STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175303	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parsons Presbyterian Manor	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a stop date for an as needed (PRN) antianxiety medication for Resident (R)2 and R5's lorazepam (an antianxiety medication). Findings included:- R2's Electronic Medical Record (EMR) documented a diagnosis of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R2's Significant Change Minimum Data Set (MDS), dated [DATE], documented R2 had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. She received antianxiety medication (a class of medications that calm and relax people) during the assessment period. R2's Psychotropic Drug Use Care Area Assessment (CAA), dated 03/02/2026, documented she had a diagnosis of anxiety and took antianxiety medication. R2's Quarterly MDS, dated [DATE], documented she had a BIMS score of 14, indicating intact cognition. She received antianxiety medication during the assessment period. R2's Care Plan, revised 03/15/2026, instructed staff to monitor the resident for side effects of her antianxiety medication. R2's EMR under the Orders tab, revealed the following physician's order: Lorazepam 0.5 milligrams, by mouth, every four hours, PRN, for a diagnosis of anxiety, ordered 04/08/2026. The order lacked a stop date. On 06/03/2026 at 08:30 AM, Administrative Nurse D confirmed R2's order for PRN lorazepam lacked a stop date, as required. The facility policy for Psychoactive Psychopharmacological Medications, revised 04/15/2025, included: PRN psychotropic medications shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. - R5's EMR documented a diagnosis of anxiety. R5's Significant Change MDS, dated [DATE], documented she had a BIMS score of six, indicating severe cognitive impairment. She did not receive antianxiety medication (a class of medications that calm and relax people) during the assessment period. R5's Psychotropic Drug Use Care Area Assessment (CAA), dated 04/16/2026, documented she took psychotropic medications. R5's Quarterly MDS, dated [DATE], documented she had a BIMS score of 11, indicating moderately impaired cognition. She did not receive antianxiety medication during the assessment period. R5's Care Plan, revised 04/26/2026, instructed staff to monitor the resident for side effects of her antianxiety medication. R5's EMR under the Orders tab, revealed the following physician's order: Lorazepam 0.5 milligrams, by mouth, every four hours, PRN, for a diagnosis of anxiety, ordered 10/19/2025. The order lacked a stop date. On 06/03/2026 at 08:30 AM, Administrative Nurse D confirmed R2 and R5's order for PRN lorazepam lacked a stop date, as required. The facility policy for Psychoactive Psychopharmacological Medications, revised 04/15/2025, included: PRN psychotropic medications shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration.

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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide Resident (R) 31 with a written notification of transfer to the resident and/or his representative as soon as practicable and failed to send a copy of that notification to the ombudsman. Findings included:- R31's Electronic Medical Record (EMR) revealed a diagnosis of left femur fracture and cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R31's admission Minimum Data Set (MDS), dated [DATE], documented R31 had a BIMS of 15, indicating intact cognition. R31's Discharge MDS, dated 03/18/2026, documented R31 had an unplanned discharge on [DATE]. R31's Health Status Note, dated 03/17/2026 at 04:07 PM, documented R31's daughter requested to have R31's medications and laundry ready to discharge the next day. R31's Health Status Note, dated 03/18/2026 at 01:17 PM, documented R31's family took R31 home with her medications and belongings. R31's EMR lacked documentation of a written notification to the residents and/or the representative, which explained the reason for the transfer to the hospital, or that the ombudsman was notified of the transfer. During an interview on 06/02/2026 at 12:51 PM, Administrative Staff A did not find where the letter to the family was for R31's discharge on [DATE] or the ombudsman notification was for this discharge. Another staff member was supposed to take over the ombudsman notifications for March and April and that staff member did not do it. The facility's policy Discharge Policy documented the facility shall notify the resident or representative of the transfer or discharge in writing and must send that notification to the ombudsman.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to provide grooming opportunities related to shaving of facial hair to maintain good personal hygiene and dignity for Resident (R)3. Findings included:- Review of R3's Physician Orders (POS), dated 05/01/2026, included diagnoses of vascular dementia (progressive mental deterioration characterized by confusion and memory failure), self-care care deficit, and major depressive disorder (MDD-major mood disorder which causes persistent feelings of sadness). R3's Significant Change Minimum Data Set (MDS), dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of eight, indicating moderate cognition impairment. She reported choosing her type of bath was very important. The resident was dependent on staff for bathing and personal hygiene. She did not exhibit behaviors of rejection of care. The Functional Abilities (Self Care and mobility) Care Area Assessment, (CAA), dated 03/11/2026, documented the resident had diagnoses that included vascular dementia, MDD, self-care care deficit due to periods of unsteadiness, impaired mobility, weakness, episodes of unsteady balance, poor safety, and cognitive impairment. The staff provided this dependent resident with bathing that included set-up assistance with hygiene/grooming tasks. She received Dressing/Grooming Restorative Nursing Program. R3's Care Plan, dated 05/29/2026, directed staff that the resident was able to perform hygiene/grooming task with set up assistance, initiated 01/29/2025. Her cognition and poor safety awareness deficit limited her ability to be independent. She required staff assistance for safety, initiated 04/11/2025. Staff should explain each procedure to R3 so she can participate in her activities of daily living (ADL) and maximize her abilities. Staff were to provide showers on Wednesday and Sunday evenings. She received restorative nursing program for dressing and grooming. A Restorative Nursing Assistant/Certified Nurse Aide (RNA/CNA) would encourage or involve the resident's active participation with dressing/grooming tasks for 15 minutes while providing daily assistance in the morning and evening up to seven day a week Date, initiated 05/20/2025. Review of Electronic Medical Record (EMR) Bathing Tasks dated 05/01/2026 through 06/02/2026 and Bath Sheets revealed they lacked evidence that the staff offered or provided shaves with bathing and/or grooming on scheduled bath/shower days or as needed. On 06/01/2026 at 11:33 AM, R3 sat in lobby in a chair. She had chin hair approximately one-quarter inch present. On inquiry, R3 stated she would like staff assistance with removal of her facial hair. She inquired if the facial hair was visible. On 06/02/2026 at 11:18 AM, R3 sat in common area/lobby. Certified Nurse Aide (CNA) N applied a gait belt and positioned R3's walker then ambulated with R3 down the length of hall to her room. CNA N confirmed R3 had chin hair and needed shaving. CNA N stated the residents should be offered assistance with shaving as part of their bath and as needed. She reported that the resident refused her bath sometimes, but the staff should offer help with shaving when needed. CNA N asked the resident if she wanted her to shave her chin hair, R3 said Yes. On 06/03/2026 at 08:49 AM, Administrative Nurse D reported that when residents were observed with chin hair, staff should offer to shave the residents when needed and when bathed as a part of grooming. She verified the lack of evidence that the resident had been offered an opportunity to have staff assist her with shaving. Administrative Nurse D reported the facility lacked a policy to address shaving as a part of ADL care. The facility did not provide a policy to address shaving as part of ADL care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform restorative care for Resident (R) 6 who had a contracture (abnormal permanent fixation of a joint or muscle) to her right hand. Findings included: - R6's Electronic Medical Record (EMR) documented a diagnosis of hemiparesis/hemiplegia (weakness and paralysis on one side of the body). R6's Annual Minimum Data Set (MDS), dated [DATE], documented she had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. She had a limitation in range of motion (ROM) on one side of her upper and lower extremities. R6 did not receive restorative nursing care (care provided to maintain a person's highest level of physical, mental, and psychosocial function in order to prevent declines that impact quality of life) during the assessment period. R6's Activities of Daily Living (ADL) Care Area Assessment (CAA), dated 04/14/2026, documented the resident required staff assistance with ADLs due to left sided hemiplegia and limited mobility. R6's Quarterly MDS, dated [DATE], documented she had a BIMS score of 10, indicating moderately impaired cognition. She had limited ROM one side of her upper and lower extremities. R6 did not receive restorative nursing care during the assessment period. R6's Care Plan, revised 04/14/2026, instructed staff to perform passive ROM (PROM-when staff manipulate the joint rather than the resident) restorative care to R6's left upper extremity daily; staff instructed to open and close R6's left hand, perform elbow extension (the straightening of a limb), and assist with shoulder raises for 15 minutes, up to seven days per week. R6's EMR from 05/04/2026 through 06/01/2026 (30 days), lacked documentation of PROM taking place with R6. On 06/01/2026 at 09:09 AM, R6 sat at the dining room table feeding herself breakfast with her right hand. R6's left hand rested in her lap with her fingers curled inward into a fist. On 06/03/2026 at 09:45 AM, Certified Nurse Aides (CNA) O and CNA P transferred R6 from her wheelchair to her bed with the use of a full body lift. R6's left hand remained with her fingers curled inward into a fist. On 06/02/2026 at 08:57 AM, CNA O stated she would open the resident's left hand enough to clean her fingers and palm but R6 was not able to fully open her hand and move her fingers. CNA O stated she was unsure if R6 received restorative care. On 06/02/2026 at 01:27 PM, CNA M stated she did restorative care with the residents. CNA M stated R6 did not receive restorative care. On 06/02/2026 at 01:30 PM, Administrative Nurse E confirmed R6 should receive PROM to her left hand but had not been receiving the care. Administrative Nurse E was unsure why R6 was not receiving restorative care, as care planned, for her left-hand contracture. On 06/03/2026 at 08:30 AM, Administrative Nurse D confirmed R6 had not received restorative nursing cares, as care planned. The facility policy for Nursing Restorative Care Program, revised 02/03/2025, included: The facility shall provide restorative nursing care to residents in order to maintain their optimal physical function and to prevent further impairment.