

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056</p> <p>The facility reported a census of 30 residents with 14 residents sampled, including three residents reviewed for dignity. Based on observation, interview, and record review, the facility failed to show respect and dignity to one Resident (R)4, when two staff members entered her room during cares. This placed the resident at risk for impaired dignity and embarrassment.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of R4's Electronic Medical Record (EMR) revealed a diagnosis of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord). <p>The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She was dependent on staff for rolling side to side in bed, toileting, and wheelchair mobility.</p> <p>The Urinary Incontinence/Indwelling Catheter Care Area Assessment (CAA), dated 02/25/25, triggered but lacked an analysis of findings.</p> <p>The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 15. She was dependent on staff for rolling side to side in bed, toileting, and wheelchair mobility.</p> <p>R4's Care Plan revised 04/17/25, revealed the resident was dependent on two staff for bed mobility and dependent on one staff for toileting.</p> <p>On 04/22/25 at 08:26 AM, Certified Nurse Aide (CNA) N and Certified Medication Aide (CMA) R were doing morning cares with the resident. The resident laid on top of the bed, uncovered, while staff were providing peri-care. The privacy curtain in the room was not pulled around the resident's bed. CNA M knocked on the resident's door to which CNA N responded, resident care. At that time, CNA M opened the door to the resident's room and spoke to the staff, with the door open, leaving the resident visible to residents or staff in the hall.</p> <p>On 04/22/25 at 08:30 AM, CMA R stated staff should not enter a resident's room while cares were being done.</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 |
|---|-------|-----------|
|---|-------|-----------|

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 04/22/25 at 10:01 AM, CNA N stated staff should not enter a resident's room while cares were being done.</p> <p>On 04/22/25 at 11:17 AM, Administrative Nurse D stated it was the expectation for staff to not enter a resident's room while the resident received cares.</p> <p>The facility policy for Promoting/Maintaining Resident Dignity, revised 12/18/24, included: The facility shall protect and promote resident's rights and treat each resident with respect and dignity while maintaining the resident's privacy.</p> |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52154</p> <p>The facility reported a census of 30 residents with 14 residents sampled. Based on observation, interview, and record review, the facility failed to verify Resident (R) 10's advanced directives (a legal document in which a person specifies what actions should be taken for their health, which may or may not include a do not resuscitate [DNR-decision whether, or not, to withhold medical intervention in the event the resident's heart stops] order). Additionally, the facility failed to ensure R10's DNR was signed by the resident. This deficient practice had the potential to lead to uncommunicated needs specifically to end-of-life care.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of the Electronic Health Record (EHR) for R10 included diagnoses of Parkinson's disease (a progressive neurodegenerative disorder that primarily affects the central nervous system, leading to both motor and non-motor symptoms), atherosclerotic heart disease of native coronary artery (a condition where plaque builds up inside the coronary arteries, which are the blood vessels that supply oxygen-rich blood to the heart), unspecified epilepsy (a person is known to have epilepsy but the specific type [focal, generalized, etc.] is not known or can't be determined), heart failure (a condition where the heart cannot pump enough blood to meet the body's needs, leading to fluid buildup in the lungs, legs, and other areas), essential hypertension (persistent elevated blood pressure with no identifiable cause) <p>The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) of 14, which indicated intact cognition.</p> <p>The Quarterly Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) of 14, which indicated intact cognition.</p> <p>R10's Care Plan documented on 03/21/25 that hospice care started, and the primary care physician had given a terminal diagnosis and estimated life expectancy of less than six months.</p> <p>R10' Care Plan documented on 03/21/25 that R10 wished to remain a DNR.</p> <p>A look back review of R10's EHR revealed a hospice certificate of terminal illness, dated 03/21/25, and listed R10 as full code.</p> <p>A look back review of the Physician Orders revealed an order for DNR, the date on the DNR was unreadable</p> <p>R10's EHR Home screen documented R10's code status (full code or DNR) as DNR.</p> <p>R10's EHR, under the scanned documents section, revealed a Do-Not-Resuscitate Directive signed by the physician, dated 02/24/23. The directive was not signed by the resident or representative.</p> <p>During an interview on 04/21/25 at 11:38 AM, R10 reported that she wished to be a DNR.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 04/21/25 at 01:56 PM, Administrative Nurse D reported that the DNR, dated 02/24/23, in the EHR was not signed by the resident and should have been.</p> <p>During an interview on 04/21/25 at 02:24 PM, Licensed Nurse (LN) G stated that the EMR lists the code status of the residents and that R10's code status listed her as DNR. LN G then reviewed R10's DNR and reported that it was not signed by R10.</p> <p>On 08/15/24 at 02:24 PM, Administrative Nurse D stated that if a discrepancy between the DNR order and the full code order was present, the expectation was for staff to honor the advanced directives that had the most recent date.</p> <p>The facility did not provide a policy for Advanced Directives.</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>51334</p> <p>The facility identified a census of 30 residents, with 14 residents sampled, including five residents reviewed for unnecessary medications. Based on record review, interview, and observation, the facility failed to notify the physician when Resident (R) 8 had a weight gain in 24 hours while on a diuretic (a class of medications used to promote the formation of urine and prevent fluid accumulation). This placed R8 at risk for delayed physician involvement and treatment options.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R8's Electronic Medical Record (EMR) documented a diagnosis of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). <p>The 08/22/24 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS recorded R8 weighed 289 pounds and took a diuretic.</p> <p>The 08/22/24 Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) documented R8 took a diuretic medication.</p> <p>The 02/20/25 Quarterly MDS documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS recorded R8 weighed 286 pounds and took a diuretic.</p> <p>R8's Care Plan documented R8's weight was monitored daily due to being on a diuretic.</p> <p>R8's EMR under the Physician Orders documented an order for daily weight due to being on a diuretic, dated 01/04/24.</p> <p>R8's EMR under the Physician Orders documented an order for furosemide (diuretic) 20 milligrams daily, dated 12/28/23</p> <p>R8's EMR from 01/01/25 through 04/01/25, revealed the resident gained weight on the following dates:</p> <ul style="list-style-type: none"> On 01/21/25, R8 gained seven pounds from the previous day. On 01/26/25, R8 gained four pounds from the previous day. On 02/10/25, R8 gained 5.6 pounds from the previous day. On 02/15/25, R8 gained four pounds from the previous day. On 03/31/25, R8 gained four pounds from the previous day. <p>R8's EMR lacked documentation of physician notification for the above dates with weight gain noted.</p> <p>(continued on next page)</p> | | |

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an observation on 04/23/25 at 09:02 AM, R8 sat in her wheelchair in the dining area. She had some swelling in her legs. She reported that sometimes the swelling was worse. She was wearing support hose and reported she wore them to keep the swelling down.</p> <p>During an observation on 04/21/25 at 08:22 AM, staff assisted R8 to get dressed, then assisted her to sit up on the side of the bed and transfer with a sit to stand lift. R8 was short of breath with the activity but recovered quickly once in the chair.</p> <p>During an interview on 04/22/25 at 04:38 PM, Licensed Nurse (LN) H stated that Administrative Nurse E tracked the weights and called the doctor except on the weekends, and then the nurse on duty did it.</p> <p>During an interview on 04/22/25 at 04:40 PM, Administrative Nurse E stated that the nurse on duty should call the doctor, following the order; or if the order does not have parameters, they should use their nursing judgment and call if the resident has a three-pound weight gain in a day. Administrative Nurse E said the nurse should have called the doctor for those weights.</p> <p>During an interview on 04/23/25 09:58 AM, Administrative Nurse D stated that the nurse should notify the doctor according to the parameters in the order. Administrative Nurse B said if there were no parameters ordered, she would reweigh the resident and notify the doctor if there was a 3-5 pound weight gain.</p> <p>The facility did not have a policy related to notifying a provider of weight changes for a resident with CHF and on a diuretic.</p> |

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056</p> <p>The facility had a census of 30 residents. The sample included 14 residents. Based on record review and interview, the facility failed to complete the comprehensive Minimum Data Set Assessment (MDS) for three sampled residents, Resident (R)4, R16, R26, R15, R30, and R22 when staff failed to ensure the triggered Care Area Assessments (CAA) were completed as required. This placed the residents at risk for unmet care needs and inaccurate assessments.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of R4's Electronic Medical Record (EMR) recorded a quarterly MDS, dated [DATE]. R4's EMR recorded a comprehensive MDS, dated [DATE], which lacked completion of the triggered CAAs, as required. Review of R16's EMR recorded a quarterly MDS, dated [DATE]. R16's EMR recorded a comprehensive MDS, dated [DATE], which lacked completion of the triggered CAA, as required. Review of R26's EMR recorded a quarterly MDS, dated [DATE]. R26's EMR recorded a comprehensive MDS, dated [DATE], which lacked completion of the triggered CAA, as required. Review of R15's EMR recorded a quarterly MDS, dated [DATE]. R5's EMR recorded a comprehensive MDS, dated [DATE], which lacked completion of the triggered CAA, as required. Review of R30's EMR recorded a significant change MDS, dated [DATE], which lacked completion of the triggered CAA, as required. Review of R22's EMR recorded a quarterly MDS, dated [DATE]. R22's EMR recorded a comprehensive MDS, dated [DATE], which lacked completion of the triggered CAA, as required. <p>The facility follows the Resident Assessment Instrument (RAI) in accurate completion of the MDSs.</p> | | |

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident receives an accurate assessment.</p> <p>51334</p> <p>The facility reported a census of 30 residents with 14 residents selected for review. Based on observation, interview, and record review, the facility failed to complete the Minimum Data Set for Resident (R) 7 within the required timeframes. This placed the resident at risk for unidentified care needs and inadequate plan of care.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R7's Electronic Medical Record (EMR) documented a diagnosis of schizoaffective disorder (a mental illness characterized by symptoms of both schizophrenia (like hallucinations and delusions) and a mood disorder (like bipolar disorder or depression), panic disorder [episodic paroxysmal anxiety], irritability and anger, seizure disorder (violent involuntary series of contractions of a group of muscles), post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), anxiety (class of medications that calm and relax people), insomnia (inability to sleep), and depressive disorder (major mood disorder which causes persistent feelings of sadness). <p>The 10/08/24 Admission Minimum Data Set (MDS) documented R7 had a Brief Interview for Mental Status (BIMS) of nine, indicating moderate cognitive decline, and a PHQ-9 severity score of one indicating no depression. R7 had no behaviors documented. R7 took an antidepressant (a class of medications used to treat mood disorders), and an anticonvulsant (medication used to prevent seizures) on a routine basis.</p> <p>The 10/08/24 Psychotropic Drug Use Care Area Assessment (CAA) documented R7 was admitted on an antidepressant medication. R7 had no adverse effects with these medications but had four falls since the last review.</p> <p>The 01/06/25 Quaterly MDS documented a BIMS of nine. PHQ-9 score of one. R7 had no behaviors documented and took an antidepressant and an anticonvulsant.</p> <p>The 03/18/25 Quarterly MDS was not completed.</p> <p>R7's Care Plan documented she received antidepressant medication observe for side effects initiated on 10/08/23. R7's plan directed staff to encourage her to verbalize her thoughts to a trusted staff member and assist R7 to identify and implement effective coping skills, initiated on 10/08/23. Those medications had Black Box Warnings (BBW- highest safety-related warning that medications can have assigned by the Food and Drug Administration).</p> <p>During an observation on 04/21/25 at 10:21 AM, R7 was in bed with her eyes closed. R7 was not aroused when staff talked in the room or called her name. Staff reported that she slept a lot.</p> <p>During an interview on 04/23/25 at 09:58 AM, Administrative Nurse D stated she expected the MDS and CAAs to be completed accurately.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | The Resident Assessment Instrument (RAI- is a comprehensive, standardized tool used in long-term care facilities to assess residents, guide care planning, and monitor quality of care.) documented a quarterly assessment must be completed every 92 days. | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>51334</p> <p>The facility identified a census of 30 residents. The sample included 14 residents with one sampled for catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). Based on observation, interview, and record review, the facility failed to address catheter care on Resident (R) 83's baseline care plan. This deficient practice had the risk for adverse outcomes and complications for R83 due to uncommunicated care needs.</p> <p>Findings:</p> <ul style="list-style-type: none"> - R83's Electronic Medical Record (EMR) documented a diagnosis of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). <p>The 04/14/25 Admission Minimum Data Set (MDS), documented a Brief Interview for Mental Status (BIMS) of 11, indicating moderately impaired cognition. The MDS recorded R83 required assistance from staff with activities of daily living (ADLs) and had a catheter.</p> <p>The 04/14/25 Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) R83 had a diagnosis of neurogenic bladder. She was unable to bear weight to access the toilet. The CAA noted the catheter was put in while she was in the hospital.</p> <p>R83's Baseline Care Plan, dated 04/09/25, documented R83 will have her wounds assessed and pain addressed. R83's Baseline Care Plan lacked documentation that R83 had a catheter or instructions for catheter care.</p> <p>R83's EMR under the Orders tab documented the following orders:</p> <p>Foley catheter with dependent drainage for neurogenic bladder and to prevent skin breakdown started on 04/14/2025.</p> <p>On 04/22/25 at 08:22 AM, R83 laid in bed with her catheter bag hanging on the side of her bed. The catheter bag had dark red urine.</p> <p>On 04/22/25 at 08:50 AM, Certified Medication Aide (CMA) R reported that R83 always had red, dark urine.</p> <p>On 04/23/25 at 09:16 AM, Certified Medication Aide (CMA) T reported that the staff look up information on how to care for the residents by looking on the matrix.</p> <p>On 04/23/25 at 09:48 AM, Administrative Nurse E stated the catheter care should be on the Baseline Care Plan that is completed on admission.</p> <p>On 04/23/25 at 09:58 AM, Administrative Nurse D stated that the Baseline Care Plan should have included catheter care.</p> <p>(continued on next page)</p> | | |

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The facility policy for 48-hour Care Plan, undated, noted the facility will develop and implement a baseline care plan for each resident to meet their immediate care needs.</p> |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056</p> <p>The facility reported a census of 30 residents with 14 residents sampled, including two residents reviewed for activities of daily living (ADL). Based on observation, interview, and record review, the facility failed to recognize, assess, and implement interventions consistent with Resident (R)26's current level and/or mode of assistance required for transfers. This placed the resident at risk for injury and further ADL decline.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R26's Electronic Medical Record (EMR) revealed a diagnosis of cerebrovascular accident (CVA-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). <p>The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She required substantial to maximal assistance of staff for transfers and had an impairment on one side of her lower extremity (LE).</p> <p>The Functional Abilities Care Area Assessment (CAA), and the Fall CAA, dated 01/29/25, triggered but lacked an analysis of findings.</p> <p>The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 15. She had an impairment in her range of motion (ROM) on one side of her upper extremity (UE) and LE.</p> <p>R26's Care Plan for ADL, revised 01/29/25, instructed staff the resident had a CVA affecting her right side. Staff were to ensure the resident's feet were flat on the floor during the transfer and she required substantial assistance of one staff for transferring.</p> <p>Review of the resident's EMR lacked staff documentation of the assistance required to transfer the resident.</p> <p>On 04/22/25 at 09:50 AM, Certified Nurse Aide (CNA) N and CNA O transferred the resident from her wheelchair to her recliner in her room. Staff utilized a gait belt and transferred the resident with total assist of both staff. The resident was unable to bear weight on either leg during the transfer and her feet were not flat on the floor.</p> <p>On 04/22/25 at 08:30 AM, CNA O stated the resident could bear weight at times, but not always. CNA O confirmed the resident's feet were not flat on the floor during the transfer.</p> <p>On 04/22/25 at 08:30 AM, CNA N stated the resident could bear weight at times, but it depended on the day.</p> <p>On 04/22/25 at 09:59 AM, Administrative Nurse D stated a resident should be able to bear weight during a transfer.</p> <p>The facility policy for ADLs was not available.</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056</p> <p>The facility reported a census of 30 residents with 14 residents sampled, including four residents reviewed for positioning and range of motion (ROM). Based on observation, interview and record review, the facility failed to perform restorative cares for Residents (R)4, R26, and R16 and failed to properly position R4 while in her Geri-chair (a specialized wheelchair).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R4's Electronic Medical Record (EMR) revealed a diagnosis of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord). <p>The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She had a limitation in functional ROM on both sides of her lower extremities and was dependent on staff for transfers and wheelchair mobility. The resident did not receive restorative cares during the assessment period.</p> <p>The Functional Ability Care Area Assessment (CAA), dated 02/25/25, triggered but lacked an analysis of findings.</p> <p>The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 15. She had a limitation in ROM to her bilateral lower extremities and was dependent on staff for transfers and wheelchair mobility. The resident did not receive restorative cares during the assessment period.</p> <p>R4's Care Plan revised 04/17/25 instructed staff the resident received restorative care with active range of motion to her bilateral upper extremities (UE) for 20 repetitions in a pain-free range, six to seven days per week for 15 minutes, to maintain her current functional capacity as well as flexion (bending) and extension (straightening) of the resident's shoulders, elbows and arms, six to seven days per week for 15 minutes, to maintain her current functional capacity.</p> <p>Review of the resident's EMR from February 1, 2025, through 04/22/25, revealed restorative cares had not been completed with the resident.</p> <p>On 04/22/25 at 08:26 AM, Certified Nurse Aide (CNA) N and Certified Medication Aide (CMA) R entered the resident's room to perform cares. The resident bilateral lower extremities were contracted in an abnormal manner and her UE had no limitation in ROM. CNA N and CMA R transferred the resident from her bed to her Geri-chair and took her to the dining room for breakfast. Once at the dining room table, staff sat the Geri-chair up from a reclining position to set the resident at the dining table. The resident's bilateral feet dangled above the dining room floor by several inches and had no support.</p> <p>On 04/22/25 at 09:19 AM, the resident's feet continued to dangle above the dining room floor as she sat in her Geri-chair.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 04/22/25 at 09:50 AM, CNA O stated restorative cares were documented in the computer every time they were done. CNA O stated she was unaware the resident's feet dangled above the floor while her Geri-chair was in a sitting position.</p> <p>On 04/22/25 at 10:01 AM, CNA N stated she did not know the resident's feet did not have support when the Geri-chair was put up into the upright position for meals. CNA N stated the restorative cares are done by the restorative person and that CNAs did not do restorative cares.</p> <p>On 04/22/25 at 11:17 AM, Administrative Nurse D stated the restorative cares had not been getting done. Administrative Nurse D confirmed the resident's feet needed some type of support while her Geri-chair was in an upright sitting position at the dining room table.</p> <p>The facility policy for Wheelchair Positioning, implemented 12/18/24, included: All wheelchair users will be positioned appropriately to support optimal posture, functional mobility, comfort, and skin integrity.</p> <p>The facility policy for Restorative Nursing Programs, revised 01/06/25, included: The facility shall provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level.</p> <p>- Review of R26's Electronic Medical Record (EMR) revealed a diagnosis of cerebrovascular accident (CVA-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).</p> <p>The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. She had no functional limitation in range of motion (ROM) and required substantial to maximal staff assistance with transfers; she did not ambulate during the assessment period. The resident did not receive restorative care during the assessment period.</p> <p>The Functional Abilities Care Area Assessment (CAA), dated 01/29/25, triggered but lacked an analysis of findings.</p> <p>The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 15. She had a limitation in ROM on one side of her lower extremity and required substantial to maximal staff assistance with transfers. The resident did not ambulate during the assessment period. She received passive range of motion (PROM) and active range of motion (AROM) two days of assessment period.</p> <p>R26's Care Plan revised 01/29/25 instructed staff the resident was on a restorative nursing program and to perform AROM with her lower extremities for 20 repetitions in a pain-free range, six to seven days per week for 15 minutes. Staff were instructed to complete upper extremity exercises with the resident with one-pound weights with her left arm for 10 repetitions each for shoulder and elbow flexion (bend) and flexion (straighten), for 15 minutes, six to seven days per week.</p> <p>Review of the resident's EMR from 02/01/25 through 04/22/25, revealed the resident received restorative cares for 12 days in February, eight days in March and one day in April. No other restorative cares were documented.</p> <p>(continued on next page)</p> | | |

| | | | |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 04/22/25 at 09:50 AM, Certified Nurse Aide (CNA) N and CNA O transferred the resident from her wheelchair to her recliner in her room. Staff utilized a gait belt and transferred the resident with total assist of both staff. The resident was unable to bear weight on either leg during the transfer.</p> <p>On 04/22/25 at 09:50 AM, CNA O stated the resident was to receive daily restorative cares but was not getting it daily.</p> <p>On 04/22/25 at 09:59 AM, Administrative Nurse D stated restorative cares would be documented in the computer. Administrative Nurse D confirmed the facility was not getting the restorative cares done at this time.</p> <p>The facility policy for Restorative Nursing Programs, revised 01/06/25, included: The facility shall provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level.</p> <p>- Review of R16's Electronic Medical Record (EMR) revealed a diagnosis of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord).</p> <p>The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. She had no limitation in range of motion (ROM) and did not receive restorative care during the assessment period.</p> <p>The Functional Abilities Care Area Assessment (CAA), dated 04/14/24, triggered but lacked an analysis of findings.</p> <p>The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 15, indicating intact cognition. She had no impairment in ROM and did not receive restorative care during the assessment period.</p> <p>R16's Care Plan revised 01/15/25 instructed staff to complete upper extremity) exercises with the resident with one-pound weights with her left arm for 10 repetitions each for shoulder and elbow flexion (bend) and flexion (straighten), for 15 minutes, six to seven days per week.</p> <p>Review of the resident's EMR revealed she had not received restorative cares.</p> <p>On 04/22/25 at 09:50 AM, Certified Nurse Aide (can) O stated the resident was to receive daily restorative cares but was not getting it daily.</p> <p>On 04/22/25 at 09:59 AM, Administrative Nurse D stated restorative cares would be documented in the computer. Administrative Nurse D confirmed the facility was not getting the restorative cares done at this time.</p> <p>The facility policy for Restorative Nursing Programs, revised 01/06/25, included: The facility shall provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level.</p> | | |

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>34056</p> <p>The facility reported a census of 30 residents. Based on observation, interview, and record review, the facility failed to have Registered Nurse (RN) coverage for at least eight consecutive hours as required. This placed the residents in the facility at risk for unsupervised nursing care and services.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of the facility's Daily Staff Posting from 05/01/24 through 07/30/24, revealed the facility did not have the required eight consecutive hours of RN coverage, as required, on 05/05/24, 06/02/24, 06/16/24, 07/13/24, 07/14/24, 07/20/24, 07/21/24, 07/27/24, and 07/28/24. <p>On 04/23/25 at 08:17 AM, Administrative Nurse E was unable to verify the facility had an RN for eight consecutive hours on the mentioned dates.</p> <p>The facility did not provide a policy for having an RN on duty for at least eight consecutive hours every 24 hours.</p> |

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p> | <p>Post nurse staffing information every day.</p> <p>34056</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of the facility's Daily Staffing Sheets, for the past 30 days, revealed the actual hours worked had not been completed on the daily staffing sheets. <p>On 04/23/25 at 08:17 AM, Administrative Nurse E stated she was unaware the daily staff postings needed to include the actual hours worked.</p> <p>The facility policy for Posting Direct Care Daily Staffing Numbers, revised July 2016, included: The facility shall post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents, including the actual time worked during that shift for each category.</p> |

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175415 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Elmhaven East | | STREET ADDRESS, CITY, STATE, ZIP CODE 1400 S 15th Street 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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>52154</p> <p>The facility reported a census of 30 residents. The sample included 14 residents. Based on interviews, record reviews, and observation, the facility staff failed to implement adequate and acceptable infection control practices for Resident (R) 15 whose oxygen tubing was allowed to drag the floor as he wheeled himself through the facility. This deficient practice placed the resident at risk of infections.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - During an observation on 04/21/25 at 08:30 AM, R15 sat in the dining room in his wheelchair wearing an oxygen nasal cannula (a device that delivers extra oxygen through a tube and into your nose). R15's oxygen tubing was wrapped around part of his wheelchair and dragging on the floor. During an observation on 04/21/25 at 10:13 AM, R15 was wearing continuous oxygen, and his oxygen tubing was tangled on his wheelchair axle and dragging on the floor as he wheeled himself down the hall. During an observation on 04/21/25 at 01:31 PM, R15 was sat in his room watching TV and his oxygen tubing was on the floor under his wheelchair. During an observation on 04/22/25 at 08:15 AM, R15 was in the dining room, sitting in his wheelchair and his oxygen tubing draped over his wheelchair axle and rested on the floor. During an interview on 04/22/25 at 08:24 AM, Licensed Nurse (LN) G reported that R15's oxygen tubing should not have been dragging on the floor, it should have been stored in the black pouch on the back of his wheelchair. During an interview on 04/22/25 at 08:28 AM, Administrative Staff A stated that R15's excess oxygen tubing should have been secured in the pocket on the back of his wheelchair. During an interview on 04/22/25 at 08:32 AM, Administrative Nurse D reported that R15's oxygen tubing should not have been draped over the wheelchair axles or dragging on the floor. During an interview on 04/22/25 at 08:58 AM, Certified Nurse Aide (CNA) P reported that oxygen tubing should not have been dragging the ground or have been wrapped around the wheelchair, tubing should have been placed in the wheelchair pocket. <p>The facility's policy titled Oxygen Administration, dated 12/18/24, failed to document the storage and management of oxygen-delivering devices to prevent contamination or infection.</p> | | |