STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMA OPERATOR, LLC	605 E MELVIN STREET , ARMA, Kansas, 66712

(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 04/07/26 to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Complaint reference numbers KS002722723, KS002744366 and KS002646859 were investigated. The facility census on the first day of the survey was 42. The sample size included three residents. Based on this survey, deficiencies were identified.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure an environment free from accident hazards for Resident (R) 1, who required staff assistance and a Hoyer (total body mechanical lift) lift for safe transfers. On 01/20/26, R1 slid through the opening in the toileting lift sheet while one staff member manned the lift, and when the other staff member took their hands off the resident and the lift sheet, R1 fell to the floor. R1 sustained an abrasion to her head, pain, and a negative psychosocial outcome as she was afraid and anxious during lift transfers after the incident. Findings included: - The Electronic Medical Record (EMR) for R1 documented diagnoses of polyosteoarthritis (a chronic,	F0689	"Past Noncompliance - no plan of correction required"	

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: 175353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMA OPERATOR, LLC	605 E MELVIN STREET , ARMA, Kansas, 66712

(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
F0689 SS = G	Continued from page 1 degenerative disease affecting five or more joints simultaneously, characterized by cartilage breakdown, joint pain, stiffness, and potential deformity), generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), muscle weakness (a reduced ability to exert force, often felt as difficulty lifting, walking, or rising from a chair), unsteadiness on feet (a lack of balance, stability, or coordination while standing or walking, leading to a high risk of falls), and need for assistance with personal care. R1's "Quarterly Minimum Data Set (MDS)," dated 01/05/26, documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The assessment documented that she had no impairment to her upper or lower extremities and used a wheelchair for mobility. The MDS did not indicate R1 used a mechanical lift for transfers. The MDS documented she required supervision or touching assistance for eating, partial to moderate assistance for oral and personal hygiene, substantial to maximum assistance for upper body dressing, and she was dependent on staff for all other activities of daily living (ADL). The MDS recorded that the resident had no falls since the previous assessment. R1's "Significant Change MDS," dated 02/08/26, documented a BIMS score of 12, indicating moderate cognitive impairment. The assessment documented that she had no impairment to her upper or lower extremities, used a wheelchair for mobility, and did not indicate the use of a mechanical lift. The MDS also documented she required supervision or touching assistance for eating, partial to moderate assistance for oral and personal hygiene, substantial to maximum assistance for upper body dressing, and she was dependent on staff for all other ADL. The MDS recorded the resident had one fall with injury since the last assessment. R1's "Functional Abilities Care Area Assessment" (CAA), dated 02/08/26, documented she was dependent on staff for chair/bed-to-chair transfers and tub/shower transfers. R1's "Psychosocial" CAA, dated 02/08/26, documented the resident had little interest or pleasure in activities.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMA OPERATOR, LLC	605 E MELVIN STREET , ARMA, Kansas, 66712

(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
F0689 SS = G	Continued from page 2 R1's "Fall" CAA, dated 02/08/26, documented she had a fall since the previous assessment, and she received antianxiety (a class of medications that calm and relax people) and antidepressant (a class of medications used to treat mood disorders) medication during the look-back period. The "Nursing: Lift and Transfer Evaluation," signed and dated 01/05/26, was not completed. R1's "Care Plan," with a revision date of 03/30/25, documented she had an ADL self-care performance deficit related to activity intolerance, dementia, and impaired balance. The staff intervention for R1 to use a commode with Hoyer lift transfer by two staff was resolved with a date of 01/20/26. The intervention, with a date of 01/20/26, instructed staff that R1 was to use a bedpan and that she was a Hoyer lift, with two staff, for transfers. The intervention, initiated on 01/20/26 and revised 03/16/26, documented R1 was a Hoyer lift for all transfers and for staff to use a medium sling. The "Nursing Progress Note" on 01/20/26 at 07:30 PM, documented the certified nurse assistant (CNA) called the nurse to R1's room and told her that R1 slid out of the Hoyer lift sling during a transfer. When the nurse entered the room, the nurse found R1 lying on her back, her legs laid over the top of the lift's legs, and the lift sling was attached to the Hoyer lift. The nurse moved R1's legs off the Hoyer lift leg and assessed a large bump on the back of R1's head. R1 informed the nurse that she had back pain. The note also documented the nurse notified Administrative Nurse D and was instructed to notify Emergency Medical Transport (EMS) to transfer R1 to the Emergency Department (ED) for evaluation. R1 left the facility by EMS to the ED at approximately 07:30 PM. The note documented that staff training for Hoyer lift transfers was provided. The "Nursing Progress Note," on 01/20/26 at 11:45 PM, documented R1 returned to the facility. She had a two-centimeter (cm) by one cm abrasion to the back of her head. The nurse and CNA used a Hoyer lift and assisted R1 from her wheelchair to her bed. The "Nursing Progress Note," on 01/21/26 at 11:05 AM, documented R1 told the nurse that the abrasion on her	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMA OPERATOR, LLC	605 E MELVIN STREET , ARMA, Kansas, 66712

(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
F0689 SS = G	Continued from page 3 head was sore. The “Nursing Progress Note,” on 01/21/26 at 07:05 PM, documented R1 continued to have complaints of feeling sore and told the nurse that the abrasion on her head was sore. The “Nursing Progress Note,” on 01/22/26 at 01:24 AM, documented R1 had complaints of pain and being sore all over. The “Nursing Progress Note,” on 01/23/26 at 12:16 AM, documented R1 had complaints of back and shoulder pain and had a red/purple bruise on the back of her head. The EMR revealed no “Nursing: Lift and Transfer Evaluation” was completed on R1 until 04/05/26. The untitled facilities’ incident report 2722723, dated 01/26/26, documented that on 01/20/26 around 07:00 PM, CNA M and CNA N Hoyer lift transferred R1 from her bedside commode back to her chair. During the transfer, R1 slipped out of the Hoyer lift and landed on the ground. The nurse immediately notified Administrative Nurse D and R1 went to the ED due to R1 bumping her head and had a large bump on her head. Administrative Nurse D arrived at the facility and had the staff re-enact the transfer. The staff said they had to put R1 down and reposition her during that transfer because R1 was moving her arm. When the staff lifted R1 a second time, she started to wiggle, and before they could react, R1 fell through the lift sheet. Administrative Nurse D further documented the lift sheet was the appropriate size and staff utilized the lift sheet and Hoyer appropriately during the re-enactment. Administrative Nurse D documented corrective actions taken included: R1 was changed back to bedpan use for toileting, and nursing staff were re-checked and re-educated on Hoyer lift transfers, and Hoyer transfers monitored monthly at Quality Assurance and Performance Improvement (QAPI). The facility sign-off for Hoyer lift training and education showed a completion date of 01/25/26. CNA M’s “Witness Statement,” dated 01/27/26, documented she and CNA N adjusted the Hoyer sheet under R1 so they	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMA OPERATOR, LLC	605 E MELVIN STREET , ARMA, Kansas, 66712

(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
F0689 SS = G	Continued from page 4 could clean her up. CNA N then cleaned R1 up, and when CNA N turned to throw the dirty wipes away and move the commode, R1 complained that her back was hurting and was moving. R1 then slipped through the “butt” part of the lift sheet, hit her head on the ground first, and then her back hit. CNA N’s “Witness Statement,” dated 01/27/26, documented she and CNA M went into R1’s room to move her off the commode, and when they hooked R1 to the Hoyer lift, she made sure the back was down far enough. The other CNA ran the Hoyer and lifted R1 up, and CNA N wiped and cleaned R1 and then turned around and threw the dirty wipes away. When CNA N turned back around, she saw R1’s head hit the ground. CNA O’s “Witness Statement,” dated 01/27/26, documented she assisted with taking R1’s vitals after she fell out of the Hoyer sling and R1 complained of her head hurting. An observation on 04/07/26 at 09:50 AM revealed CNA P and CNA Q performed a Hoyer transfer on R1 and moved her from her chair to her bed and performed care. Both CNAs maintained good communication with each other and with R1 throughout the transfer. Both CNAs provided instructions to R1 during the transfer, verified the lift sheet was the proper sheet for R1, and instructed R1 to cross her arms on her chest and not move during the transfer. CNA P maintained positive contact with R1 during the transfer and made sure she was not swaying while CNA Q operated the lift. During an interview on 04/07/26 at 10:11 AM, R1 stated after she fell from the Hoyer lift, she was nervous and anxious about using it but had recently become more comfortable with it. R1 also said no staff asked her if she was afraid of using the Hoyer lift, before or after falling from it. She said that ever since falling, she felt like she was sore and her back hurt more. During an interview on 04/07/26 at 09:50 AM, CNA P stated when performing a Hoyer transfer there would always be a minimum of two staff. CNA P said she would verify the lift sheet size, communicate with the resident, one staff would control the lift, the other would stabilize the resident during the transfer, the lift legs would be open for stability when lifting and lowering the resident, and the wheels would be	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMA OPERATOR, LLC	605 E MELVIN STREET , ARMA, Kansas, 66712

(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
F0689 SS = G	Continued from page 5 locked. CNA P also said the sling would be attached to the lift by the same loops on all sides. During an interview on 04/07/26 at 10:43 AM, CNA N stated there should be a minimum of two staff when transferring with a Hoyer lift. She said one staff member would operate the Hoyer and the other would have stabilized the resident during the transfer, and the lift sheet would have been verified for the correct size, the legs of the lift would have been opened for stability, and the wheels would be locked when the resident was raised or lowered. During an interview on 04/07/26 at 12:15 PM, Administrative Nurse D stated two was the minimum number of staff required for any Hoyer lift transfer. She said one staff member would position the resident by maintaining constant contact with the resident when in the sling and guided to ensure there was no unnecessary movement during the transfer, and the other staff would operate the lift. Administrative Nurse D stated the lift legs and wheel locks would be positioned and maintained per the manufacturer's recommendation for safety purposes. On 04/07/26 at 01:50 PM, Administrative Nurse D said after R1 fell from the Hoyer lift on 01/20/26, she continued to be transferred with the Hoyer. Administrative Nurse D also said that after the fall, R1 was not re-assessed for increased anxiety, and she did not display any increase in fear or anxiety and did not express any increased anxiety to staff. She further said there was no evaluation of transfer assessment performed after the fall on 01/20/26 until the "Significant Change MDS" was done on 02/08/26, as it was not necessary because R1 was assessed on admission on 01/05/26, and it was determined that she required a medium-sized lift sling. Administrative Nurse D also said it was not necessary for therapy to re-evaluate her, as she had already attempted therapy and had not improved with strength or physical ability. Administrative Nurse E said that she performed the MDS assessments and performed the lift assessment and psychosocial assessment for R1 on 02/08/26 when she did the "Significant Change MDS." The facility policy "Safe Lifting and Movement of Residents," dated 03/2026, documented that nursing staff, in conjunction with the rehabilitation staff, would assess individual residents' needs for transfer	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175353	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARMA OPERATOR, LLC	605 E MELVIN STREET , ARMA, Kansas, 66712

(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
F0689 SS = G	Continued from page 6 assistance on an ongoing basis. Staff would document the resident's transferring and lifting needs in the care plan, and the assessment would include the resident's preferences for assistance, the resident's mobility (degree of dependency), the resident's size, weight-bearing ability, cognitive status, and whether the resident was usually cooperative with staff. The policy also documented that staff responsible for direct resident care would be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. It further documented that enough slings, in sizes required by residents in need, would always be available. The facility completed corrective actions on 01/25/26, prior to the survey. The surveyor verified completion of the actions via observation, review of training records, and staff interviews; therefore, the deficient practice was deemed past noncompliance at a "G" (isolated, actual harm).	F0689		