

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Parsons Presbyterian Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 3501 Dirr Avenue Parsons, KS 67357	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881</p> <p>The facility reported a census of 28 residents with 13 residents sampled, which included one resident sampled for abuse. Based on observation, interview, and record review, the facility staff failed to report an allegation of staff to resident, verbal abuse (the use of oral, language that willfully includes disparaging and derogatory terms to residents or within their hearing distance regardless of their age ability to comprehend, or disability) related to calling Resident (R)4 lazy in the presence of another resident.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of Resident (R)4's Physician Orders, dated 08/01/24, documentation included diagnoses of diabetes (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), heart failure, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), morbid obesity (severely overweight), chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and supplemental oxygen dependence. <p>The Annual Minimum Data Set (MDS)dated 03/09/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. He did not demonstrate any behaviors, mood indicators, nor depression indicators. He required staff assistance and supervision for activities of daily living (ADLs) which included transfers and wheeling his wheelchair. He was 69 inches (five foot nine inches tall) and weighed 353 pounds (lb). The resident received as needed (prn) pain medication and reported almost constant pain rated 08/10. He received medications which included anti-anxiety (medications used to treat mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), antidepressants (medications used to treat depression), opioids (medication/controlled substance used to treat pain), and diuretics, (medications to promote the formation and excretion of urine). The resident received restorative nursing program for active range of motion and walking for two days of the look back period.</p> <p>The Quarterly MDS dated [DATE], documented change from the above assessment included the resident weight as 372 lbs.</p> <p>(continued on next page)</p>

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 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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Care Plan (CP) dated 06/20/24, directed staff the resident had left knee pain and received pain medication twice a day. R4 had a new wheelchair with foot pedals. He was pleasant, cooperative, and participated in exercise, activities, and restorative nursing program and required staff assistance with his ADLs.</p> <p>Review of the facility self-report to the State agency dated 07/08/24, revealed on 06/29/24, Certified Medication Aide (CMA) R and Certified Nurse's aide (CNA) N witnessed CNA O verbally insult R4 while in the dining room in the presence of other residents. The event described included CNA O propelled R4 to his room, CNA O was yelling at him, calling him names, such as lazy and telling him he could do it himself. CNA O exclaimed she did not care if she got wrote up again. The investigation documentation revealed CNA N did not report the incident to facility staff until she gave the facility her resignation on 07/08/24. She identified CMA R as a witness to the event. The facility suspended CNA O pending investigation upon having knowledge of the event. The administration interviewed CMA R who confirmed the above findings. All facility staff completed training regarding Abuse Neglect, and Exploitation as of 07/11/24. CNA O was terminated related to failure to respond to previous counseling by the facility.</p> <p>CMA R's witness statement, dated 07/08/24, documented R4 wanted staff assistance to his room. CMA R asked CNA O to take R4 to his room. CNA O responded that R4 could push himself to his room. CNA O approached R4, yelling and calling him names such as lazy and told R4 he could do it himself. CNA O assisted R4 out of the dining room.</p> <p>CNA O's witness statement, dated 08/08/24, documented I do not recall that weekend. Sorry.</p> <p>On 09/10/24 at 11:10 AM, R 4 stated he had been a resident for three years. He reported he felt safe, and he had no worries about his care. The resident stated he did not recall ever being abused or mistreated and had not seen any other resident abused or mistreated.</p> <p>On 09/10/24 at 11:56 AM, Certified Nurse Aide (CNA) M provided the resident with incontinence care which included peri-care, applied a new incontinence brief, and changed his wet clothes.</p> <p>On 09/11/24 at 08:33 AM, R4 sat in a wheelchair while CNA M propelled the resident to his room. He thanked CMA M for her help and stated the staff sometime tell him he should roll his own wheelchair, but he would get tired.</p> <p>On 09/12/24 at 01:24 PM, CMA R confirmed the above findings with the exception of the date of the event. She stated the event described occurred on 06/29/24 verses 06/23/24. She stated on the morning of 06/29/24, she was passing her medications and R4 asked for assistance to return to his room. CMA R reported she was holding medications and she saw that CNA O was available to assist R4. CNA O verbally insulted R4 in the dining room in the presence of other residents. The event described included CNA O yelled the resident was lazy and she did not care if she got written up again. He could push himself to his room. Additionally, CNA O continued to call the resident names such as lazy when she assisted the resident in the wheelchair to his room. Approximately 10 other residents were in the dining area at the time, and they appeared to be shocked and were talking amongst themselves. CNA N heard what happened and talked to her about it and CMA R thought CNA N reported the event to the facility management. CMA R stated she should have stopped CNA O and reported the event to her charge nurse at the time.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/12/24 at 02:24 PM, Administrative Staff A confirmed the above findings and agreed facility staff failed to report the allegation of verbal abuse at the time it occurred as they should have. She reported when she was informed, CNA O was immediately suspended pending investigation. Administrative Staff A was told about the verbal abuse on 07/08/24, nine days afterwards. Staff should have reported the event at the time it occurred so immediate action could have been taken to protect the residents.</p> <p>The facility policy ANE: Abuse Prevention, intervention, Reporting and Investigation-Staff Treatment of Residents, dated 03/04/24, documentation included it is the responsibility of employees to promptly report to community management any occurrence or suspected occurrence of neglect or resident abuse. Verbal/Written abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging a derogatory term to residents within their hearing distance regardless of their age ability to comprehend, or disability.</p> <p>The facility staff failed to report an allegation of staff to resident, verbal abuse to this resident.</p> <p>The deficient practice was deemed past non-compliance when the facility completed the following:</p> <p>On 07/08/24, the facility conducted staff interviews with the identified staff present during the alleged verbal abuse. (CNA O, CMA R, and CNA N).</p> <p>On 07/08/24, the facility staff notified R 4's Durable Power of Attorney (DPOA)/representative of the allegation of verbal abuse.</p> <p>On 07/08/24, upon notification of allegation of verbal abuse, the facility suspended the alleged perpetrator, CNA O, pending investigation. CNA N resigned. CMA R received Teachable Moment training regarding reporting abuse immediately, as the first step of disciplinary action due to her failure to report an allegation of verbal abuse immediately.</p> <p>On 07/08/24, the facility interviewed R 4 who had no recall of the above event of verbal abuse on 06/29/24.</p> <p>On 07/08/24, the facility interviewed three additional residents that reported they felt safe at the facility and got the help they needed when they asked the staff for help.</p> <p>On 07/08/24, the facility initiated all staff education/training regarding abuse neglect and exploitation, which included immediate reporting of allegations of abuse, and completed the re-education and training for all staff on 07/11/24.</p> <p>On 07/11/24, the facility terminated CNA O following the investigation, related to her lack of response to prior counseling regarding her tone of voice.</p> <p>The facility plans for monitoring effectiveness of corrective action plan through Quality Assurance Performance Improvement (QAPI) Risk Committee quarterly meeting.</p> <p>The onsite surveyor verified the implementation of the above actions on 09/12/24 and the deficient practice remained at a D scope and severity.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881</p> <p>The facility reported a census of 28 residents, with 13 residents sampled which included three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to complete a thorough investigation to determine causes and contributing factors related to a skin tear and failed to implement appropriate immediate interventions to prevent further skin tear for Resident (R)18.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of Resident (R)18's Physician Orders, dated 08/01/24, documentation included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) with psychotic disturbances (gross impairment in reality perception), dizziness, and hypertension (high blood pressure). <p>The Significant Change in Status Minimum Data Set, (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. He exhibited continuous altered level of consciousness and fluctuating disorganized thinking. The resident had no functional limitation in range of motion in his upper or lower extremities. He required maximum/substantial assistance of staff for transfers, toilet use, and personal hygiene.</p> <p>The Falls Care Area Assessments (CAA) dated 06/13/24, documented the resident at risk for falls but he would call and wait on staff to arrive.</p> <p>The Care Plan, (CP) dated 6/20/24, directed the staff the resident had self-care deficit. He required total assistance with repositioning and transfers. The resident had poor safety awareness, was impulsive, would attempt to get up on his own, and became easily annoyed and agitated if staff attempted to assist him if he did not want to be assisted. R18 was at risk for skin impairment such as skin tears and staff should apply long sleeves and pants to protect his extremities.</p> <p>Review of the Interdisciplinary Team Notes,(IDT) dated 09/07/24 at 11:48 AM, documentation included the staff discovered a C shaped skin tear with dried blood on the back of the resident's right hand between the thumb and his forefinger. The administered treatment included cleaning the area with wound cleanser, applied skin prep, applied seven steri-strips (wound closures), applied folded and secured with paper tape for protection. The documentation lacked identification of cause or contributing factors related to the skin tear or an immediate intervention to prevent further injury.</p> <p>On 09/10/24 at 10:49 AM, the resident sat in a high back reclining chair. His left arm was bent at his elbow with his left hand cupped beneath his right elbow. The top of his right-hand had a bordered foam dressing in place, dated 9/10/24, On inquiry, R18 stated he did not know what happened to his hand.</p> <p>On 09/11/24 at 09:00 AM, the resident sat in a high back reclining chair rubbing his right shoulder with his left hand. The back of his right hand had seven steri-strips visible without a covering for protection. Observation revealed there was dried blood on top of his hand. There was no bordered foam dressing in place.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/11/24 at 09:47 AM, Licensed Nurse (LN) E reported the resident wheeled himself down the hall and would hit his hand against the wall and the doorway. She stated the skin tear happened over the weekend. LN E reviewed the resident's electronic medical record and confirmed the lack of an order related to R18's right hand skin tear. She stated the facility had standing orders for skin tears. LN cleaned the skin tear with wound cleaner and verified the placement of seven steri-strips, and the wound measured 3.7 centimeters (cm) by 0.5 cm by 0.1 cm. R18's right hand had a blue-black discolored area around the approximated wound edges. LN E stated she did not know the immediate intervention implemented by the facility to prevent further skin tears.</p> <p>On 09/11/24 11:25 AM, Administrative Nurse D confirmed the resident's hand skin tear lacked a thorough investigation to determine the cause or contributing factors as well as lacked an immediate intervention to prevent further injuries for dependent R 18.</p> <p>The facility lacked a policy to address the root cause analysis for skin tears to determine the causes and contributing factors and implementation of an immediate intervention to prevent further injury.</p> <p>The facility failed to complete a thorough investigation to determine causes and contributing factors related to a skin tear and failed to implement appropriate immediate interventions to prevent further skin tear for Resident (R)18.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560</p> <p>The facility reported a census of 28 residents with 13 selected for review, which included four residents reviewed for pressure ulcers. Based on observation, interview, and record review, the facility failed to ensure pressure relieving device was in working order for one Resident (R)21, of the four residents reviewed for pressure ulcers.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of Resident (R)21's medical record revealed diagnoses that included diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), polyneuropathy (disorder of many of the nerves outside of the brain and spinal cord), venous ulcers (sores due to poor circulation), and stage two pressure ulcer (partial thickness skin loss into but no deeper than the dermis including intact or ruptured blisters). <p>The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15, which indicated normal cognitive function. The resident required partial/moderate assistance for transfers. The resident had no impairment in range of motion in his upper or lower extremities. The resident had no pressure ulcers.</p> <p>The Pressure Ulcer Care Area Assessment (CAA), dated 03/12/24, assessed the resident not at risk for pressure ulcer development.</p> <p>The Five Day Admission MDS dated [DATE], assessed the resident with a BIMS of 14, which indicated normal cognitive function. R21 had no impairment of upper or lower extremities. The resident assessed as not at risk for pressure ulcer development and had no pressure ulcers. The resident had two venous ulcers (wounds caused by poor circulation).</p> <p>The Quarterly MDS dated [DATE], assessed the resident with a BIMS score of 14, with one stage two pressure ulcer, and two venous stasis ulcers. The resident had a pressure reducing device for his chair and bed and received pressure ulcer care. The resident required supervision for standing and transfers.</p> <p>The Care Plan updated 06/20/24 instructed staff to ensure a low air loss mattress was on the resident's bed and a cushion in his chair.</p> <p>An update to the care plan dated 07/12/24, instructed staff to cleanse the open area to R21's right and left buttocks with wound cleanser and apply a foam dressing every three days. Staff instructed to encourage and assist the resident to reposition every two hours.</p> <p>The Additional Orders from wound care, dated 09/05/24, instructed the facility to provide a roho (a type of pressure relieving cushion that utilizes flowing air cubes that adjust to meet individual contouring needs to decrease pressure) type of cushion to any surface the resident sat on. Staff were to cleanse the sacral pressure ulcer with wound cleanser and apply a sacral (large triangular bone between the two hip bones) dressing every three days.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation, on 09/10/24 at 10:34 AM, revealed the resident seated in his recliner. The resident sat on two cushions. The resident stated he has a sore area on his bottom, and the two cushions help relieve the discomfort of the sore area.</p> <p>Observation, on 09/11/24 at 01:48 PM, revealed Administrative Nurse E prepared to provide a dressing change to R21's sacral pressure ulcer. The resident sat in his recliner and stood up as requested. The cushion in the recliner contained multiple areas of malfunctioning air cells and were deflated. Administrative Nurse E stated staff did not report the deflated cushion to her and proceeded to remove the cushion for reinflation and placed a foam cushion in the resident's recliner. Administrative Nurse E removed the foam dressing and noted the wound as pink in color and measured the area as 0.3 by 1.2 centimeter (cm) and 0.4 by 0.3 cm. Administrative Nurse E cleansed the resident's sacral wounds with wound cleanser and applied a foam dressing to the resident's sacrum. Administrative Nurse E stated the wound care provider managed the resident's vascular and this pressure ulcer.</p> <p>The facility policy Therapeutic Support Surface revise 09/05/24, instructed staff positioning techniques, devised and chair seat cushions should be considered for resident who are in the sitting position.</p> <p>The facility failed to monitor the status of R21's roho cushion to ensure optimal functioning to provide pressure reduction for this resident's stage two sacral pressure ulcer.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881</p> <p>The facility reported a census of 28 residents, with 13 residents sampled which included three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to complete a safe transfer for dependent (R)18 using a sit to stand lift related to the lack of use of the sling's safety belt to ensure the resident's safe transfer.</p> <p>Finding included:</p> <ul style="list-style-type: none"> - Review of Resident (R)18's Physician Orders, dated 08/01/24, documentation included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) with psychotic disturbances (gross impairment in reality perception), dizziness, and hypertension (high blood pressure). <p>The Significant Change in Status Minimum Data Set, (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. He exhibited continuous altered level of consciousness and fluctuating disorganized thinking. The resident had no functional limitation in range of motion in his upper or lower extremities. He required maximum/substantial assistance of staff for transfers, toilet use, and personal hygiene.</p> <p>The Falls Care Area Assessments (CAA) dated 06/13/24, documented the resident at risk for falls but he would call and wait on staff to arrive. He required assistance of two staff members for transfers using a sit to stand lift.</p> <p>The Care Plan, (CP) dated 6/20/24, directed the staff the resident had self-care deficit. He required total assistance with repositioning and transfers. The resident had poor safety awareness, was impulsive, would attempt to get up on his own, and became easily annoyed and agitated if staff attempted to assist him if he did not want to be assisted. Two staff should use a sit to stand lift for all transfers. At times staff should use a full body lift when he was not feeling well.</p> <p>On 09/11/24 at 09:25 AM, Administrative Nurse D propelled the resident in his wheelchair to his room. She requested Certified Nurse Aide (CNA) Q and CNA P to check the resident for incontinence and to provide care if needed. Staff reported the resident required the use of the sit to stand lift and two direct care staff to transfer the resident. They positioned the sling beneath the residents back and hooked it to the lift. Staff failed to secure the safety belt prior to lifting the resident from the chair with the lift. Upon inquiry, they reported the safety belt was broken and was not able to secure the Velcro around the resident. Staff reported the lift was broken for over a week, but they continued to use it. Furthermore, they stated they had not reported the safety belt as broken.</p> <p>On 09/11/24 at 09:47 AM, Licensed Nurse (LN) E, reported staff should report any equipment that needed repair to the maintenance department prior to using the equipment. She confirmed the safety belt should be used to ensure the safety of the resident.</p> <p>(continued on next page)</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>36881</p> <p>The facility reported a census of 28 residents. Based on observation, interview, and record review, the facility failed to maintain and/or dispose of garbage and refuse properly in a sanitary condition to prevent the harborage and feeding of pests.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 09/10/24 at 10:13 AM, initial tour with Dietary Staff BB revealed two of four compartments dumpster open with exposed trash and garbage. Additionally, discarded building supplies surrounded the dumpster with grass grown over the edges. Dietary Staff BB confirmed the above findings. She reported the facility staff should dispose of garbage and trash in a closed container to prevent harboring of pests and rodents from nesting around the facility. Dietary Staff BB stated the staff facility used the dumpsters and they should keep all compartment lid closed to contain the garbage and trash when placed in the dumpster. <p>On 09/12/24 at 11:15 AM, during environmental tour with Housekeeping and Maintenance Director U and Consultant GG, revealed the trash dumpster lacked one lid which exposed trash and garbage. The building materials and overgrown grass that surrounded the dumpster remained as noted above. He reported the trash company replaced the dumpster approximately two weeks ago and agreed the dumpster compartment lids should be closed to maintain and/or dispose of garbage and refuse in a sanitary condition.</p> <p>The facility lacked a policy to address garbage and refuse disposal and containment.</p> <p>The facility failed to maintain and/or dispose of garbage and refuse properly in a sanitary condition to prevent the harborage and feeding of pests.</p>

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>28560</p> <p>The facility reported a census of 28 residents. Based on interview and record review, the facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. Payroll Base Journal (PBJ), related to licensed nursing staffing information, when the facility failed to accurately report 24 hour per day Licensed Nurse coverage on 12 dates between 07/01/23 and 09/30/23 and 10 dates between 01/01/24 and 03/31/24.</p> <p>Findings Included:</p> <p>- Review of the Payroll Base Journal (PBJ) Staffing Data Report for Fiscal year (FY), Quarter 4, 2023 (07/01/23 and 09/30/23) revealed a lack of License Nurse (LN) for 24 hours/seven days a week 24 hour/day on the following dates:</p> <p>On 07/01/23 , Saturday (SA),</p> <p>On 07/02/23, Sunday (SU),</p> <p>On 07/15/23, SA,</p> <p>On 07/22/23, SA,</p> <p>On 07/23/23, SU,</p> <p>On 08/12/23, SA,</p> <p>On 08/13/23, SU,</p> <p>On 08/19/23, SA,</p> <p>On 08/20/23, SU,</p> <p>On 09/03/23, SU</p> <p>On 09/23/23, SA, and</p> <p>On 09/24/23, SU.</p> <p>Review of the Payroll Base Journal (PBJ) Staffing Data Report for Fiscal year (FY), Quarter 2, 2024 (01/01/24 and 03/31/24) revealed a lack of License Nurse (LN) for 24 hours/seven days a week 24 hour/day on the following dates:</p> <p>On 02/17/24, SA,</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Parsons Presbyterian Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 3501 Durr Avenue Parsons, KS 67357	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 02/18/24, SU,</p> <p>On 02/24/24, SA,</p> <p>On 02/25/24, SU,</p> <p>On 03/02/24, SA,</p> <p>On 03/03/24 SU,</p> <p>On 03/09/24, SA,</p> <p>On 03/10/24, SU,</p> <p>On 03/16/24, SA, and</p> <p>On 03/17/24, SU.</p> <p>On 09/12/24 at 01:41 PM, interview with Administrative Staff A revealed as far as she knew, the PBJ was submitted correctly and stated the licensed nurse that worked on weekend do not leave the facility or take a lunch break and the facility had 24-hour licensed nurse coverage.</p> <p>The facility policy for PBJ Reporting Procedure, undated, instructed staff report to PBJ hours to CMS on a quarterly basis and must include the download from Time Tracker (an electronic method to record time worked by staff) to include agency staff.</p> <p>The facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e., Payroll Base Journal (PBJ), related to licensed nursing staffing information when the facility failed to accurately report 24 hour per day Licensed Nurse coverage on 12 dates between 07/01/23 and 09/30/23 and 10 dates between 01/01/24 and 03/31/24.</p>