

Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/13/2026
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, KS 66207		
(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following represents the findings of a resurvey with attached complaint 198394, 198126, and 197870 at the above-named assisted living facility conducted 08/10/26-08/13/26.	S 000		
S3026 SS=J	26-41-101 (f) (1) Staff Treatment of Residents ANE (f)The administrator or operator shall ensure that all of the following requirements are met: (1) No resident shall be subjected to any of the following: (A) Verbal, mental, sexual, or physical abuse, including corporal punishment and involuntary seclusion; (B) neglect; or (C) exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(1)(B) The facility reported a census of 83 residents with five residents included in the sample and one closed record review. Based on observation, interview, and record review, the facility failed to protect cognitively impaired Resident (R) 2 from neglect when he exited the locked memory care unit through the main building lobby, out the front door, to the outside in 39-degree weather without staff knowledge. This placed the R2 in immediate jeopardy. Findings included: - Record review for R2 revealed an admission date of 01/22/26 with the following diagnoses:	S3026		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S3026	Continued From page 1 dementia, glaucoma, heart disease, hearing loss, and orthostatic hypotension. The 01/21/26 admission "Functional Capacity Screen" (FCS) identified R2 as independent with dressing, toileting, transfers, walking/mobility, and eating. He was unable to perform management of medications and treatments; had short and long-term memory, impaired memory recall, and decision-making cognitive difficulties; was understandable and understood others during communication; was at risk for wandering; and had impaired vision, hearing, and decision-making. The 01/21/26 admission "Negotiated Service Agreement" (NSA) also functioned as the facility's Healthcare Service Plan (HSP) and identified facility staff provided management of medications and treatments; direction and reminders for cognitive difficulties, and protection and supervision due to unsafe and inappropriate decisions. The NSA indicated R2 wandered but did not jeopardize the resident's safety and failed to describe services staff provided to prevent elopement from the facility. The 01/21/26 "Saint Louis Mental Status Examination" documented R2 with nine total points out of 30, which indicated severe cognitive impairment/dementia. The 01/16/26 (prior to admission) "Elopement Assessment" signed by Administrative Nurse C documented R2 was at "HIGH" risk for elopement. The "risk category" column indicated high risk interventions were required. The 01/21/26 at 11:33 AM "Pre-Admission Note" for R2 by Administrative Nurse C documented R2	S3026		

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S3026	Continued From page 2 left home to walk and would end up in the middle of a golf course or near multiple restaurants and it was difficult to find him. R2's wife planned to move him into locked memory care unit. The 02/20/26 at 08:41 PM "Nursing Note" documented R2 eloped through the memory care door, staff and law enforcement were searching for him. Administrative Staff A reviewed camera footage from when he left the locked unit at 04:45 PM and then exited through the facility's front door without staff knowledge. R2 was later found at an intersection approximately 2.1 miles away after he had fallen and was taken to a local emergency room. R2's wife returned him to the facility at approximately 08:45 PM. R2 sustained a cut on his head. The facility's intake report to the department documented 02/20/26 at 05:37 PM Administrative Nurse C reported to Administrative Staff A R2 was missing. Staff began searching for him and his two jackets he was known to have shortly before leaving. Administrative Staff A watched R2 on camera exit the memory care unit less than a minute after a food service worker entered. He was found by a passerby about two miles from the facility and reported to law enforcement he was taken to a local hospital. The facility's investigation report to the department documented R2 was taken to the local hospital on 02/20/26 at 06:24 PM. The report included the following witness statements: By Certified Nurse Aide (CNA) I: R2 "came up to me" 02/20/26 at 04:30 PM while helping residents to dining area seats for meal. "As I finished serving everyone, I didn't see" R2 at his seat. CNA I notified other staff he was missing.	S3026		

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S3026	Continued From page 3 By receptionist H: Watched R2 push on the glass in the main lobby and notified him it was not the door on 02/20/26 around 05:00 PM. She noticed he had two jackets and suggested he put one on due to the lower outside temperature, which he did not follow. By Certified Medication Aide (CMA) J: R2 approached CMA J on 02/20/26 at approximately 04:30 PM asking how to get out the door. By CNA K: On 02/20/26 around 04:30 PM R2 left the "zen room" and CNA K notified him it was almost time for dinner. He refused to sit at the dining table and voiced desire to go to the door. She told him the door was locked. The weather on 02/20/26 at approximately 04:53 PM according to Wunderground.com was 39 degrees Fahrenheit with a wind speed of six miles per hour (MPH). There was sunlight until 06:01 PM. Observation on 08/10/26 at 05:00 PM revealed the dining table was approximately 25 steps from the memory care front door. The front door in the main lobby was another 75 steps from the memory care door. The west side of the building was at the bottom of a steep slope from a four-lane 35 MPH road. Approximately 1,000 feet east of the facility front door is a large body of water with a walking trail. Further observation revealed all possible routes from facility front door to location R2 was found included four-lane 30-40 MPH roads to walk beside and at multiple times, heavily traveled main roads to cross. Not all crossings in the area included stop lights. All roads are in an urban area with traffic at all times of the day and night.	S3026		

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S3026	Continued From page 4 Observation on 08/11/26 at approximately 09:04 AM revealed the memory care door did not latch with one single click. The door was secured after a second audible click. The door had a sign posted on the assisted living side of the door to notify staff and visitors to close the door completely but failed to include a sign on the memory care side. The sign did not indicate a second click was required to ensure it was fully latched. On 08/11/26 at 09:18 AM receptionist G stated she knew if a resident was not to leave the building when the wanderguard alarm sounded on the staff pagers and the doors locked. On 08/11/26 at 09:35 AM Administrative Staff A stated residents in the memory care unit had no need for use of wanderguard because there was a locked door and staff at the front desk knew residents who should not leave on their own. She confirmed R2 still wandered and exit sought at times. On 08/11/26 at 11:25 AM R2 stated he had been outside all morning walking around with a friend and he was able to leave at any time with or without anyone else. He could not recall what he ate for breakfast and stated he did not go outside to walk around in the wintertime. The facility's "Wander Management System" policy revised 07/2024 instructed the facility nurse to recommend a wander management bracelet to promote safety if resident was identified at risk of elopement. The intervention was to be documented in the residents medical record. The facility failed to protect cognitively impaired	S3026		

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S3026	Continued From page 5 R2 from neglect when he exited the locked memory care unit, through the main building lobby, out the front door without staff knowledge and was missing for 99 minutes, sustained a fall, and required physician assessment and treatment at an emergency room. The facility's removal plan included the following interventions: 1. Administrative Staff A checked doors to ensure proper closing immediately and at least once per week thereafter. 2. A wanderguard bracelet was placed on R2 upon return from emergency room on 02/20/26 at 08:41 PM. 3. Signs were placed on the memory care door to instruct visitors to ensure the door is latched behind them on 02/20/26. 4. Assessment and care plans completed for residents who required the wander system on 02/23/26. 5. Review of R2's medications completed 02/25/26. 6. In-services for all staff on door safety and latching completed 02/23/26. 7. Administrative Staff A to complete "At Risk" sheets with each new move-in started 02/21/26. 8. Every 30 minute checks on R2 initiated 02/20/26 for a "couple of days." 9. All memory care resident charts audited for completed elopement risk assessments 03/04/26 for residents who exhibited exit-seeking behavior. 10. Administrative Nurses B and C to ensure elopement assessments for appropriate residents was ongoing.	S3026		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment	S3081		

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S3081	Continued From page 6 (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c) (1) The facility reported a census of 83 residents with five residents included in the sample and one closed record review. Based on interview and record review the facility failed to ensure designated staff completed a "Functional Capacity Screen" (FCS) for Resident (R) 3 every 365 days, and for R3 and R6 upon change of condition as defined in K.A.R. 26-39-100. Findings included: - Review of R3's record revealed an admission date of 12/02/24 with diagnoses of multiple sclerosis and depression. Review of R3's chart revealed a "Functional Capacity Screen" (FCS) was completed on 05/30/25. The FCS did not indicate R3 at risk of falls. R3's next FCS completed 08/05/26 identified R3 required physical assistance with bathing, dressing, toileting, transfers and management of	S3081		

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S3081	Continued From page 7 medications and treatments. The FCS failed to indicate R3 at risk of falls. The 08/05/26 "Negotiated Service Agreement" (NSA) read R3 had a history of falls and staff were to ensure clutter free apartment, encourage proper footwear, and remind R3 to ask for assistance when needed. Review of "Incident" note dated 03/05/26 at 01:38 AM revealed R3 was lowered to the floor by a staff member when transferring from wheelchair to shower chair. R3's record lacked evidence of an FCS after R3 sustained a fall on and failed to include an annual FCS between 05/30/25 and 08/05/26 which was 67 days overdue. On 08/13/26 at 01:16 PM Administrative Nurse B confirmed a FCS for R3 was not completed on change in condition or within 365 days of 05/30/25. - Record review for R6 revealed an admission date of 09/08/22 with a diagnosis of mild cognitive impairment. The 05/22/25 (most recent) FCS identified R6 required physical assistance with bathing, mobility, dressing, and management of medications and treatments; required supervision with toileting and transfers; had, memory/recall and decision-making cognitive difficulties; and was at risk of falls and had impaired decision-making. The 05/22/25 NSA identified facility staff would provide R6 physical assistance with bathing, dressing, mobility, and administration of	S3081		

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S3081	Continued From page 8 management of medications; directions or reminders for cognitive difficulties; and clutter free apartment and reminders to ask for assistance if needed. The NSA indicated family had a camera to monitor falls. R6's record lacked evidence of an FCS since 05/22/25. Review of "Incident" note dated 01/13/26 at 07:45 PM revealed R6's daughter notified the facility nurse on duty R6 had fallen. R6 could not remember what happened and she was sent to the local hospital for evaluation and treatment. Review of "Nursing" note dated 01/14/26 at 11:39 AM revealed R6 had a fractured clavicle and multiple ribs. Review of "Nursing" note dated 01/19/26 at 01:53 PM revealed R6 returned to the facility at "noon" with "speech mostly nonsensical." Report from the local hospital was R6 was a two-person pivot transfer, was incontinent of bladder, required to be fed, and required medications in applesauce. Review of "Nursing" note dated 01/21/26 at 03:50 PM revealed R6 was admitted to hospice. On 08/13/26 at 01:16 PM Administrative Nurse B confirmed R6's most recent FCS was on 05/22/25 and should have been done on change in condition after hospitalization and admission to hospice. The facility's revised 08/2025 "Resident Assessments" policy instructed staff to review and update the functional capacity assessment with a significant change of condition.	S3081			

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S3081	Continued From page 9 The facility failed to ensure designated staff completed a FCS for R3 at least every 365 days, and for R3 and R6 upon change of condition.	S3081			
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(d) The facility reported a census of 83 residents with five included in the sample and one closed record review. Based on interview and record review the facility failed to ensure staff administered all medications to Resident (R) 1 and R4 in accordance with their medical care provider's orders.	S3200			

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S3200	Continued From page 10 Findings included: - Record review for R1 revealed an admission date of 08/18/25 with a diagnosis of Lewy Body neurocognitive disorder. The 03/17/26 "Functional Capacity Screen" (FCS) identified R1 required physical assistance with management of medications. The 03/17/26 "Negotiated Service Agreement" (NSA) identified facility staff would administer R1 medications. The 11/12/25 medical provider's order for hydralazine hydrochloride (vasodilator) 50 milligram (mg) tablet by mouth twice a day with instructions to hold the medication if R1's systolic blood pressure was less than 130. The "eMAR Summary" (Medication Administration Record) for July and August 2026 documented R1 was administered hydralazine on 07/24/26 at 07:00 PM with systolic blood pressure (SBP) 126, 07/28/26 at 07:00 PM with SBP 122, 07/31/26 at 07:00 PM with SBP 129, 08/06/26 at 07:00 PM with SBP 121, and 08/07/26 at 07:00 PM with SBP 103. Review of R1's record revealed facility staff failed to hold hydralazine five times when his systolic blood pressure was less than 130 per the medical provider's order. - Review of R4's record revealed an admission date of 06/13/24 with diagnoses of pulmonary fibrosis and orthostatic hypotension. The 08/12/26 FCS identified R4 required physical assistance with management of medications.	S3200		

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S3200	Continued From page 11 The 08/12/26 NSA identified facility staff would admin R4's medications. The 07/10/25 medical provider's order for midodrine (vasopressor) five mg tablet by mouth twice daily included instructions to hold the medication if R4's SBP was greater than 125. The July 2026 eMAR documented R4 was administered midodrine on 07/05/26 with SBP 142 and 07/11/26 with SBP 131 at 08:00 AM; 07/02/26 with SBP 141, 07/04/26 with SBP 138, 07/12/26 with SBP 142, 07/14/26 with SBP 133, 07/16/26 with SBP 132, 07/23/26 with SBP 134, 07/24/26 with SBP 153, 07/25/26 with SBP 177, and 07/29/26 with SBP 142 at 08:00 PM; and on 07/05/26 at 08:00 PM and 07/13/26 at 08:00 AM when no blood pressure was completed. Midodrine was not given on 07/07/26 at 08:00 PM when SBP was 121. Review of R4's record revealed facility staff failed to hold midodrine for 11 days her systolic blood pressure was greater than 125 per the medical provider's order and two days when her systolic blood pressure was not taken in July of 2026. The staff failed to give midodrine for a SBP less than 125 on one day in July of 2026. Review of "Pharmacist Recommendations" dated 06/01/26 revealed R4 was administered midodrine outside of the parameters "regularly" with details of dates and blood pressure readings. The error occurred 18 times in the month of May 2026. Review of "Pharmacist Recommendations" dated 03/24/26 revealed R4 was administered midodrine outside of the parameters "regularly"	S3200			

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S3200	Continued From page 12 with details of dates and blood pressure readings. The error occurred 15 times in the month of March 2026. On 08/11/26 at 11:55 AM Administrative Nurse B confirmed facility staff failed to administer R1 and R4's medications per their medical provider's orders. The facility's revised 08/2025 " Medication Administration" policy documented medications must be administered per the written order of the attending physician. The facility failed to ensure staff administered medications to R1 and R4 in accordance with their medical care provider's orders.	S3200			
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and	S3215			

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S3215	Continued From page 13 self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides. (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The facility reported a census of 83 residents. Based on observation and interview, the facility failed to ensure medications were stored in accordance with each pharmacy or manufacturer's recommendations or those of federal and state laws and regulations. Findings included: - Observation on 08/10/26 at 01:08 PM of the first-floor medication cart revealed the following medications: One bottle guaifenesin 100 milligrams (mg) per 5 milliliters, 16 fluid ounces expired 01/29/26 per pharmacy One bottle duloxetine 30 mg, 90 capsules to discard after 07/31/26 per pharmacy One bottle benzonatate 100 mg, 21 capsules expired 01/20/26	S3215		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: N046106	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/13/2026
NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, KS 66207		
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S3215	Continued From page 14 One box Calm aid, 30 softgels with manufacturer expired date of 01/2026 One bottle acetaminophen 650 mg suppositories, 5 suppositories use by 06/60/26 per pharmacy One bottle nystatin 100,000 units per gram, 15 grams expired 05/14/26 per pharmacy and 04/30/26 per manufacturer One bottle bisacodyl 10 mg, 2 suppositories use by 06/06/26 per pharmacy On 08/10/26 at approximately 01:15 PM Administrative Nurse C confirmed the medications were past date of use. - Observation on 08/10/26 at 01:32 PM revealed the second-floor medication cart contained the following medications: One bottle nystatin 100,000 units per gram, 30 grams with discard date 08/1/25 per pharmacy One bottle furosemide 20 mg, 45 tablets expired 03/18/26 per pharmacy One bottle bismuth subsalicylate 525 mg, 8 fluid ounces manufacturer expiration date 05/2026 One tube nystatin 1000,000 units per gram ointment with expiration 01/22 per manufacturer One Tresiba insulin pen without opened date and manufacturer instructions to discard 56 days after opening On 08/10/26 at 01:40 PM Administrative Staff A confirmed the medications were past date of use or not labeled appropriately to know what the discard date should have been. - Observation on 08/10/26 at approximately 01:50 PM revealed the second-floor medication room refrigerator contained the following medications: One box of five novolog insulin pens with	S3215		

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NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, KS 66207		
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S3215	Continued From page 15 pharmacy expiration 01/29/26 One box with one novolog insulin pen with expiration 8/10/26 per pharmacy One bag with three insulin lispro pens with expired date 11/25/25 On 08/10/26 at approximately 01:55 PM Administrative Staff A confirmed the medications were past date of use. The facility's revised 08/2025 "Medication Labeling" policy detailed medications in multiple dose vials were dated when first opened. The facility's revised 08/2025 "Insulin" policy instructed staff to date and time when an insulin pen is opened and discard per manufacturer's instructions. The facility's "Medication Administration" policy failed to include any instruction to staff regarding when to not use and discard medications. The facility failed to ensure medications were stored in accordance with each pharmacy or manufacturer's recommendations or those of federal and state laws and regulations.	S3215		
S3228 SS=E	26-41-205 (I) (3) Medication Regimen Review Record (I) (3) The administrator or operator, or the designee, shall ensure that the medication regimen review is kept in each resident ' s clinical record. This REQUIREMENT is not met as evidenced	S3228		

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NAME OF PROVIDER OR SUPPLIER MEADOWBROOK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 PARKSIDE DRIVE PRAIRIE VILLAGE, KS 66207		
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S3228	Continued From page 16 by: KAR 26-41-205 (I) (3) The facility reported a census of 83 residents with five residents sampled and one closed record review. Based on interview and record review the facility failed to ensure medication regimen reviews were kept in the residents' clinical records. Findings included: - Record review for R2 revealed an admission date of 01/22/26 with a diagnosis of dementia. The 02/25/26 "Functional Capacity Screen" (FCS) identified R2 was unable to perform management of medications and treatments. The 02/25/26 "Negotiated Service Agreement" (NSA) also functioned as the facility's Healthcare Service Plan (HSP) and identified facility staff provided management of medications and treatments. Review on 08/13/26 at 12:45 PM of R2's paper record revealed the "Chart Order" read pharmacy consults were in the medication tab. The medication tab lacked documentation of quarterly medication regimen reviews. - Review of R3's record revealed an admission date of 12/02/24 with diagnoses of multiple sclerosis and depression. The 08/05/26 FCS identified R3 required physical assistance with management of medications and treatments. The 08/05/26 NSA for R3 identified facility nurse	S3228		

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S3228	Continued From page 17 or Certified Medication Aide would administer medications. Review on 08/13/26 at 12:45 PM of R3's record revealed lacked pharmacy review of medications. - Review of R4's record revealed an admission date of 06/13/24 with diagnoses of pulmonary fibrosis and orthostatic hypotension. The 08/12/26 FCS identified R4 required physical assistance with management of medications and treatments. The 08/12/26 NSA for R4 identified facility staff would administer medications. Review on 08/13/26 at 12:45 PM of R4's record revealed lacked pharmacy review of medications. Review of facility pharmacy consult binder revealed R2 and R3 had pharmacy recommendations on 06/01/26 and R4 had a recommendation on 03/24/26. On 08/10/26 at 03:20 PM Administrative Nurse B stated the pharmacy review and recommendations are kept in a single binder in her office. The facility failed to ensure quarterly medication regimen reviews were kept in each resident clinical record.	S3228			
S3298 SS=F	26-41-206 (d) Food Preparation (d) Food preparation. Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be	S3298			

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S3298	Continued From page 18 served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations. (2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident 's family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-41-206 (d) (2) The facility reported a census of 83 residents. The facility had a main kitchen where food was stored, prepared and served to all residents. Based on interview and observation, the facility failed to ensure food in cans with significant defects including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening not be used. Findings included: - Observation on 08/10/26 at 02:15 PM of the kitchen revealed a pantry with canned food storage rack which contained one gallon can of refried beans dented on top and bottom rims and five cans of apple pie filling dented on top and bottom rims or severely dented on the side.	S3298			

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S3298	Continued From page 19 On 08/10/26 at approximately 02:22 PM Dietary Staff E confirmed the food cans were dented and/or bulging and should not be used. The facility failed to ensure food in cans with significant defects including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening was not used.	S3298			