

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER Arma Operator, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 605 E Melvin Street Arma, KS 66712	
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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop an individualized activity plan for Resident (R) 25. Findings included:- R25's Electronic Medical Record (EMR) documented a diagnosis of severe intellectual disabilities (a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life). R25's Annual Minimum Data Set (MDS), dated [DATE], documented the staff interviewed R25 and documented she had severe cognitive impairment. The MDS documented it was very important for her to listen to the music she liked, go outside when the weather was nice, and somewhat important to participate in religious activities. The MDS documented R25 was dependent on staff for all activities of daily living (ADL). R25's Activity Care Area Assessment (CAA), dated 08/10/2025, was not triggered. R25's Quarterly MDS, dated [DATE], documented that she had severe cognitive impairment. The MDS documented that she was dependent on staff for all ADLs. R25's Care Plan, revised 06/10/2025, documented that she was dependent on staff for activities, cognitive stimulation, and social interaction due to her cognitive deficits. R25's Recreation Assessment, dated 08/01/2025, documented she preferred to participate in activities once weekly in her room. R25's EMR, from 06/28/26 through 07/26/2026 (30 days), lacked documentation of any activities offered or participated in. Observed on 07/27/2026 at 09:20 AM, R25 sat in her wheelchair in the TV commons area with her eyes open. The TV was turned off, and there was no visual or audible stimulation provided for R25. Observed on 07/27/2026 at 01:44 PM, R25 sat in her wheelchair in the TV commons area with her eyes open. The TV was turned on, and R25 sat with her back towards it. On 07/27/2026 at 02:05 PM, Certified Nurse Aide (CNA) M stated she had not seen anyone do activities with R25 in her room. CNA M stated R25 would go to Bingo at times but was unable to participate in the activity and would usually fall asleep. On 07/28/2026 at 09:08 AM, Activity Staff Z stated she had not done any in-room activities with R25. Activity Staff Z stated R25 should have had one-to-one (1:1) activities due to her cognitive impairment, but those had not taken place. On 07/28/2026 at 09:29 AM, Licensed Nurse (LN) H stated R25 had not received any 1:1 activity in her room. On 07/28/2026 at 03:00 PM, Administrative Staff A stated it was the expectation for dependent residents to have 1:1 activity when they were unable to participate in other activities. The facility policy for Activities and Social Events, approved 10/2025, included: activities, social events, and schedules are developed in conjunction with the residents' interests, assessment, and plan of care.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 175353	Facility ID: 175353
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure Resident (R)1 remained free from unnecessary medications when staff failed to monitor R1's consumption and accurately record the total amount of potassium received by R1. Findings included:- R1's Electronic Medical Record (EMR) documented a diagnosis of hypokalemia (low level of potassium in the blood). R1's EMR included the following physician's order: Potassium liquid 20 milliequivalents/15 milliliters, by mouth, three times a day, for a diagnosis of hypokalemia, ordered 07/15/2026. R1's Medication Administration Record (MAR) for July 2026 documented the medication was held eight times and refused one time by R1, since the facility received the order on 07/15/26. R1's EMR lacked documentation that he did not receive the full dose of the potassium liquid for the times when staff provided him the diluted medication. On 07/27/2026 at 01:51 PM, Certified Medication Aide (CMA) R stated the liquid potassium was to be diluted before staff could administer the medication. CMA R stated she diluted the medication in R1's house shake every morning. However, R1 did not always consume all of the house shake, so she was unable to document that R1 had received the medication. CMA R stated she would document the medication was either held or refused. CMA R stated she notified the nurse on duty when R1 did not consume the full dose of potassium. On 07/27/2026 at 02:01 PM, Licensed Nurse (LN) G stated she was unaware of R1 not receiving the full dose of the potassium medication. On 07/28/2026 at 09:31 AM, LN H stated she was unaware of R1 not receiving the full dose of the potassium medication. On 07/28/2026 at 03:00 PM, Administrative Nurse E stated it was the expectation for staff to administer residents' medications, as ordered. When a resident did not receive the ordered dose of a medication, the resident's physician should be notified. The facility policy for Refusal of Treatment, approved 10/2025, included: Documentation pertaining to a resident's refusal of a medication must include the date and time of refusal, the medication refused, and the date and time the physician was notified by the facility staff of the resident's refusal.		

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to electronically submit complete and accurate staffing information to the federal regulatory agency through Payroll-Based Journaling (PBJ) when the facility failed to accurately submit hourly staffing data for all nursing personnel. Findings included:- Review of the PBJ Staffing Data Report for the following time frames revealed Excessively Low Weekend Staffing.Fiscal Year (FY) for:Quarter (Q) 4 of FY 2025 for the timeframe of July 01, 2025, through September 31, 2025.Q1 of FY 2026 for the time frame of October 1, 2025, through December 31, 2026.Q2 of FY 2026 for the time frame of January 1, 2026, through March 31, 2026. Review of the Nursing Schedule and Payroll Data Sheets for the above dates lacked indicators of discernibly excessively low weekend staff as compared to the weekday (Monday through Friday) direct care staffing. On 07/28/2026 at 10:47 AM, Administrative Staff A reported the corporate office made changes to the PBJ report for coding the administrative nurses' hours for providing direct care to the residents when working the weekends. The facility staff at the weekends at the same levels on the weekends as during the weekday. The PBJ reports are submitted by the corporate accounting department. Administrative Staff A stated the facility ran the same staff level on the weekends as throughout the week. The facility's Payroll Based Journal Policy policy, dated 2026, documented that the community will submit payroll data in a uniform format to Centers for Medicare and Medicaid (CMS), including staffing information for community, agency, and contract staff. Direct Care staff are defined as those individuals who have direct interpersonal contact with residents or residents. facility submits the data electronically based upon specifications determined by CMS, which indicate the category of work for each person on direct care staff (including but not limited to whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS.		

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F 0921 Level of Harm - Potential for minimal harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, record review, and interview, the facility failed to provide housekeeping and maintenance services to ensure a safe and sanitary environment in the facility laundry. Findings included: - On 07/28/2026 at 08:19 AM, laundry tour with Housekeeping/Laundry staff U revealed the following items in need of repair in the laundry: The ceiling had an approximate 18-inch by 18-inch unsealed/unfinished sheetrock patch with an approximate one foot by two-inch linear brown section surrounded with approximate four inch unfinished spackling compound. The laundry exit door had a missing door facing/jam surrounding the three sides of the door, exposing irregular, unfinished bare sheetrock through which laundry staff passed to transport laundry. On 07/28/2026 at 08:19 AM, Housekeeping/Laundry Staff U confirmed the above findings and stated the facility maintenance man should be responsible for the repairs in the laundry to ensure a safe, sanitary environment. She indicated the unfinished laundry ceiling repair was initiated to repair damage due to a leak in the roof. The roof was replaced to correct the leak a while ago, but the overhead repair was not completed. On 07/28/2026 at 10:37 AM, Maintenance Staff V verified the above findings and reported he was replacing door frames throughout the facility. Additionally, he was not aware of the need for repair of the ceiling in the laundry area. The facility policy titled Handling of Clean Linen and Linen Distribution, dated 2026, lacked documentation of the repair and maintenance in the laundry area.		