STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175379	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNONITE FRIENDSHIP COMMUNITIES INC	600 W BLANCHARD AVENUE , SOUTH HUTCHINSON, Kansas, 67505

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following citations are the result of an abbreviated survey for complaint 2590946, 2590272, and 1559172. The 2567 was sent electronically on 09/08/25.	F0000		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility	F0627		

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 reverse for further 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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F0627 SS = D	Continued from page 1 may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient	F0627		

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F0627 SS = D	Continued from page 2 preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth	F0627		

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F0627 SS = D	Continued from page 3 at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data,	F0627		

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F0627 SS = D	Continued from page 4 data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: 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	F0627		

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F0627 SS = D	Continued from page 5 of oxygen), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), weakness, and a need for assistance with personal care R1's "Discharge – Return Not Anticipated Minimum Data Set" (MDS) dated 06/27/25 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 07/21/25 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 paperwork Administrative 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	F0627		

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F0627 SS = D	Continued from page 6 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.	F0627		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F0628		

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F0628 SS = D	Continued from page 7 (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;	F0628		

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F0628 SS = D	Continued from page 8 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	F0628		

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F0628 SS = D	Continued from page 9 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F0628		

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F0628 SS = D	Continued from page 10 This REQUIREMENT is NOT MET as evidenced by: 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 care R1's "Discharge – Return Not Anticipated Minimum Data Set" (MDS) dated 06/27/25 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.	F0628		

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F0628 SS = D	Continued from page 11 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 06/27/25. 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	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175379	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNONITE FRIENDSHIP COMMUNITIES INC	600 W BLANCHARD AVENUE , SOUTH HUTCHINSON, Kansas, 67505

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F0628 SS = D	Continued from page 12 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, recapitulation of stay, or medication reconciliation was performed. 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 paperwork 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.	F0628		