| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175379 | A. Building<br>B. Wing | 08/26/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mennonite Friendship Communities Inc | 600 W Blanchard Avenue<br>South Hutchinson, KS 67505 |

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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>(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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 68 residents. The sample included six residents with one resident reviewed for involuntary discharge. Based on interviews and record review, the facility failed to ensure the involuntary discharge notice issued to Resident (R)1 or their representative contained a statement of appeal rights, the location to which the resident would be discharged and the contact information for the required state agencies (SA). The facility additionally failed to ensure the reason for the involuntary discharge was documented in the resident's medical record. This placed the resident at risk for impaired rights and inappropriate discharge. Findings included:- R1's Electronic Health Record (EHR) documented diagnoses that included respiratory failure (severely impaired lung function) with hypoxia (inadequate supply of oxygen), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), weakness, and a need for assistance with personal careR1's Discharge - Return Not Anticipated Minimum Data Set (MDS) dated [DATE] documented R1 had a planned discharge from the facility to another long-term care facility on 06/27/25.R1's EHR under the Physician Orders did not contain an order to discharge from the facility.R1's EHR Resident Documents contained a scanned order, dated 06/26/25, to discharge R1 to a different long-term care facility on 06/27/25, signed by the provider on 06/25/25.Review of an untitled document dated 05/22/25, provided by Administrative Nurse D on 08/26/25 at 11:18 AM, revealed a letter sent to R1's representative, which informed R1's representative of a pending discharge on [DATE] for non-payment of services. The letter informed R1's representative she would need to find alternative living arrangements for R1 before 07/21/25 and offered assistance from facility staff. The letter contained contact information for the long-term care ombudsman (LTCO- an official appointed to investigate an individual's complaints). The letter contained a list of long-term care facilities in the area with telephone numbers. The letter did not contain the location to which R1 would be discharged , a statement of appeal rights (including name, address, and telephone number of the entity which receives such requests), nor information on how to initiate and/or submit an appeal or contact information for the SA. The letter was signed by Administrative Staff A.During an interview on 08/26/25 at 11:58 AM, Administrative Nurse D confirmed R1 was discharged for non-payment of services and provided supporting documentation that indicated R1 had been denied Medicaid services due to failure to submit required paperworkAdministrative Staff A was unavailable for interview on 08/26/25.The facility's Resident Rights policy, dated 01/30/12, did not address the discharge process.The facility's Admission, Transfer, and Discharge Policy policy, dated 11/2024, documented the facility would follow the regulations and policies regarding appropriate notification of discharge, including the right to appeal. If the facility staff mandated a transfer or discharge from the facility, documentation would be made in the clinical record (EHR) of the reason(s) for and conditions under which the transfer/discharge was mandated. This would include methods for transitioning care and responsibility from one clinician, organization, program, or service to another. The policy did not address providing a written discharge summary, recapitulation of stay, or medication reconciliation to the resident or the resident's representative. |

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|---|---|
| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>(continued on next page) |

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|---|---|
| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 68 residents. The sample included six residents with one resident reviewed for involuntary discharge. Based on interviews and record review, the facility failed to provide a written discharge summary, recapitulation of the stay or reconciliation of medications for Resident (R) 1 who discharged . This placed the resident at risk for impaired rights related to continuity of care and missed community healthcare services. Findings included:- R1's Electronic Health Record (EHR) documented diagnoses that included respiratory failure (severely impaired lung function) with hypoxia (inadequate supply of oxygen), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), weakness, and a need for assistance with personal careR1's Discharge - Return Not Anticipated Minimum Data Set (MDS) dated [DATE] documented R1 had a planned discharge from the facility to another long-term care facility on 06/27/25.R1's EHR under the Physician Orders did not contain an order to discharge from the facility.R1's EHR Resident Documents contained a scanned order, dated 06/26/25, to discharge R1 to a different long-term care facility on 06/27/25, signed by the provider on 06/25/25.R1's EHR Resident Documents contained a Transfer / Discharge Instructions form dated 06/27/25, documented the resident was discharged to another facility. The form noted attachments included R1's demographic data, most recent diagnostic results, advanced directives (a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves), immunization records, and a copy of the current medication administration record (MAR). The form reviewed ADL (activities of daily living such as walking, grooming, toileting, dressing, and eating) status, recent vital signs, and state agency contact numbers. Page three of the form regarding special care needed, antibiotics, transmission-based precautions and the list of other discharge paperwork was left blank. The form was signed by staff and R1's representative on 06/27/25.R1's EHR Progress Notes documented:On 05/27/25 at 10:04 AM, staff documented R1's provider requested a list of all medications ordered to be faxed prior to discharge.On 05/30/25 at 09:52 AM, staff documented they contacted R1's representative to inform them that R1's physician would not sign discharge orders unless R1 was being discharged to another long-term care facility. Staff documented they provided information to R1's representative about other long-term care facilities.On 06/23/25 at 08:32 AM, staff documented a referral was faxed to another long-term care facility at the request of R1's representative, then called the other long-term care facility to verify receipt of the referral.On 06/24/25 at 02:35 PM, staff documented R1's representative called to notify the facility that another long-term care facility had accepted R1; R1 would discharge on [DATE]. Staff contacted the receiving long-term care facility and verified the receiving facility would pick up R1 on 06/27/25.On 06/26/25 at 10:20 AM, staff documented the provider signed the discharge order on 06/25/25.On 06/27/25 at 11:25 AM, staff documented R1 was discharged to another long-term care facility on 06/27/25 at 11:22 AM, accompanied by staff from the receiving facility and R1's representative. Staff documented R1's EHR, under the Discharge Summary tab, contained documentation of discharge instructions, recapitulation, and education provided to R1 and/or R1's representative.R1's EHR Discharge Summary tab lacked evidence that the facility provided a written discharge summary, recapitulation of the stay, or medication reconciliation to R1 or R1's representative.During an interview on 08/26/25 at 11:18 AM, Administrative Nurse D revealed that prior to any discharge, the social services designee (SSD) would arrange for continuity of care, whether the discharge was to the community or to another facility. Administrative Nurse D said at the time of discharge, the SSD would ensure arrangements were made, and the nurse on duty would review the medications with the resident and/or their representative and perform a reconciliation of medications to clearly communicate when future doses were due. Administrative Nurse D reviewed R1's EHR during the interview and confirmed R1's EHR Discharge Summary tab lacked documentation of a written discharge summary, recapitulation of stay, and medication reconciliation provided to R1 or R1's representative. Additionally, Administrative Nurse D identified the Transfer / Discharge Instructions document in the EHR's Resident Documents as an old form that was formerly used for transfers to the hospital and confirmed it lacked a written discharge summary recapitulation of stay and medication reconciliation. Administrative Nurse D stated at the time of discharge, the Transfer / Discharge Instructions form was the appropriate form to have been used, and the nurse should have documented a discharge summary, recapitulation of stay, and medication reconciliation in the Progress Notes tab of R1's EHR. Administrative Nurse D confirmed R1's Progress Notes did not contain evidence a discharge summary |