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 09/29/2026

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 Risk-Based Survey Process was used to conduct a federal recertification survey. The following citations represent the findings of a Health Recertification Survey and a complaint survey regarding allegations in 3179153 and 3183981. The census was 74. The sample included 15 residents.	F0000		
F0640 SS = E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded,	F0640		

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

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 09/29/2026

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
F0640 SS = E	Continued from page 1 accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure that Minimum Data Set (MDS) assessments were accurately completed and timely transmitted to the CMS Quality Improvement and Evaluation System (IQIES)/ IQIES database for Resident (R)4, R6, R17, R34, R36, R39, R41, R56, and R81. Findings included: - The Electronic Medical Record (EMR) for R4 documented that a discharge return, not anticipated assessment was initiated on 05/23/2026 and signed as completed on 05/27/2026. The discharge assessment was not submitted to the IQIES database until 09/28/2026. R6's EMR documented a discharge return not anticipated assessment was initiated on 05/28/2026 and signed as completed on 09/28/2026. The discharge assessment was not submitted to the IQIES database until 09/28/2026. The EMR for R17 documented an "Annual MDS"	F0640		

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 09/29/2026

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
F0640 SS = E	Continued from page 2 assessment with an Assessment Reference Date (ARD) of 06/28/2026; it was signed as completed on 07/20/2026 but was not submitted to the IQIES database until 09/28/2026. The EMR for R56 documented a “Quarterly MDS” assessment with an ARD of 07/30/2026; it was signed as completed on 08/12/2026. The MDS was not submitted to the IQIES database until 09/28/2026. The EMR documented that the following MDS assessments could not be electronically transmitted because the interdisciplinary team had not completed Section V (Care Area Assessment Summary): R34’s “Annual MDS” had an ARD of 08/07/2026 and was signed as completed on 09/28/2026. R34’s “Care Area Assessments” (CAA) were not completed and submitted to the IQIES database until 09/28/2026. R36’s “Annual MDS” had an ARD of 08/01/2026 and was signed as completed on 09/28/2026. R36’s CAAs were not completed and submitted into the IQIES database until 09/28/2026. R39’s “Annual MDS” had an ARD of 08/23/2026 and was signed as completed on 09/28/2026. R39’sCAAs were not completed and were not submitted into the IQIES database until 09/28/2026. R41’s “Annual MDS” had an ARD of 08/19/2026 and was signed as completed on 09/28/2026. R41’s CAAs were not completed and submitted into the IQIES database until 09/28/2026. R83’s “Annual MDS” had an ARD of 07/30/2026 and was signed as completed on 08/12/2026. R834’s CAAs were not completed were not completed and submitted into the IQIES database until 09/28/2026. On 09/28/2026 at 02:30 PM, Administrative Nurse D stated there are two nurse’s that completed the MDS and they are training another nurse to help. When she looked into the MDS’s that were not transmitted, some had not had the CAA’s completed, so it did not transmit. Administrative Nurse D further stated that some of the MDS were completed and not transmitted. She stated they would all be completed and transmitted today. The facility’s “MDS Submission Process” policy, dated 06/13/2025, documented that the MDS Care Coordinator would submit MDS assessments at least	F0640		

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 09/29/2026

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
F0640 SS = E	Continued from page 3 weekly. The MDS Coordinator will review the final validation report from IQIES following submission to ensure all MDS submissions are accepted. The MDS Nurse will ensure that all MDS that are ready for submission have been signed by an RN Resident Assessment Instrument (RAI) Coordinator before submission. Once the records are submitted, within 24 hours the MDS Nurse will run the MDS Validation Report for the submitted records and will document validation status in Matrix. The facility's "MDS Submission Process" policy, dated 06/13/2025, documented that the MDS Care Coordinator would submit MDS assessments at least weekly. The MDS Coordinator will review the final validation report from IQIES following submission to ensure all MDS submissions are accepted. The MDS Nurse will ensure that all MDS that are ready for submission have been signed by an RN Resident Assessment Instrument (RAI) Coordinator before submission. Once the records are submitted, within 24 hours the MDS Nurse will run the MDS Validation Report for the submitted records and will document validation status in Matrix.	F0640		