitored on a regular basis as a random quality assurance (QA) check. As problems are identified, recommendations are made for corrective action to be taken.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Medicalodges Great Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review, and interview, the facility failed to provide accommodation of needs for Resident (R) 35 when staff failed to promptly provide him with access to local channels, which he paid for. Findings included:- On 07/13/2026 at 11:05 AM, observation revealed that when R35 used the TV remote to change the channel on his TV to local stations, the channels were glitchy (the screen or sound was acting strangely, often showing as flickering, weird lines, frozen pictures, or strange colors), and he was unable to determine what the program was on each channel. R35 stated he had reported the problem with the local channels to maintenance supervisor (MS) U, but nothing had been done to fix it. R35 stated he paid for the stations and was not happy that he was not receiving them. On 07/14/2026 at 08:53 AM, Administrative Staff A stated she was unaware R35 had an issue with his TV programming. Administrative Staff A stated she knew the cable company had been out the previous day to repair the cable TV in the dining room. On 07/14/2026 at 09:11 AM, MS U stated R35 had reported to him approximately two weeks ago the issue with his TV. MS U stated he called the cable company last week regarding the issue with R35's TV and the dining room TV. The cable company staff came to the facility yesterday and fixed the dining room TV and reported to him that they could only repair the cable for residential clients. MS U stated the cable company staff reported that MS U would have to rewire the cable to the toner, and he planned on starting the next day because it would take approximately eight hours to complete it. The facility's Your Rights and Protections as a Nursing Home Resident Policy, revised 04/2025, documented that residents had the right to make a complaint to the staff of the nursing home, or any other person, without fear of punishment. The nursing home must address the issue promptly.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Medicalodges Great Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a 14-day stop date or a specified duration with rationale for Resident (R)1's ongoing as needed (PRN) antianxiety (class of medications that calm and relax people) medications. Findings included:- R1's Electronic Health Record (EHR) revealed diagnoses of epilepsy (brain disorder characterized by repeated seizures), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, irrational fear), and hypertension (HTN-elevated blood pressure). R1's Quarterly Minimum Data Set (MDS) dated [DATE] recorded R1 had moderately impaired cognition. The MDS recorded that he was independent with bed mobility and transfers. The MDS documented R1 received an antianxiety medication during the observation period. R1's Activities of Daily Living (ADL) Care Plan, dated 01/30/2026, recorded R3 was mostly independent with ADL cares, and required additional assistance during times of acute illness and following seizures. R1's Medication Use Care Plan dated 01/30/2026, documented the resident received Ativan (antianxiety medication) when he was having a seizure that lasted for more than 15 minutes. The care plan documented R1's Ativan, which was a Black Box Medication with a warning for increased side effects, adverse reactions, and staff would report concerns and changes to the nurse immediately. The care plan documented by the pharmacy consultant would review R1's medications monthly. R1's Physician's Order, dated 06/20/2026, directed staff to administer Ativan 0.5 milligrams (mg) every six hours as needed for seizure activity lasting 1-2 minutes related to convulsions. The order lacked a stop date. R1's EMR lacked evidence of a specified duration, which included a physician's rationale for the extended use of the PRN Ativan. On 07/13/2026 at 12:15 PM, observation revealed R1 sat at the dining room table dressed in street clothes. He had a hard protective cap on his head and ate lunch independently. On 07/13/2026 at 03:00 PM, Administrative Nurse D verified the resident received Ativan PRN, with a physician order date of 06/20/2026. Administrative Nurse D verified the facility had not obtained the 14 day stop date or a reason for the continued use with the appropriate rationale with a definitive stop date. The Behavioral Management and Psychotropic Medications, policy dated April 2025, documented the facility would enhance the quality of life through behavioral interventions, minimize psychotropic medication use and off-label use of medication prescribed that affect brain activity and monitoring for adverse effects. The resident would be assessed for appropriate diagnosis, utilization, adverse effects, and target behaviors related to the psychotropic medication use and off-label use of medications prescribed that affect brain activity. Psychotropic medications and off-label use of medications prescribed that affect brain activity are not to be initiated or increased without prior communication and documentation of informed consent, including the physician, resident or responsible party, and the facility interdisciplinary team. Off-label and as needed (PRN) use of psychotropic medications and off-label use of medications prescribed that affect brain activity are to be discouraged for elderly residents with dementia. Physician orders to automatically reduce and discontinue an existing or newly initiated antipsychotic medication and off-label use of that medication that affect brain activity are to be considered at the time of the order received.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Medicalodges Great Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure nursing staff followed appropriate infection control procedures related to disposal of soiled personal protective equipment, hand hygiene, and catheter care. Findings included:- On 07/14/2026 10:00 AM, Resident (R) 9 sat in a wheelchair in his room. Certified Nurse Aide (CNA) N and CNA O donned (put on) a gown, applied gloves, and entered R9's room with a Hoyer (total body mechanical lift) lift and asked R9 if he wanted to be transferred to the bed or chair, and R9 replied, his bed. CNA N and CNA O hooked the lift jacket to the machine and raised the lift over R9's bed and slowly lowered him to the bed. R9 voiced that he would like to be on his left side. Both assisted him in positioning on his left side. CNA O removed and discarded his gloves in the bathroom trash can. CNA N removed her gloves and gown, wadded them up in her right hand, and left the room. CNA N walked down the hall to the dirty utility room and then discarded the gown and gloves. On 07/14/2026 at 02:30 PM, R5 rested in bed with eyes open, playing a handheld game. CNA O donned a gown, applied gloves, and gathered a graduated cylinder from R5's bathroom, then asked R5 if he could empty his urinary catheter (tube placed in the bladder to drain urine into a collection bag). CNA O placed the graduated cylinder directly on the floor (no barrier was placed on the floor) below the urinary catheter on R5's bed, unlatched the port from the bag, opened the port, then let the urine flow into the graduated cylinder (without sanitizing the port). When the urine stopped flowing into the graduated cylinder from the catheter bag, CNA O closed the port and hooked the port back on the catheter bag (without sanitizing it). On 07/14/2026 at 10:05 AM, CNA N stated that she should have discarded the gown and gloves in R9's room and not carried them out of the room and down the hallway to the dirty utility room. On 07/14/2026 at 02:35 PM, CNA O stated that he had not placed a barrier on the floor under the graduated cylinder or used anything to sanitize the port of the catheter bag before he closed it and placed it back on the bag. CNA O stated sometimes he would sanitize the port or place a barrier on the floor. On 07/15/2026 at 10:15 AM, Administrative Nurse D, the facility's Infection Preventionist, stated that she would expect nursing staff to remove gloves and gowns in a resident's room and discard them in the trash in the resident's room. Administrative Nurse D stated it was infection standard of care to place a barrier down on the floor while emptying a catheter bag, so the graduated cylinder or the catheter bag did not contact the floor. Administrative Nurse D stated she has tried to keep her staff educated on proper EBP and catheter care, but she would review things with her staff again. Administrative Nurse D stated the facility followed CDC guidelines regarding EBP and standard precautions for catheter care.		