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 _____	C 06/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARSONS PRESBYTERIAN MANOR	**3501 DIRR AVENUE PARSONS, KS 67357**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint #153097. Furthermore A Targeted Infection Control Survey/COVID-19 Focused Survey was conducted by Kansas Department for Aging and Disability Services (KDADS)) on June 3, 2020. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID 19. The 2567 was electronically sent to the facility on 06/05/2020.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 28 residents, which included three residents reviewed for abuse.
Based on observation, interview, and record review, Licensed Nurse (LN) G failed to report immediately to administrative staff, an allegation of physical abuse verbalized by Certified Nurse Aide (CNA) N, to one Resident (R) 1.

Findings included:

- Review of R1's undated, "Physician Order Sheet," revealed diagnoses included dementia (progressive mental disorder characterized by failing memory, confusion) without behaviors and hemiplegia (paralysis of one side of the body) due to cerebral vascular accident (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).

The "Annual Minimum Data Set" (MDS), dated 03/21/2020, assessed the resident with a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment and no physical or verbal behaviors directed at self or others and no rejection of care. The resident required extensive assistance of two staff for toileting and personal hygiene. The resident had

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no impairment in range of motion in all extremities.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA,) dated 03/21/2020, assessed the resident had decreased physical functioning, weakness, poor standing balance, coordination and poor safety awareness. The resident required extensive assistance with toileting.

The "Mood State CAA" and "Behavioral Symptoms CAA" did not trigger.

The care plan, revised 04/12/20, instructed staff the resident needed extensive assistance for toileting. The resident had limited ability to interact with social interactions and may become agitated if told what to do. Staff instructed to speak to the resident in a calm manner and to allow adequate time without making the resident feel rushed.

Interview, on 06/03/2020 at 9:59 AM, with Licensed Nurse (LN) G, revealed the resident could be resistive to cares at times and had not witnessed staff to resident verbal or physical abuse. LN G stated on 05/29/2020 at approximately 02:45 PM, CNA M reported to her that she and CNA N provided incontinence care to R1. CNA M reported that CNA N told the resident to shut up, and then stated she was going to put a pillow over her head.. LN G stated staff were at the end of their shift and CNA N had left for the day. LN G stated she did not feel CNA N literally meant that she would suffocate the resident. LN G stated she did not report this to administration at that time but did report it to Administrative Nurse D on 06/01/2020.

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Observation, on 06/03/2020 at 10:49 AM, revealed the resident sitting in her wheelchair in the dining room reading a newspaper. The resident responded to questions stating that she is perfectly well and did not need staff assistance with dressing and grooming, and then made a loud startling noise and laughed. The resident did not remember the incident.

Interview, on 06/03/2020 at 11:00 AM, with CNA O, revealed the resident required staff assistance with toileting due to incontinence, and could become resistive to cares at times. CNA O stated staff should return later to provide the care to allow the resident to calm down and become distracted. CNA O stated this approach usually worked. CNA O stated she had not witnessed any verbal/physical altercations between CNA N and residents, but at times her tone could be hurried and sharp.

Interview, on 06/03/2020 at 11:15 AM, with Licensed Nurse (LN) H, revealed the resident generally cooperated with staff but could become verbally inappropriate in response to staff. LN H stated she had not witnessed staff to resident verbal or physical abusive situations with CNA N, but her tone could be sharp.

Interview, on 06/03/2020 at 1:30 PM with CNA N, revealed she did provide incontinence care to R1 on 05/29/20 with CNA M. CNA N stated the resident accused her of poking her groin area with her fingernail, and since the resident had some redness in her groin area, she was being as gentle as possible. CNA N stated she did not tell the resident to shut up and did not voice to the resident or CNA M that she would place a pillow

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over the resident's face.

Observation, on 06/03/2020 at 02:00 PM, revealed CNA O positioned the resident in bed and provided a skin check. The resident gave permission for the skin check and stated she liked the staff at the facility, and they took good care of her. The resident's incontinent brief was dry. The resident's groin area was slightly pink with evidence of protective cream. The resident stated she did have an area that hurt a while ago and pointed to an area in her groin. CNA O stated this bothered her approximately a week ago.

Interview, on 06/03/2020 at 2:15 PM, with CNA M, revealed she provided incontinence care to R1 with CNA N on 05/29/20 at approximately 02:15 PM. CNA M stated the resident did not have reddened skin in her groin area. CNA M stated the resident was known to get vocal with staff, and CNA N told the resident to shut up and under her breath, stated sometimes she would just like to put a pillow over the resident's head. CNA M stated she had worked with CNA N prior to this incident and had never heard her speak like that to residents, although she did have a concern with CNA's tone of voice when interacting with residents at times. CNA M stated she reported the incident to LN G.

Interview, on 06/03/2020 at 03:30 PM, with Administrative Nurse D revealed LN G reported the incident to her on 06/01/2020. Administrative Nurse D and Administrative staff A began the investigation at that time, and suspended CNA N (who was subsequently terminated on 06/02/2020). Administrative Nurse D stated she expected licensed staff to report to administrative

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staff immediately any allegations of abuse and provided additional education to LN G. Administrative staff A stated nursing staff were provided further education for abuse, neglect and exploitation on 03/05/2020. All staff were required to complete computerized training on abuse, neglect and exploitation throughout the year.

The facility policy "Prohibition of Any Form of Abuse Report Concerns/Complaints," dated 05 /03/19 instructed staff any report of potential abuse, neglect or misappropriation of resident property must be reported to the executive director/health services director or health care administrator within twenty-four hours of the occurrence of such event.

The facility policy "Presbyterian Manors of Mid-America Clinical and Operations A20.1", dated 05/03/2020, instructed staff upon receiving reports of suspected verbal, mental or sexual abuse or misappropriation of resident property, the community executive director and health service director or designated employee are immediately notified to arrange for the examination of the resident. Alleged perpetrators are removed from resident contact immediately and may be suspended from duty immediately by the charge nurse or other management personnel until the results of the investigation are reviewed. The policy instructs staff other residents should be protected.

The facility licensed nursing staff failed to notify administrative staff immediately of the allegation of a threat of physical abuse for this dependent, confused resident.

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F 610	Continued From page 6	F 610		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility reported a census of 28 residents, which included three residents reviewed for abuse. Based on observation, interview, and record review, Licensed Nurse (LN) G failed to report immediately to administrative staff an allegation of physical abuse verbalized by Certified Nurse Aide (CNA) N, to one Resident (R) 1 which resulted in alleged perpetrator CNA N providing unsupervised care to the 13 residents residing on the unit on which she worked on 05/30/2020 and 05/31/2020. Findings included: - Review of R1's undated, "Physician Order Sheet," revealed diagnoses included dementia	F 610		

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(progressive mental disorder characterized by failing memory, confusion) without behaviors and hemiplegia (paralysis of one side of the body) due to cerebral vascular accident (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).

The "Annual Minimum Data Set" (MDS), dated 03/21/2020, assessed the resident with a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment and no physical or verbal behaviors directed at self or others and no rejection of care. The resident required extensive assistance of two staff for toileting and personal hygiene. The resident had no impairment in range of motion in all extremities.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA,) dated 03/21/2020, assessed the resident had decreased physical functioning, weakness, poor standing balance, coordination and poor safety awareness. The resident required extensive assistance with toileting.

The "Mood State CAA" and "Behavioral Symptoms CAA" did not trigger.

The care plan, revised 04/12/20, instructed staff the resident needed extensive assistance for toileting. The resident had limited ability to interact with social interactions and may become agitated if told what to do. Staff instructed to speak to the resident in a calm manner and to allow adequate time without making the resident feel rushed.

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Interview, on 06/03/2020 at 9:59 AM, with Licensed Nurse (LN) G, revealed the resident could be resistive to cares at times and had not witnessed staff to resident verbal or physical abuse. LN G stated on 05/29/2020 at approximately 02:45 PM, CNA M reported to her that she and CNA N provided incontinence care to R1. CNA M reported that CNA N told the resident to shut up, and then stated she was going to put a pillow over her head. LN G stated staff were at the end of their shift and CNA N had left for the day. LN G stated she did not feel CNA N literally meant that she would put a pillow over the head of the resident. LN G stated she did not report this to administration at that time but did report it to Administrative Nurse D on 06/01/2020. LN G did not know the alleged perpetrator CNA N work schedule and did not ensure CNA did not have further contact with residents. CNA N provided cares on one hall in which 13 residents resided on 05/30/20 or 05/31/2020.

Observation, on 06/03/2020 at 10:49 AM, revealed the resident sitting in her wheelchair in the dining room reading a newspaper. The resident responded to questions stating that she is perfectly well and did not need staff assistance with dressing and grooming, and then made a loud startling noise and laughed. The resident did not remember the incident.

Interview, on 06/03/2020 at 1:30 PM with CNA N, revealed she did provide incontinence care to R1 on 05/29/20 with CNA M. CNA N stated the resident accused her of poking her groin area with her fingernail, and since the resident had some redness in her groin area, she was being as gentle as possible. CNA N stated she did not tell the resident to shut up and did not voice to the

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resident or CNA M that she would place a pillow over the resident's face. CNA N stated she did provide resident cares to residents on one hall on which 13 residents resided on 05/30/2020 and 05/31/2020.

Interview, on 06/03/2020 at 2:15 PM, with CNA M, revealed she provided incontinence care to R1 with CNA N on 05/29/20 at approximately 02:15 PM. CNA M stated the resident did not have reddened skin in her groin area. CNA M stated the resident was known to get vocal with staff, and CNA N told the resident to shut up and under her breath, stated sometimes she would just like to put a pillow over the resident's head. CNA M stated she had worked with CNA N prior to this incident and had never heard her speak like that to residents, although she did have a concern with CNA's tone of voice when interacting with residents at times. CNA M stated she reported the incident to LN G at that time on 05/29/2020.

Interview, on 06/03/2020 at 03:30 PM, with Administrative Nurse D revealed LN G reported the incident to her on 06/01/2020. Administrative Nurse D confirmed CNA N did provide resident cares on one hall on which 13 residents resided. Administrative Nurse D and Administrative staff A began the investigation at that time, and suspended CNA N on 06/01/2020 (who was subsequently terminated on 06/02/2020). Administrative Nurse D stated she would expect LN G to ensure the alleged perpetrator CNA N, did not provide cares to residents after the alleged verbal abuse report. Administrative Nurse D stated she expected licensed staff to report to administrative staff immediately any allegations of, and to ensure alleged perpetrator did not provide care to the residents in the facility.

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Administrative Nurse D provided additional education to LN G.

Interview, on 06/03/2020 at 3:45 PM with Administrative staff A revealed she expected nursing staff, upon notification of an alleged abuse situation, to ensure protection of residents from the alleged perpetrator by sending the alleged perpetrator home and suspending further contact with residents. Administrative staff A stated nursing staff were provided further education for abuse, neglect and exploitation on 03/05/2020. All staff were required to complete computerized training on abuse, neglect and exploitation throughout the year.

The facility policy "Presbyterian Manors of Mid-America Clinical and Operations A20 1:1", dated 05/03/2020, instructed staff upon receiving reports of suspected verbal, mental or sexual abuse or misappropriation of resident property, the community executive director and health service director or designated employee are immediately notified to arrange for the examination of the resident. Alleged perpetrators are removed from resident contact immediately and may be suspended from duty immediately by the charge nurse or other management personnel until the results of the investigation are reviewed. The policy instructs staff other residents should be protected.

The facility failed to ensure the protection of 13 residents on one hall from alleged perpetrator CNA N when Licensed nursing staff G failed to report immediately to administrative staff an allegation of physical abuse verbalized by CNA N to the resident which resulted in the alleged perpetrator providing unsupervised care to the 13

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F 610	Continued From page 11 residents residing on the unit on which she worked on 05/30/2020 and 05/31/2020.	F 610		