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 _____	08/31/2017

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 a Health Facility resurvey and investigation of complaints #102494, #105395, #106334, #106529 and # 120436.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.	F 156		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1	F 156		

(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]

(iii) Information regarding Medicare and Medicaid

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 _____	08/31/2017

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F 156	Continued From page 2	F 156		

eligibility and coverage;
[§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;
[§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]

(v) Contact information for the Medicaid Fraud Control Unit; and
[§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:

(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network,

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 _____	08/31/2017

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PARSONS PRESBYTERIAN MANOR	3501 DIRR AVENUE PARSONS, KS 67357

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F 156	Continued From page 3	F 156		

home and community based service programs, and the Medicaid Fraud Control Unit; and

(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.

(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.

(iii) Receipt of such information, and any amendments to it, must be acknowledged in

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 _____	08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 156	Continued From page 4	F 156		

writing;

(g)(17) The facility must--

(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-

(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;

(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.

(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.

(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(ii) Where changes are made to charges for other

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 _____	08/31/2017

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

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F 156	Continued From page 5	F 156		

items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.

v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 41 residents. Three residents were selected for review for receipt of Medicare Provider non coverage. Based on interview and record review, the facility failed to ensure the resident/responsible party for 3 (#2,#15, and#24) of the 3 residents who received notification and understanding of discontinuation of therapy services by proof of receipt of QIO (Quality Improvement Organization) appeal information.

Findings included:

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 _____	08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 156	Continued From page 6	F 156		

- Review of the the Notice of Medicare Provider non coverage letter revealed the following:

Resident #2: The undated notice indicated Speech therapy to end 7-11-17, Occupational therapy to end 7-13-17 and Occupational therapy to end 7-14-17. Administrative nursing staff A, signed the notice indicating a responsible party was notified via phone on 7-12-17.

Resident #15: The undated notice indicated services to end 6-17-17 due to reaching a plateau. Administrative nursing staff A signed the notice indicating he/she spoke to the resident's family member on 6-24-17.

Resident #24: The undated notice indicated services to end on 7-12-17. The resident signed the notice, but lacked a date of signature.

Interview, on 8-29-17 at 10:00 am, with administrative nursing staff H, revealed he/she provided administrative staff A with the notice, but did not know the follow up process.

Interview, on 8-29-17 at 10:30 am, with administrative nursing staff A, revealed he/she contacted the resident or responsible party of the end of therapy services and explained the Notice of Medicare Non-Coverage letter to them. Staff A stated he/she thought someone mailed the notice to the responsible party, but did not follow up to ensure the responsible party received the notice and understood the right to appeal the notice and contact the QIO.

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 _____	08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 156	Continued From page 7 Interview, on 8-30-17 at 10:30 am, with administrative staff I, revealed the facility telephoned the responsible party to notify them of the end of service, and discussed the notice with them. The facility did not request a signature by the responsible party on the notice. The facility policy, for Notice of Medicare Non-Coverage, Form Instructions 10123-NOMNC, advises staff the provider must ensure that the beneficiary or representative signs and dates the notice to demonstrate that the beneficiary or representative received the notice and understand that the termination decision can be disputed. The date of the conversation is the date of the receipt of the notice. and staff should confirm the telephone contact by written notice mailed on that same date. The facility failed to ensure the resident/responsible party signed and dated the Notice of Medicare Non-Coverage to demonstrate understanding the termination notice could be disputed, and the resident/responsible party received the QIO information to do so.	F 156		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest	F 309		

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 _____	08/31/2017

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 309	Continued From page 8	F 309		

practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 41 residents with 17 selected for review. Based on observation, interview and record review, the facility failed to assess one resident's condition (# 58) prior to and after administration of for follow up of the need for and effectiveness of Morphine(a narcotic medication for pain relief), on 3 occasions.

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 _____	08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 9	F 309		

Findings included:

- Review of resident #58's physician order sheet, dated 4-14-16, revealed diagnoses included breast cancer with metastasis (spread) to the lung, congestive heart failure(a pressure) condition with low heart output and the body becomes congested with fluid), hypertension (elevated blood and fluid retention) and fluid retention.

The admission MDS (minimum data set), dated 4-21-16, assessed the resident with a BIMS (Brief interview for mental status) score of 6 indicating severe cognitive deficit, required limited assistance with bed mobility and transfer and supervision for eating. The resident interview for pain revealed occasionally pain, rated a 5 on a scale of 1-10 (10 being the worst pain), received no scheduled pain medication but did receive as needed pain medication.

The CAA (care area assessment), dated 4-21-16, cognitive loss assessed the resident with long and short term memory issues, confusion, required limited guided assistance with eating.

The comprehensive care plan, for pain, dated 4-28-16 assessed the resident for pain related to diagnoses related to diagnoses of breast cancer, osteoarthritis, leg pain, staff advised to to encourage the resident to ask for pain medications prior to pain becoming too intense, Tylenol as needed for pain management, encourage rest when experiencing increased pain, with the pattern of pain as occasionally.

The care plan for nutrition, dated 4-28-16,

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 _____	08/31/2017

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 309	Continued From page 10	F 309		

advised staff the resident was on a regular diet, obtain a weight weekly due to significant weight loss attributed to edema, to give the resident fluids of choice at each meal and place ice water at the resident's bedside.

The physician's order, dated 6-17-16, instructed staff to administer Tylenol, 325 mg (milligrams) 2 tabs, every 4 hours for pain or temp as needed.

The physician's order, dated 6-17-16, instructed staff to administer Morphine concentrate, 20 mcg (micrograms) per ml (milliliter), 0.25 cc (cubic centimeter), by oral syringe, every 2 hours, for agitation, air hunger, or pain.

Review of the medication administration sheet for June 15, 2016 through July 14, 2016, revealed staff administered Morphine concentrate, 0.25 cc by oral syringes, on 6-24-16 at 4:20 am for back pain with no follow up on resolution, on 6-25-16 at 4:45 am, staff administered Tylenol, 650 mg, for back pain, with no follow up, and at 5:16 pm, staff administered Morphine 0.25 cc for pain with no documentation of follow up, and staff administered Morphine concentrate 0.25 cc for back pain, on 6-26-16 at 5:45 am, with no documentation of follow up.

This medication administration record for 6-26-16, contained a documentation that the resident was very lethargic and did not take medications. This record documented the resident consumed a mighty shake (nutritional supplement) at 2 pm and 7 pm.

The meal intake record, dated 6-26-17, indicated "0" intake for breakfast, lunch and dinner and "0" snack intake.

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 _____	08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 309	Continued From page 11	F 309		

Review of the nurses' notes revealed lack of notes from 6-23-16 through 6-29-16. and without a licensed nursing assessment related to the resident's pain level for justification of administration of the narcotic pain medications administered from 6-24-16 through 6-26-16.

Review of the care tracker electronic record, revealed lack of assessment of temperature monitoring from 6-25-16 through 7-2-16, lack of blood pressure from 6-25-16 through 7-1-16, lack of respiration monitoring from 6-25-16 through 7-2-16, and lack of pain assessment 6-25-16 through 7-1-16.

Interview, on 8-29-17 at 10:45 am, with direct care staff C, revealed the resident required cueing for activities of daily living and did not want to come to the dining room for meals.

Interview, on 8-30-17 at 9:20 pm, with administrative nursing staff A, revealed he/she would expect staff to follow up after administration of as needed pain medication.

Interview, on 8-30-17 at 9:40 am, with administrative nursing staff C, revealed he/she would expect staff to notify the charge nurse if a resident would not eat a meal. Staff C would expect nursing to assess a resident prior to administering pain medication and to follow up on an as needed pain medication for effectiveness.

The facility policy for administering medication, revised 1/17, advised staff to document results achieved following the administration of each as needed pain medication.

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 _____	08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 12 The facility failed to assess this resident's status prior to administration and following 3 doses of Morphine concentrate, on 3 successive days to ensure the resident received effective pain management without side effects.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: The facility reported a census of 31 residents with 14 selected for review, including 2 residents	F 323		

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 _____	08/31/2017

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 323	Continued From page 13	F 323		

reviewed for accidents. Based on observation, interview and record review, the facility failed to provide adequate supervision and assistive devices to prevent accidents for 1 of 2 residents reviewed (#14), related to failure to perform a safe transfer of with a hoyer lift which resulted in two skin tears.

Findings included:

- Review of residents #14's signed physician order sheet, dated 6/27/17, revealed his/her diagnoses included presence of right artificial hip joint.

The quarterly MDS (minimum data set), dated 8/12/17, assessed the resident with a BIMS (brief interview for mental status) score of 8, indicating moderate impairment. The resident required total dependence of two persons for transfers, had no functional limitation in range of motion to upper extremities and impairment on one side to lower extremities. Health Condition revealed since the last MDS, the resident had one non injury fall and two or more injury falls.

The CAA (care area assessment), dated 11/14/16, for activities of daily living, evidenced the resident had a progressive significant decline in status, to an extent of being placed on end of life care with Hospice services as of 11/14/16. His/her mobility is primarily maintained through use of a wheel chair. The resident had a history of falls and impaired mobility. Routine toileting to a bed side commode provided from staff and incontinence care was given after each episode. Limiting factors for self care was weakness, limitation of mobility, history of falls and progression of chronic illness.

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	175303	A. BUILDING _____ B. WING _____	08/31/2017

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 323	Continued From page 14	F 323		

The CAA, dated 11/14/16, for falls has had a significant decline in her activities of daily living functioning, health status and had recently been placed on end of life care with hospice services. He/she required extensive assistance with transfers. Risk for falls was due to progressive decline in health status, weakness, history of falls, limited mobility, potential adverse side effects from antidepressants and narcotic analgesics. The resident was alert and able to make his/her needs known when in need of assistance. He/she does wait for staff to provide assistance. The fall risk score was 14 to 15, indicating a fall risk. Continue to care plan, information obtained from the care tracker documentation, staff interview and fall risk assessment.

The change of status MDS dated 11/14/16, assessed the resident with a BIMS score of 15, indicating cognition intact. The resident required extensive 2 person physical assist with transfers. The resident required extensive 1 person physical assist with locomotion on the unit. There was no functional limitation in range of motion to the upper extremities and there was impairment on one side to the lower extremities. He/she was not steady, only able to stabilize with staff assist due to impaired range of motion to the lower extremities. The resident was frequently incontinent of urine.

The care plan, last reviewed on 8/17/17, instructed staff to use the hoyer lift for transfers and poor standing balance effective 5/18/17. The resident requires total assistance for transfers and two staff using the hoyer lift. The resident receives hospice services and hospice will

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F 323	Continued From page 15	F 323		

coordinate with the facility to ensure the resident receives appropriate activities of daily living care. On 6/8/17, staff provided the hospice aide a teachable moment in relation to the facility protocol requiring assistance of two staff with use of the hoyer lift during transfers. .

Review of nurses note, dated 6/8/17 revealed the hospice nurse was using the Hoyer lift by himself/herself when staff heard someone call for help. Other staff entered the room and found the resident slipping out of the hoyer lift sheet just above the resident's wheelchair. The certified nurses aide wrapped his/her arms around the resident's torso to avoid the resident from falling to the floor. The resident slipped out of the sling and slid into the wheel chair down to the foot pedals. The resident received two skin tears to the left upper forearms measuring 2.3 cm x 1.2 cm and 1.9 cm x 1.2 cm staff approximated. Hoyer lifts in this facility take 2 people to properly transfer patients safely to avoid accidents/falls.

Review of skin assessment, on 6/8/17 of the resident revealed skin tear to the left upper arm measuring 2.5 cm in length and 1.2 cm in width with no depth and a skin tear to the left upper arm measuring 1.9 cm in length and 0.9 cm in width with no depth

Review of the investigation report form, dated 6/8/17, confirmed the cause of the fall was the hospice aide was transferring the resident by himself/herself when the resident slipped from the lift sheet. The new intervention identified facility staff educated the hospice aide with a teachable moment related to the facility's protocol requiring the use of 2 staff when using the hoyer lift.

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F 323	Continued From page 16	F 323		

On 8/29/17 at 8:15 am, hospice direct care staff E and direct care staff D the observation revealed placed the hoyer sling under the resident. The staff provided a safe transfer.

On 8/29/17 at 3:37 pm, the resident stated that he/she had been getting up to go to the dining room for meals for a couple of weeks. Resident does not thinks that it makes a lot of difference with his/her pain.

On 8/29/17 at 8:14, with direct care staff D confirmed the use of the hoyer lift to get the resident out of bed with assist of 2 staff.

On 8/29/17 at 3:50 pm, direct care staff G confirmed the use of the hoyer lift and to always use two people to operate the lift.

On 8/29/17 at 3:50 pm, with licensed staff F, confirmed the resident gets out of bed with the use of the hoyer lift with assist of 2 staff.

On 8/29/17 at 2:13 pm with administrative staff A, confirmed that hospice aide E was transferring the resident in the hoyer lift by himself/herself and the resident was falling out of the sling into the wheelchair and received two skin tears to his/her upper arm. The hospice direct care staff E was given a teachable moment and administrative staff A spoke with hospice aide E's employer about this.

Review of the policy for use of a mechanical lift, revised 1/1/04, evidenced to assess the resident for the most appropriate method of transferring and number of staff needed to transfer the resident safely. Document in the care plan and update as needed.

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F 323	Continued From page 17 The facility failed to properly transfer resident, with the hoyer lift, with assistance of two staff as identified on the 11/14/16 MDS. The resident sustained a fall which resulted in two skin tears.	F 323		