STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175415	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elmhaven East	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to provide sanitary conditions for food storage and preparation in the facility's one kitchen to prevent the spread of food borne illness to the residents of the facility. Findings included:- Initial tour of the kitchen on 06/08/2026 at 08:28 AM with Dietary Staff DD revealed the following areas of concern: Numerous baking sheets, baking pans, and cooking pots had black staining on the interior and exterior of the cookware and bakeware. Ground nutmeg and ground cloves dated 11/11/2019. An undated, unsealed bag containing a biscuit, an unsealed, undated loaf of bread, and a box of brown rice dated 05/20/2026 with an expiration date of 03/04/2026. There were food items not clearly dated, which created an inability to confirm what year was intended for those items. One container of ketchup dated 02/12, one large container of picante sauce dated 02/24, one large container of relish dated 03/24, one jar of spicy mustard dated 06/04, one unsealed bag of meat dated 06/04, one unsealed bag of meat dated 06/05, numerous packages of butter dated 05/11, and a few packages of butter dated 06/04. There were items that were either not dated and/or the packaging was unsealed: one jar of horseradish mustard not dated, one bag of whole carrots unsealed and undated, one unsealed and undated bag of mandarin oranges, one pan of fruit cobbler that was not labeled or dated and one pan of chocolate chip cookies that was not labeled or dated sitting on top of baking sheets and pans located underneath the cooks prep table. Further observation of the cooler documented that there were five uncovered crates of eggs on the bottom of the cooler, exposed to open packages of meat and food on the open shelf above them. Five boxes of pancake mix dated 06/04, five bags oatmeal dated 05/21, and one bag of oatmeal dated 06/07, ten containers of syrup dated 05/28, three cans of jellied cranberries dated 04/03, one jug of Worcestershire sauce dated 01/19, one jug of teriyaki sauce dated 10/23, one unsealed bag of tortillas dated 06/05, two bags of sliced oranges and two bags of red grapes dated 06/04 on cart in unrefrigerated pantry, one box of no bake cheesecake dated 04/24, one package of walnut pieces dated 04/13, seven bags of powdered sugar dated 09/18, five bags of sugar dated 05/14, one unsealed bag of potato chips, one undated package of dried cranberries, an unsealed and undated large package of spaghetti noodles,. One bag of frozen sausage patties dated 5/10, one bag of sausage links dated 06/06, and one bag of uncooked frozen roll dough was unsealed, undated, and not labeled. Observation on 06/08/2026 at 09:01 AM documented a chest freezer containing several packages of frozen food without a thermometer inside the freezer. The chest freezer temperature log for June 2026 documented the following temperatures:06/09/2026 AM -4 degrees PM 3 degrees06/08/2026 AM 5 degrees PM 5 degrees06/07/2026 AM 5 degrees PM no documented temperature06/06/2026 AM 5 degrees PM -4 degrees06/05/2026 no documented temperatures06/04/2026 AM -5 degrees PM -5 degrees06/03/2026 AM -5 degrees PM 4 degrees06/02/2026 AM -5 degrees PM 5 degrees06/01/2026 AM -5 degrees PM 4 degrees Observation on 06/10/2026 at 08:15 AM documented the cooler with six bottles of undated protein shakes. During an interview on 06/08/2026 09:07 AM, Dietary Staff DD reported that the chest freezer should have a thermometer in it and that if the thermometer falls to the bottom of the freezer or it is just not in there staff does not dig through the freezer to find it and if the thermometer is not found (continued on next page)

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	they just put a temperature on the temperature log close to what temperatures had previously been recorded. Dietary Staff DD further reported that when using the sheets & pans that are blackened, she uses tin foil to cover the pans and sheets prior to using them. During an interview on 06/10/2026 at 10:23 AM, Dietary Staff BB reported that the coolers and freezers should always have a working thermometer, and any recorded temperature should be the observed temperature; staff should never document a temperature if it was not observed. All food items should be dated with a visible and readable date that includes the day, month, and year. Dietary Staff BB also reported that spices & any food item that is expired should be removed and not used, and food packaging should be secured. Eggs should have protection if they are stored underneath open food items. Food should never be stored on bakeware and should always be labeled and dated. Dietary Staff BB did dispose of the undated and unlabeled cobbler and cookies as soon as she saw them. During an interview on 06/10/2026 at 11:12 AM, Dietary Staff CC reported that staff should be dating food items accurately, and the date should have the year on it as well. Food items should always be accurately dated and labeled with the contents of the container. Dietary Staff CC further reported that no temperature should ever be logged if it was not observed. All coolers and freezers should always have a working thermometer, and temperatures should be monitored daily, eggs should not be stored below any food item that has the possibility to contaminate them. The facility's undated Food Storage (Dry, refrigerated, and frozen) guideline documented that all food shall be stored on shelves in a clean, dry area free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure the mandatory 12 hours of education was completed for Certified Nurse Aides (CNA)/Certified Medication Aides (CMA) as required. Findings included:- A review of the facility's staffing list revealed the following CNAs were employed with the facility for more than 12 months: CNA M was hired on 11/20/2024. She had no specific hours tracked for in-service training.CNA O was hired on 01/23/2023. She had no specific hours tracked for in-service training.CNA LL was hired on 07/18/2024. He had no specific hours tracked for in-service training.CNA PP was hired on 07/19/2021. She had no specific hours tracked for in-service training.CNA QQ was hired on 08/16/2024. She had no specific hours tracked for in-service training. Upon request of the CNA in-service hours, the facility provided monthly in-service sign-in sheets for the months from 05/2025 through 05/2026 that included staff names and signatures in attendance. The list lacked staff certification or position. The sheets lacked specific times for the required topics. During an interview on 06/09/2026 at 01:46 PM, Administrative Staff A stated that there was CNA/CMA training throughout the year as needed, with meetings where they review the policy, including in-house videos, huddles with education, and constant in-service meetings with staff that were documented, and he felt that was acceptable as it keeps track of all hours of the meetings. He stated he had another sheet to keep track of the hours for that and would bring it to us. During a second interview on 06/09/2026 at 02:03 PM, Administrative Staff A stated that he did not have anything that showed that the hours and training were done for the specific training, just timecards showing they clocked in and out for the day, and he had a meeting for training but nothing that kept track of each one individually and what the training was. He had a sign-in sheet for in-service meetings. During an interview on 06/10/2026 at 10:38 AM, Administrative Nurse F stated that they do not use any computer-based training. They use an outline on a written sign in sheet and give handouts for staff to refer to. Administrative Nurse F stated they do not keep track of specific hours. During an interview on 06/10/2026 at 11:17 AM, CNA M stated that they received annual abuse, neglect, and exploitation training and that they have meetings where they would watch videos as a group and receive paperwork to refer to by clocking in for the meeting if they were not already clocked in.The facility policy In-Service Training Program, Nurse Aide dated 2001, revised on 12/2016, documented that all nurse aide personnel would participate in regularly scheduled in-service training classes. Annual in-services must be no less than 12 hours per employment year.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interviews, record reviews and observation, the facility staff failed to implement adequate infection control practices related to hand hygiene and sanitization of shared equipment. The facility staff also failed to implement adequate Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) for Resident (R) 1 while flushing his urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag). Findings included:- Observed on 06/09/2026 at 07:50 AM, R16 had an EBP gown and gloves with signage outside her room. Observed on 06/09/2026 at 07:58 AM, Licensed Nurse (LN) G performed hand hygiene and then donned a gown and gloves and proceeded to apply skin lotion to R16's arms and legs. R16 had a skin tear to her left forearm, a scabbed wound on her left hand, a deep tissue wound to her right heel, and a wound on her right shin that had Steri-strips (adhesive wound closures) on it. LN G did not change gloves or perform hand hygiene before applying lotion to R16's different limbs. Once the lotion was applied, LN G removed her gloves, performed hand hygiene and then put on clean gloves and placed the clean dressing supplies directly on R16's bed sheet, next to her right leg. The bed sheet was visibly soiled and had a large amount of blood on it next to her head. LN G then performed wound care on R16's right leg and heel without placing a barrier between the leg and the bed sheet. LN G cleaned the wound and applied the clean dressings without changing gloves and performing hand hygiene. Once the wound care was completed, LN G removed her gloves, touched the clean dressing with her bare hand, and dated it. Observed on 06/09/2026 at 08:50 AM, the Hoyer lift was taken into R16's room without being sanitized. Staff used the Hoyer and then it was removed from R16's room and taken to another room without being sanitized. Observed on 06/09/2026 at 08:57 AM, LN G performed hand hygiene, donned clean gloves, and then flushed R1's urinary catheter. She did not wear a gown for EBP. On 06/09/2026 at 10:40 AM, LN G stated that she should have changed gloves and performed hand hygiene when she applied lotion to each limb of R16, and she should have had a barrier on the sheet when she performed wound care. She also said that she should not have placed the clean wound supplies directly on the sheet, should have changed gloves and performed hand hygiene between each step of the wound care, and should have maintained gloves when dating the dressing. LN G also said she should have worn a gown along with gloves when performing the catheter flush. On 06/09/2026 at 11:05 AM, Administrative Nurse E stated that when handling or performing any urinary catheter care, there should have been gloves and a gown worn. She also said that after every Hoyer lift use, it was to be properly sanitized regardless of EBP PPE. Administrative Nurse then said that gloves and hand hygiene were to be performed from dirty to clean dressing changes and from wound area to wound area, and there should have been a barrier placed on the surface under the limb or body part that the wound was on, and the clean supplies should not have been placed directly on a surface without barrier protection. The facility policy Infection Control Policy, dated 05/21/2023, documented that hand hygiene would be performed before and after contact with a resident, immediately after touching blood, body fluids, non-intact skin, mucous membranes or contaminated items (even when gloves were worn during contact), immediately after removing gloves, when moving from contaminated body sites to clean body sites during resident care, and after touching objects and medical equipment in immediate resident care area. The policy also documented that routine cleaning and disinfection of resident care equipment, including equipment shared among residents, would be performed prior to and after each use.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview, observation, and record review, the facility failed to protect the dignity of Resident (R) 16 when staff left her breasts exposed unnecessarily while proving care and did not offer or place to a cover for the exposed areas not being cared for. Findings included:- The Electronic Medical Record (EMR) for R16 documented diagnoses of anorexia nervosa (an eating disorder and serious mental health condition), history of falling, gout (inflammation of the joints), type 2 diabetes mellitus with diabetic neuropathy (a common complication of type 2 diabetes mellitus where chronically high blood sugar damages nerves throughout the body), and major depression. R16's admission Minimum Data Set (MDS), dated 05/06/2026, documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The assessment documented that she used a wheelchair for mobility. The MDS did not indicate R16 used a mechanical lift for transfers. The MDS documented that she required substantial to maximum assistance with oral and personal hygiene, as well as upper-body dressing. R16 was dependent on staff for all other activities of daily living (ADL) and all transfers. R16's ADL-Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 05/06/2026, documented that she had falls, contractures (abnormal fixation of a joint or muscle), was incontinent, required substantial to maximum assistance for oral and personal hygiene and upper body dressing, and was dependent on staff for all other ADL's. R16's Urinary Incontinence and Indwelling Catheter CAA, dated 05/06/2026, documented that she was always incontinent of bowel and bladder. R16's Care Plan, dated 05/10/2026, documented that she was no longer capable of completing her own ADL's due to a decline in physical functioning from multiple past falls at home before admission that have resulted in overwhelming fear of falling again. The interventions, dated 05/10/2026, documented that R16 was dependent on staff for toileting hygiene and lower body dressing, and she required substantial staff assistance for personal hygiene and upper body dressing. Observed on 06/09/2026 at 08:21 AM, R16 had a bowel movement, and Licensed Nurse (LN) G, Certified Nurse Aide (CNA) M, and CNA N cleaned her up and then dressed her. During the entire ADL care process, she was left fully naked on her bed with no dignity cover offered or placed over her body. Her breasts were left exposed unnecessarily. On 06/09/2026 at 08:51 AM, CNA N said that during the ADL cares performed on R16, a sheet should have been placed over R16's upper body for dignity. On 06/09/2026 at 11:05 AM, Administrative Nurse E stated that when ADL cares were performed on a naked resident, there should have been some type of dignity cover placed over the resident, the curtain pulled, and the door closed. On 06/09/2026 at 11:17 AM, Administrative Nurse D stated that when ADL cares were performed on a resident, staff should have ensured the window blinds were closed, the privacy curtain and/or door were shut, and the area where the resident cares were not performed should have had a dignity cover. The facility policy Resident Rights, dated December 2016, documented that employees would treat all residents with kindness, respect, and dignity.

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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. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 7's psychotropic as-needed (PRN) medication had the required 14 days stop date or a specified duration with a physician documented, rationale for the extended duration. Findings included:-R7's Electronic Medical Record (EMR) revealed the following diagnoses: anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), and dementia (a progressive mental disorder characterized by failing memory and confusion) with delusions and/or hallucinations. R7's 12/10/2025 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS recorded R7 took an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), anticonvulsant, and opioid (a class of controlled drugs used to treat pain). R7's 12/10/2025 Psychotropic Drug Use Care Area Assessment (CAA) documented that R7 had behaviors and was transferred to a behavior unit. R7 returned with an antipsychotic and appeared cheerful and no longer tried to exit without staff knowledge. R7 took an antidepressant and an antianxiety routine as needed. R7's Care Plan documented that R7 took two different antianxiety medications, an antidepressant, and an antipsychotic. R7's Physician's Orders documented an order for Ativan (medication to treat anxiety) 0.5mg twice a day as needed, start date 12/24/2025. The order lacked a stop date. On 06/08/26 at 10:25 AM, R7 went to her room and invited this nurse in to visit. R7 appeared relaxed, in a very pleasant mood, and answered questions appropriately. On 06/09/26 at 10:42 AM, Administrative Nurse E stated she called the doctor every two weeks to continue the order for the as needed Ativan, but the order did not have a stop date. She did not know it was a requirement for the order to have an actual stop date. Administrative Nurse E stated the doctor did not provide a rationale for extending the as-needed Ativan stop date longer than two weeks. On 06/10/2026 11:23 AM, Administrative Nurse D stated she was unaware that antianxiety medications that were given PRN were required to have a two week stop date unless there is a rationale for an extended duration with a stop date. The facility policy for Antipsychotic Medication Use, undated, documented that the need to continue as-needed orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration for the as needed order will be indicated in the order.

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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. Based on observation, interview, and record review, the facility failed to provide Resident (R) 3 with a written notification of transfer to the resident and/or his representative as soon as practicable after R3 was transferred to the hospital. Findings included:- R3's Electronic Medical Record (EMR) revealed a diagnosis of severe sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body), renal failure (inability of the kidneys to excrete waste, concentrate urine, and conserve electrolytes), and below-the-knee amputation (surgical removal of a body part). R3's 04/27/2026 at 10:04 AM Nurse's Note documented that he lay on his bed staring off. R3's pupils were dilated, and his response was sluggish. R3 slurred his words; he was unable to finish a sentence, unable to communicate what was wrong, and his breathing was rapid. The nurse notified the doctor, and R3 was transported to the hospital by ambulance. R3's EMR lacked evidence that written notification of the transfer was provided to R3 or his representative. Upon request, the facility was unable to provide evidence. Observed on 06/08/2026 at 09:13 AM, R3 sat on his bed while putting on his below-the-knee prosthesis. He had a dialysis port on his chest that he reported was placed when he was in the hospital with renal failure. On 06/09/2026 at 09:05 AM, Social Services X stated that she had obtained the signed bed holds. Social Services X said she had not been aware of the regulation that required residents or their representative to be notified in writing of transfers and the reason for the transfer. On 06/09/2026 at 10:30 AM, Administrative Staff A stated he had notified the ombudsman when a resident was transferred out of the facility but had not notified the residents' representative in writing of the discharge or transfer. The facility's undated policy Transfer or Discharge Documentation documented that upon a transfer or discharge, appropriate notice was provided to the resident or legal representative and would be documented in the chart.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to review and revise Resident (R) 6's Care Plan to reflect her current and accurate advance directives. Findings included:R6's Electronic Medical Record (EMR) documented diagnoses of anxiety, depression, weakness, and hemiplegia (paralysis of one side of the body)and hemiparesis (weakness and paralysis on one side of the body) following cerebral infarction (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). R6's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of seven, indicating a severe impairment. R6's Care Plan dated [DATE] and revised on [DATE] documented that cardiopulmonary resuscitation (CPR) would be initiated when the resident's heart function or respirations ceased. CPR would continue until emergency medical staff arrived to transport R6 to the emergency department. R6's EMR, under the Documents tab, listed a DNR Do-Not-Resuscitate Directive signed by R6 on [DATE]. Observation of R6' s name tag on [DATE] at 11:53 AM revealed a red heart sticker. During an interview on [DATE] at 11:47 AM, Certified Nurse Aid (CNA)N stated that the code status of a resident was on their name tag on the outside of their door with a red heart sticker for DNR or a yellow heart sticker for a full code. CNA N stated that R6 had a red sticker next to her name outside her door indicating that she was a DNR. CNA N also stated there was a list at the nurse's station that documented R6 was a DNR, and it would be in her chart. During an interview on [DATE] at 11:53 AM, Licensed Nurse (LN) G stated that there is a red or yellow heart sticker on the resident's door next to their name indicating their code status. LN G stated that R6 showed that she was a DNR on her door. LN G stated that it would be indicated on the MAR, on the nurse shift report sheet, and on the care plan. During an interview on [DATE] at 11:57 AM Administrative Nurse D. Administrative Nurse D stated that she was not sure if the code status should be documented in the care plan, as Administrative Nurse F oversees care plan revisions. During an interview on [DATE] at 12:01 PM, Administrative Nurse F stated the code status was documented in the care plan. Administrative Nurse F said the director of nursing and the charge nurse could update the care plans if needed. She confirmed that R6's Care Plan was not updated to show the code status of DNR, and she would make sure it would be updated. The facility policy Care Plans. Comprehensive Person-Centered, undated, documented it was the policy for a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs and is developed and implemented for each resident.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to offer and administer or obtain an informed declination for the influenza (highly contagious viral infection) immunization for Resident (R) 21 and R12. This placed the residents at risk for complications related to influenza infections. Findings included:- R21's Electronic Medical Record (EMR) revealed a signed vaccine record that documented he declined the influenza immunization on 08/09/2023. R21's EMR lacked evidence that the vaccine was offered and/or lacked evidence of informed declination for the 2025 flu season. - R12's EMR revealed a signed vaccine record that documented that her legal representative had declined for her to have the influenza immunization on 05/10/2024. R12's EMR lacked evidence that the vaccine was offered and/or lacked evidence of informed declination for the 2025 flu season. On 06/08/2026 at 01:45 PM, Administrative Nurse E stated there are no vaccine refusals for the 2025/2026 influenza season for R21 and R12. She said that they were verbally offered the immunizations and declined, but it was not documented. On 06/09/2026 at 11:25 AM, Administrative Nurse D stated that she did not know when or how often the influenza immunization was offered to residents and said she would have to ask Administrative Nurse E. A few minutes later, Administrative Nurse D said that residents were to be offered influenza immunizations annually regardless of past refusals and then documented in the chart. The facility policy Influenza, Prevention and Control of Seasonal documented that the infection preventionist would promote and administer the seasonal influenza vaccine. Unless contraindicated, all residents and staff would be offered the vaccine.