STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175122	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR GARDENS OF LENEXA	**9701 MONROVIA STREET , LENEXA, Kansas, 66215**

(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 A complaint survey was conducted on 06/08/2026 to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint reference numbers 3025427, 3016471, 3011274, and 3023340 were investigated. The facility census on the day of the survey was 164. The sample size included eight residents. Based on this survey, deficiencies were identified under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably	F0582		

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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F0582 SS = D	Continued from page 1 possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to provide R1’s durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) with the Medicare Liability Notice, CMS 101123- Notice of Medicare Non-Coverage (NOMNC) prior to the last day of skilled coverage on 05/21/2026. Findings included: - R1 admitted to the facility on 04/21/2026 and discharged home to his independent living apartment on 05/22/2026. R1’s Electronic Medical Record (EMR) documented diagnoses of acute kidney failure (inability of the kidneys to excrete waste, concentrate urine, and conserve electrolytes), dementia (a progressive mental disorder characterized by failing memory and confusion), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness).	F0582		

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F0582 SS = D	Continued from page 2 R1's "Admission Minimum Data Set (MDS)" dated 04/24/2026 documented he had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment. The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 04/30/2026 documented R1 had a BIMS score of nine, which indicated moderate cognitive impairment. R1 had a diagnosis of dementia and was able to make his needs known. R1's 04/30/2026 "Care Plan" documented R1 had problems with temporal orientation and short-term memory due to a diagnosis of dementia. The "Care Plan" documented the following interventions: 04/30/2026- Staff always told R1 what they were going to do before they initiated care. 04/30/2026- Staff anticipated R1's needs and helped with them, such as toileting, meals, and grooming. 04/30/2026- R1 needed simple choices to allow him to make decisions with his care, such as clothes to wear, activities to attend, and food choices at meals. 04/30/2026- R1 needed his call light within reach to call for assistance if he remembered. 04/30/2026- Staff provided cueing and prompting for decisions and participation in his care as needed. R1's medical record revealed the following: A "Nursing" note on 04/21/2026 at 02:32 PM, documented R1 admitted around 01:40 PM via facility transportation and R1 required a Hoyer lift. R1's "Notice of Medicare Non-Coverage" documented his skilled services coverage would end on 05/21/2026. R1 and Social Services X signed and dated the notice on 05/19/2026. A "Social Services" note on 05/19/2026 at 03:05 PM, documented the facility issued a NOMNC with a last day of coverage date of 05/21/2026 and an anticipated discharge from skilled rehabilitation on	F0582		

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F0582 SS = D	Continued from page 3 05/22/2026. The facility presented the NOMNC to R1 and he voiced an understanding of the coverage date, discharge date, and his right to appeal. R1 indicated he was not ready to return to his prior living environment because he could not walk. R1 requested the appeal contact to be written in large numbers so he could appeal. R1's medical record lacked evidence that the facility sent R1's DPOA the NOMNC or attempted to call R1's DPOA to discuss the NOMNC and R1's right to appeal. A "Social Services" note on 05/21/2026 at 03:18 PM, documented Social Services X visited R1 to clarify his discharge plan. R1's DPOA had not spoken with IDT since the care plan meeting and she had not returned calls. R1 indicated he did not appeal the NOMNC, and the facility never received a notice of appeal. Social Services X presented R1 with a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) and R1 indicated he did not want skilled rehab services to continue as he did not have resources to continue skilled rehab services out-of-pocket. R1 stated he planned to discharge to his previous living environment and needed assistance with discharge transportation. R1 stated he was open to home health transitional services and he did not have a provider preference. The facility sent a referral to a home health service. R1's DPOA called and discussed R1's discharge plan with Social Services X. R1's DPOA requested referral packets be sent to LTC facilities. Social Services X compiled a referral packet to be sent to appropriate facilities. R1's DPOA spoke with Administrative Staff A, who clarified that R1 was not accepted for in-house long-term care. A "Physical Therapy (PT) PT Discharge Summary" dated 05/21/2026, documented R1 made improvement over the course of treatment but was limited, likely due to lack of R1's full participation in PT sessions. R1's bed mobility improved from total assistance to supervision, and his transfers improved from total assistance to moderate assistance. R1 refused to participate in standing tolerance training or gait training. R1's insurance denied further skilled stay. R1 did not have a discharge plan in place at that time. Therapy documented a discharge home alone for R1 was not recommended.	F0582		

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F0582 SS = D	Continued from page 4 A “Nursing” note on 05/22/2026 at 10:30 AM, documented R1 discharged from the facility at 10:30 AM. The facility sent R1’s personal belongings and his medications with him. On 06/11/2026 at 01:01 PM, R1’s representative stated she was R1’s DPOA and the facility had a care plan meeting a couple weeks prior to his discharge. She stated therapy discussed how R1 was not progressing and that he would need long-term care, to which she agreed. R1’s DPOA stated she visited R1 on 05/21/2026 and he was very upset because the facility told him had to leave because his insurance ran out. She stated she immediately went to the front desk to talk to Social Services X, but she was gone. She stated the facility did not contact her about the NOMNC and R1’s right to appeal and she would have appealed it if she received the NOMNC. R1’s DPOA stated after the care plan meeting, the facility never contacted her about further healthcare decisions except for new orders and results. On 06/08/2026 at 01:31 PM, Social Services X stated she presented a resident with a NOMNC 48-hours prior to discharge from skilled services, and she met with the resident to talk to them about their discharge plan. She stated if a resident had a DPOA in place, she contacted the DPOA. She stated when she presented R1 with the NOMNC, he was concerned about returning to his prior living environment and intended to appeal but did not end up appealing. Social Services X stated R1’s DPOA was not present when she issued the NOMNC, and she did not try to call R1’s DPOA when she issued the NOMNC to R1. She stated she presented R1 with the NOMNC because she could not get ahold of R1’s DPOA previously. She confirmed there was no documentation that noted the facility could not get ahold of R1’s DPOA prior to the note on 05/21/2026. Social Services X stated if a resident had a BIMS score lower than 12 then their DPOA should be contacted. On 06/08/2026 at 02:22 PM, Administrative Staff A stated the Social Services X delivered the NOMNC to the resident and their family. She stated it depended on the resident’s cognition on who received the NOMNC but a lot of times the facility issued it to the resident unless they knew their DPOA was active. The facility did not provide a policy on beneficiary	F0582		

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F0582 SS = D	Continued from page 5 notice.	F0582		
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 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.	F0627		

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F0627 SS = D	Continued from page 6 §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 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-	F0627		

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F0627 SS = D	Continued from page 7 (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 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.	F0627		

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F0627 SS = D	Continued from page 8 (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, 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	F0627		

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F0627 SS = D	Continued from page 9 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: Based on record review and interviews, the facility failed to develop and implement an effective discharge plan in consideration with R1 and his Durable Power of Attorney (DPOA). The facility failed to ensure R1 safely discharged, including notifying his DPOA that he discharged and providing her with post-discharge instructions for R1. Findings included: - R1 admitted to the facility on 04/21/2026 and discharged home to live independently on 05/22/2026. R1's Electronic Medical Record (EMR) documented diagnoses of acute kidney failure (inability of the kidneys to excrete waste, concentrate urine, and conserve electrolytes), dementia (a progressive mental disorder characterized by failing memory and confusion), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). R1's "Admission Minimum Data Set (MDS)" dated 04/24/2026, documented he had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment. R1 was dependent on staff for toileting hygiene, showering, dressing, and transfers. The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 04/30/2026, documented R1 had a BIMS score of nine, which indicated moderate cognitive impairment. R1 had a diagnosis of dementia and was able to make his needs known.	F0627		

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F0627 SS = D	Continued from page 10 The “Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA” dated 04/30/2026, documented needed staff assistance with both mobility and completion of ADLs. R1 was non-ambulatory and required staff assistance with two staff for safe transferring using the Hoyer lift. R1’s goal was to return home, but therapy recommended long-term care at that time. R1’s 04/30/2026 “Care Plan” documented R1 had problems with temporal orientation and short-term memory due to a diagnosis of dementia. The plan documented the following interventions: 04/30/2026- Staff always told R1 what they were going to do before they initiated care. 04/30/2026- Staff anticipated R1’s needs and helped with them, such as toileting, meals, and grooming. 04/30/2026- R1 needed simple choices to allow him to make decisions with his care, such as clothes to wear, activities to attend, and food choices at meals. 04/30/2026- R1 needed his call light within reach to call for assistance if he remembered. 04/30/2026- Staff provided cueing and prompting for decisions and participation in his care as needed. R1’s “Care Plan” did not address his ADL assistance requirements or his discharge goals and plan. R1’s medical record revealed the following: A “Nursing” note on 04/21/2026 at 02:32 PM, documented R1 admitted around 01:40 PM via facility transportation and R1 required a Hoyer lift. A “Nursing” note on 05/04/2026 at 04:04 PM, documented R1 was non-compliant with care and he appeared less motivated to complete ADLs. The nurse updated R1’s DPOA on lab results and new orders. R1’s DPOA expressed concerns with how therapy was going and she was transferred to the therapy department for an update. R1’s DPOA stated she would try to go to the facility the next week to	F0627		

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F0627 SS = D	Continued from page 11 see if R1 wanted to go on hospice or do more therapy and be compliant with cares. R1's medical record lacked documentation of discharge planning from 04/21/2026 to 05/07/2026. A "Care Conference Report" on 05/08/2026, documented the facility held an initial care plan meeting in the social services office. Social Services X, Administrative Nurse D, and Therapy GG present with R1's DPOA on the phone. R1 did not wish to be present for the care plan meeting. Therapy GG gave an update on R1's progress with therapy and stated R1 sometimes participated, but also asked therapy to come back later or stated he did not want therapy that day. R1 was not very motivated, would sometimes get up in his wheelchair, but preferred to stay in bed. R1 was unable to ambulate and required substantial/maximal assistance for mobility and ADLs. Therapy GG indicated that R1's cognition was a barrier. The interdisciplinary team (IDT) indicated to R1's DPOA that R1 may need a higher level of care upon discharge. Administrative Nurse D indicated R1 needed 24-hour care at that time. R1's DPOA stated R1 did not have Medicaid, and he would do what he wanted which was probably go back home. She asked how to get Medicaid for R1 and Social Services X indicated R1 needed to provide R1's DPOA with bank statements. R1's DPOA stated she had not been to visit R1 yet but planned to the following week to have the hard conversation with R1 regarding discharge and the Medicaid application. R1's DPOA stated R1 lived at home alone and handled his own bills. Social Services X asked R1's DPOA to give her a call once she spoke with R1 and let her know what the plan was, so Social Services X could send any referrals needed. R1's DPOA stated she would and indicated she felt overwhelmed because she was all R1 had, and she was busy with work. R1's DPOA stated she would talk to R1 and give Social Services X a call the following week. IDT indicated that it was a good plan, and they would reconvene once they had more information. R1's medical record lacked evidence of follow-up for R1's discharge plans from 05/09/2026 to 05/18/2026. A "Social Services" note on 05/19/2026 at 03:05 PM, documented the facility issued a Notice of Medicare Non-Coverage (NOMNC) with a last day of coverage date of 05/21/2026 and an anticipated	F0627		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0627 SS = D	Continued from page 12 discharge from skilled rehabilitation on 05/22/2026. The facility presented the NOMNC to R1 and he voiced an understanding of the coverage date, discharge date, and his right to appeal. R1 indicated he was not ready to return to his prior living environment because he could not walk. R1 requested the appeal contact to be written in large number so he could appeal. R1's medical record lacked evidence the facility attempted to call R1's DPOA related to his discharge plans from 05/09/2026 to 05/20/2026. A "Social Services" note on 05/21/2026 at 03:18 PM, documented Social Services X visited R1 to clarify his discharge plan. R1's DPOA had not spoken with IDT since the care plan meeting and she had not returned calls. R1 indicated he did not appeal the NOMNC and the facility never received a notice of appeal. Social Services X presented R1 with a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) and R1 indicated he did not want skilled rehab services to continue as he did not have resources to continue skilled rehab services out-of-pocket. R1 stated he planned to discharge to his previous living environment and needed assistance with discharge transportation. R1 stated he was open to home health transitional services and he did not have a provider preference. The facility sent a referral to a home health service. R1's DPOA called and discussed R1's discharge plan with Social Services X. R1's DPOA requested referral packets be sent to LTC facilities. Social Services X compiled referral packet to be sent to appropriate facilities. R1's DPOA spoke with Administrative Staff A who clarified that R1 was not accepted for in-house long-term care. A "Physical Therapy (PT) PT Discharge Summary" dated 05/21/2026, documented R1 made improvement over the course of treatment but was limited, likely due to lack of R1's full participation in PT sessions. R1's bed mobility improved from total assistance to supervision and his transfers improved from total assistance to moderate assistance. R1 refused to participate in standing tolerance training or gait training. R1's insurance denied further skilled stay. R1 did not have a discharge plan in place at that time. Therapy documented a discharge home alone for R1 was not recommended. A "Nursing" note on 05/22/2026 at 10:30 AM,	F0627		

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F0627 SS = D	Continued from page 13 documented R1 discharged from the facility at 10:30 AM. The facility sent R1's personal belongings and his medications with him. On 06/11/2026 at 01:01 PM, R1's representative stated she was R1's DPOA and the facility had a care plan meeting a couple weeks prior to his discharge. She stated therapy discussed how R1 was not progressing and that he would need long-term care to which she agreed. R1's DPOA stated in the care plan meeting, she said she and R1 needed to apply for R1 to get Medicaid, and she asked the facility for referrals. She stated they did not get a discharge plan in place because the facility said she needed to get R1 on Medicaid before they would send referrals. R1's DPOA stated she visited R1 on 05/21/2026 and he was very upset because the facility told him had to leave because his insurance ran out. She stated she immediately went to the front desk to talk to Social Services X, but she was gone. She stated she talked to Administrative Staff A and told her she wanted referrals sent out to places that would accept him as Medicaid pending. She stated the facility did not contact her about the NOMNC and R1's right to appeal because she would have appealed it if she received the NOMNC. R1's DPOA stated after the care plan meeting, the facility never contacted her about further healthcare decisions except for new orders and results. She stated the facility did not start discharge planning with her and R1 when he admitted. She stated the facility discharged him to his former independent living apartment and left him there. The independent living contact called her and told her R1 was at his apartment, and it was not safe. She stated that was how she found out R1 had been discharged from the facility. R1's DPOA stated she called the facility and asked what they did with R1 when they had discussed sending referrals to nursing homes and the facility did not really have an answer as to why they discharged him in that way. She stated the facility never called her to tell her R1 was being discharged that day, nor did they go over any post-discharge instructions with her. On 06/08/2026 at 01:31 PM, Social Services X stated skilled resident discharge planning started on admission and the facility liked to have at least one care plan meeting before the resident discharged. She stated when she presented a resident with a NOMNC 48-hours prior to discharge from skilled and she met with the resident to talk to them about their discharge plan. She stated the resident's care plan documented whether the resident planned to stay in	F0627		

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F0627 SS = D	Continued from page 14 the facility or discharge. She stated when she presented R1 with the NOMNC, he was concerned about returning to his prior living environment and intended to appeal but did not end up appealing. Social Services X stated R1's DPOA indicated his prior living environment was not good and she wanted R1 to go somewhere else. She stated when the facility discussed what R1's options were with R1's DPOA, R1's DPOA had no knowledge about his resources and Social Services X requested she had a conversation with R1 about his resources and what he wanted to do. Social Services X stated she had not tried to call R1's DPOA when she issued the NOMNC to R1. On 06/08/2026 at 01:50 PM, Administrative Nurse D stated when a resident admitted, the facility tried to have a care conference within 48 to 72 hours depending on the situation and family. She stated the care plan had the resident's discharge plan and she tried to get the care plan in as soon as she completed the MDS and whenever something came up. On 06/08/2026 at 02:22 PM, Administrative Staff A stated the facility had a care plan meeting to assess and figure out the resident's goals and review the resident's progress with the family as they went along. She stated the facility tried to prepare the resident as much as possible before they had to issue a NOMNC. Administrative Staff A stated the facility went over the resident's discharge planning as much as they could in the care plan meeting. On 06/08/2026 at 02:29 PM, Administrative Nurse E stated that usually Social Services helped a resident with discharge planning and discharge planning started as soon as a resident admitted to the facility. She stated every resident had a care plan meeting to go over discharge goals and plans and if they felt safe going home. The facility's "Discharge Planning Process" policy, effective November 2017, directed a discharge plan was consistent with the discharge rights and included the following: 1. The discharge needs of each resident were identified and resulted in the development of a discharge plan for each resident. 2. The facility regularly re-evaluated residents to	F0627		

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F0627 SS = D	Continued from page 15 identify changes that required modification of the discharge plan and the facility updated the discharge plan as needed to reflect those changes. 3. The facility involved the IDT in the ongoing process of developing the discharge plan. 4. The facility considered the resident's caregiver/support person's availability and the resident or caregiver/support person's capacity and capability to perform required care, as part of the discharge needs. 5. The facility involved the residents and their representatives in the development of the discharge plan and informed the residents and their representatives of the final plan. 6. The facility addressed the resident's goals of care and treatment preferences. 7. The facility documented that the resident had been asked about their interest in receiving information regarding their return to the community.	F0627		