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 _____	09/12/2024

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 deficiencies represent the findings of a Health Resurvey and investigation of complaint # 189064. This 2567 was electronically sent to the facility on 09/18/24.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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. §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.	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/17/2024

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
	175303	A. BUILDING _____ B. WING _____	09/12/2024

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 609	Continued From page 1 This REQUIREMENT is not met as evidenced by: The facility reported a census of 28 residents with 13 residents sampled, which included one resident sampled for abuse. Based on observation, interview, and record review, the facility staff failed to report an allegation of staff to resident, verbal abuse (the use of oral, language that willfully includes disparaging and derogatory terms to residents or within their hearing distance regardless of their age ability to comprehend, or disability) related to calling Resident (R)4 "lazy" in the presence of another resident. Findings included: - Review of Resident (R)4's "Physician Orders," dated 08/01/24, documentation included diagnoses of diabetes (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), heart failure, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), morbid obesity (severely overweight), chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and supplemental oxygen dependence. The "Annual Minimum Data Set" (MDS)dated 03/09/24, revealed the resident had a "Brief Interview for Mental Status" (BIMS) score of 15, indicating cognitively intact. He did not	F 609	Past noncompliance: no plan of correction required.	

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 _____	09/12/2024

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 609	Continued From page 2	F 609		

demonstrate any behaviors, mood indicators, nor depression indicators. He required staff assistance and supervision for activities of daily living (ADLs) which included transfers and wheeling his wheelchair. He was 69 inches (five foot nine inches tall) and weighed 353 pounds (lb). The resident received as needed (prn) pain medication and reported almost constant pain rated 08/10. He received medications which included anti-anxiety (medications used to treat mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), antidepressants (medications used to treat depression), opioids (medication/controlled substance used to treat pain), and diuretics, (medications to promote the formation and excretion of urine). The resident received restorative nursing program for active range of motion and walking for two days of the look back period.

The "Quarterly MDS" dated 06/08/24, documented change from the above assessment included the resident weight as 372 lbs.

The "Care Plan" (CP) dated 06/20/24, directed staff the resident had left knee pain and received pain medication twice a day. R4 had a new wheelchair with foot pedals. He was pleasant, cooperative , and participated in exercise, activities, and restorative nursing program and required staff assistance with his ADLs.

Review of the facility self-report to the State agency dated 07/08/24, revealed on 06/29/24, Certified Medication Aide (CMA) R and Certified Nurse's aide (CNA) N witnessed CNA O verbally insult R4 while in the dining room in the presence of other residents. The event described 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 _____	09/12/2024

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 609	Continued From page 3	F 609		

CNA O propelled R4 to his room, CNA O was "yelling at him, calling him names, such as lazy and telling him he could do it himself." CNA O exclaimed she did not care if she "got wrote up again." The investigation documentation revealed CNA N did not report the incident to facility staff until she gave the facility her resignation on 07/08/24. She identified CMA R as a witness to the event. The facility suspended CNA O pending investigation upon having knowledge of the event. The administration interviewed CMA R who confirmed the above findings. All facility staff completed training regarding Abuse Neglect, and Exploitation as of 07/11/24. CNA O was terminated related to failure to respond to previous counseling by the facility.
CMA R's witness statement, dated 07/08/24, documented R4 wanted staff assistance to his room. CMA R asked CNA O to take R4 to his room. CNA O responded that R4 could push himself to his room. CNA O approached R4, yelling and calling him names such as "lazy" and told R4 he could do it himself. CNA O assisted R4 out of the dining room.

CNA O's witness statement, dated 08/08/24, documented "I do not recall that weekend. Sorry."

On 09/10/24 at 11:10 AM, R 4 stated he had been a resident for three years. He reported he felt safe, and he had no worries about his care. The resident stated he did not recall ever being abused or mistreated and had not seen any other resident abused or mistreated.

On 09/10/24 at 11:56 AM, Certified Nurse Aide (CNA) M provided the resident with incontinence care which included peri-care, applied a new incontinence brief, and changed his wet clothes.

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 _____	09/12/2024

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 609	Continued From page 4	F 609		

On 09/11/24 at 08:33 AM, R4 sat in a wheelchair while CNA M propelled the resident to his room. He thanked CMA M for her help and stated the staff sometime tell him he should roll his own wheelchair, but he would get tired.

On 09/12/24 at 01:24 PM, CMA R confirmed the above findings with the exception of the date of the event. She stated the event described occurred on 06/29/24 verses 06/23/24. She stated on the morning of 06/29/24, she was passing her medications and R4 asked for assistance to return to his room. CMA R reported she was holding medications and she saw that CNA O was available to assist R4. CNA O verbally insulted R4 in the dining room in the presence of other residents. The event described included CNA O yelled "the resident was lazy" and she did not care if she got written up again. He could push himself to his room. Additionally, CNA O continued to call the resident names such as lazy when she assisted the resident in the wheelchair to his room. Approximately 10 other residents were in the dining area at the time, and they appeared to be shocked and were talking amongst themselves. CNA N heard what happened and talked to her about it and CMA R thought CNA N reported the event to the facility management. CMA R stated she should have stopped CNA O and reported the event to her charge nurse at the time.

On 09/12/24 at 02:24 PM, Administrative Staff A confirmed the above findings and agreed facility staff failed to report the allegation of verbal abuse at the time it occurred as they should have. She reported when she was informed, CNA O was immediately suspended pending investigation.

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 _____	09/12/2024

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 609	Continued From page 5	F 609		

Administrative Staff A was told about the verbal abuse on 07/08/24, nine days afterwards. Staff should have reported the event at the time it occurred so immediate action could have been taken to protect the residents.

The facility policy "ANE: Abuse Prevention, intervention, Reporting and Investigation-Staff Treatment of Residents," dated 03/04/24, documentation included it is the responsibility of employees to promptly report to community management any occurrence or suspected occurrence of neglect or resident abuse. Verbal/Written abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging a derogatory term to residents within their hearing distance regardless of their age ability to comprehend, or disability.

The facility staff failed to report an allegation of staff to resident, verbal abuse to this resident.

The deficient practice was deemed past non -compliance when the facility completed the following:

On 07/08/24, the facility conducted staff interviews with the identified staff present during the alleged verbal abuse. (CNA O, CMA R, and CNA N).

On 07/08/24, the facility staff notified R 4's Durable Power of Attorney (DPOA)/representative of the allegation of verbal abuse.

On 07/08/24, upon notification of allegation of verbal abuse, the facility suspended the alleged perpetrator, CNA O, pending investigation. CNA N resigned. CMA R received "Teachable Moment"

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 _____	09/12/2024

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 609	Continued From page 6 training regarding reporting abuse immediately, as the first step of disciplinary action due to her failure to report an allegation of verbal abuse immediately. On 07/08/24, the facility interviewed R 4 who had no recall of the above event of verbal abuse on 06/29/24. On 07/08/24, the facility interviewed three additional residents that reported they felt safe at the facility and got the help they needed when they asked the staff for help. On 07/08/24, the facility initiated all staff education/training regarding abuse neglect and exploitation, which included immediate reporting of allegations of abuse, and completed the re-education and training for all staff on 07/11/24. On 07/11/24, the facility terminated CNA O following the investigation, related to her lack of response to prior counseling regarding her tone of voice. The facility plans for monitoring effectiveness of corrective action plan through Quality Assurance Performance Improvement (QAPI) Risk Committee quarterly meeting. The onsite surveyor verified the implementation of the above actions on 09/12/24 and the deficient practice remained at a "D" scope and severity.	F 609		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		

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 _____	09/12/2024

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 684	Continued From page 7	F 684		

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.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 28 residents, with 13 residents sampled which included three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to complete a thorough investigation to determine causes and contributing factors related to a skin tear and failed to implement appropriate immediate interventions to prevent further skin tear for Resident (R)18.

Findings included:

- Review of Resident (R)18's "Physician Orders," dated 08/01/24, documentation included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) with psychotic disturbances (gross impairment in reality perception), dizziness, and hypertension (high blood pressure).

The "Significant Change in Status Minimum Data Set," (MDS), dated 06/11/24, documented a "Brief Interview for Mental Status" (BIMS) score of two, indicating severe cognitive impairment. He exhibited continuous altered level of consciousness and fluctuating disorganized thinking. The resident had no functional limitation in range of motion in his upper or lower extremities. He required maximum/substantial

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 _____	09/12/2024

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 684	Continued From page 8	F 684		

assistance of staff for transfers, toilet use, and personal hygiene.

The "Falls Care Area Assessments" (CAA) dated 06/13/24, documented the resident at risk for falls but he would call and wait on staff to arrive.

The "Care Plan," (CP) dated 6/20/24, directed the staff the resident had self-care deficit. He required total assistance with repositioning and transfers. The resident had poor safety awareness, was impulsive, would attempt to get up on his own, and became easily annoyed and agitated if staff attempted to assist him if he did not want to be assisted. R18 was at risk for skin impairment such as skin tears and staff should apply long sleeves and pants to protect his extremities.

Review of the "Interdisciplinary Team Notes,"(IDT) dated 09/07/24 at 11:48 AM, documentation included the staff discovered a "C" shaped skin tear with dried blood on the back of the resident's right hand between the thumb and his forefinger. The administered treatment included cleaning the area with wound cleanser, applied skin prep, applied seven steri-strips (wound closures), applied folded and secured with paper tape for protection. The documentation lacked identification of cause or contributing factors related to the skin tear or an immediate intervention to prevent further injury.

On 09/10/24 at 10:49 AM, the resident sat in a high back reclining chair. His left arm was bent at his elbow with his left hand cupped beneath his right elbow. The top of his right-hand had a bordered foam dressing in place, dated 9/10/24, On inquiry, R18 stated he did not know what

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 _____	09/12/2024

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 684	Continued From page 9	F 684		

happened to his hand.

On 09/11/24 at 09:00 AM, the resident sat in a high back reclining chair rubbing his right shoulder with his left hand. The back of his right hand had seven steri-strips visible without a covering for protection. Observation revealed there was dried blood on top of his hand. There was no bordered foam dressing in place.

On 09/11/24 at 09:47 AM, Licensed Nurse (LN) E reported the resident wheeled himself down the hall and would hit his hand against the wall and the doorway. She stated the skin tear happened over the weekend. LN E reviewed the resident's electronic medical record and confirmed the lack of an order related to R18's right hand skin tear. She stated the facility had standing orders for skin tears. LN cleaned the skin tear with wound cleaner an verified the placement of seven steri-strips, and the wound measured 3.7 centimeters (cm) by 0.5 cm by 0.1 cm. R18's right hand had a blue-black discolored area around the approximated wound edges. LN E stated she did not know the immediate intervention implemented by the facility to prevent further skin tears.

On 09/11/24 11:25 AM, Administrative Nurse D confirmed the resident's hand skin tear lacked a thorough investigation to determine the cause or contributing factors as well as lacked an immediate intervention to prevent further injuries for dependent R 18.

The facility lacked a policy to address the root cause analysis for skin tears to determine the causes and contributing factors and implementation of an immediate intervention to prevent further injury.

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 _____	09/12/2024

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 684	Continued From page 10 The facility failed to complete a thorough investigation to determine causes and contributing factors related to a skin tear and failed to implement appropriate immediate interventions to prevent further skin tear for Resident (R)18.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility reported a census of 28 residents with 13 selected for review, which included four residents reviewed for pressure ulcers. Based on observation, interview, and record review, the facility failed to ensure pressure relieving device was in working order for one Resident (R)21, of the four residents reviewed for pressure ulcers. Findings included: - Review of Resident (R)21's medical record revealed diagnoses that included diabetes (when	F 686		

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 _____	09/12/2024

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 686	Continued From page 11	F 686		

the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), polyneuropathy (disorder of many of the nerves outside of the brain and spinal cord), venous ulcers (sores due to poor circulation), and stage two pressure ulcer (partial thickness skin loss into but no deeper than the dermis including intact or ruptured blisters).

The "Admission Minimum Data Set" (MDS), dated 03/12/24, assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15, which indicated normal cognitive function. The resident required partial/moderate assistance for transfers. The resident had no impairment in range of motion in his upper or lower extremities. The resident had no pressure ulcers.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 03/12/24, assessed the resident not at risk for pressure ulcer development.

The "Five Day Admission MDS" dated 04/03/24, assessed the resident with a BIMS of 14, which indicated normal cognitive function. R21 had no impairment of upper or lower extremities. The resident assessed as not at risk for pressure ulcer development and had no pressure ulcers. The resident had two venous ulcers (wounds caused by poor circulation).

The "Quarterly MDS" dated 06/08/24, assessed the resident with a BIMS score of 14, with one stage two pressure ulcer, and two venous stasis ulcers. The resident had a pressure reducing device for his chair and bed and received pressure ulcer care. The resident required supervision for standing and transfers.

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 _____	09/12/2024

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 686	Continued From page 12	F 686		

The "Care Plan" updated 06/20/24 instructed staff to ensure a low air loss mattress was on the resident's bed and a cushion in his chair.

An update to the care plan dated 07/12/24, instructed staff to cleanse the open area to R21's right and left buttocks with wound cleanser and apply a foam dressing every three days. Staff instructed to encourage and assist the resident to reposition every two hours.

The "Additional Orders" from wound care, dated 09/05/24, instructed the facility to provide a roho (a type of pressure relieving cushion that utilizes flowing air cubes that adjust to meet individual contouring needs to decrease pressure) type of cushion to any surface the resident sat on. Staff were to cleanse the sacral pressure ulcer with wound cleanser and apply a sacral (large triangular bone between the two hip bones) dressing every three days.

Observation, on 09/10/24 at 10:34 AM, revealed the resident seated in his recliner. The resident sat on two cushions. The resident stated he has a sore area on his bottom, and the two cushions help relieve the discomfort of the sore area.

Observation, on 09/11/24 at 01:48 PM, revealed Administrative Nurse E prepared to provide a dressing change to R21's sacral pressure ulcer. The resident sat in his recliner and stood up as requested. The cushion in the recliner contained multiple areas of malfunctioning air cells and were deflated. Administrative Nurse E stated staff did not report the deflated cushion to her and proceeded to remove the cushion for reinflation and placed a foam cushion in the resident's recliner. Administrative Nurse E removed the

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 _____	09/12/2024

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 686	Continued From page 13 foam dressing and noted the wound as pink in color and measured the area as 0.3 by 1.2 centimeter (cm) and 0.4 by 0.3 cm. Administrative Nurse E cleansed the resident's sacral wounds with wound cleanser and applied a foam dressing to the resident's sacrum. Administrative Nurse E stated the wound care provider managed the resident's vascular and this pressure ulcer. The facility policy "Therapeutic Support Surface" revise 09/05/24, instructed staff positioning techniques, devised and chair seat cushions should be considered for resident who are in the sitting position. The facility failed to monitor the status of R21's roho cushion to ensure optimal functioning to provide pressure reduction for this resident's stage two sacral pressure ulcer.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 28 residents, with 13 residents sampled which included three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to complete a safe transfer for	F 689		

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 _____	09/12/2024

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 689	Continued From page 14	F 689		

dependent (R)18 using a sit to stand lift related to the lack of use of the sling's safety belt to ensure the resident's safe transfer.

Finding included:

- Review of Resident (R)18's "Physician Orders," dated 08/01/24, documentation included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) with psychotic disturbances (gross impairment in reality perception), dizziness, and hypertension (high blood pressure).

The "Significant Change in Status Minimum Data Set," (MDS), dated 06/11/24, documented a "Brief Interview for Mental Status" (BIMS) score of two, indicating severe cognitive impairment. He exhibited continuous altered level of consciousness and fluctuating disorganized thinking. The resident had no functional limitation in range of motion in his upper or lower extremities. He required maximum/substantial assistance of staff for transfers, toilet use, and personal hygiene.

The "Falls Care Area Assessments" (CAA) dated 06/13/24, documented the resident at risk for falls but he would call and wait on staff to arrive. He required assistance of two staff members for transfers using a sit to stand lift.

The "Care Plan," (CP) dated 6/20/24, directed the staff the resident had self-care deficit. He required total assistance with repositioning and transfers. The resident had poor safety awareness, was impulsive, would attempt to get up on his own, and became easily annoyed and agitated if staff attempted to assist him if he did

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 _____	09/12/2024

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 689	Continued From page 15	F 689		

not want to be assisted. Two staff should use a sit to stand lift for all transfers. At times staff should use a full body lift when he was not feeling well.

On 09/11/24 at 09:25 AM, Administrative Nurse D propelled the resident in his wheelchair to his room. She requested Certified Nurse Aide (CNA) Q and CNA P to check the resident for incontinence and to provide care if needed. Staff reported the resident required the use of the sit to stand lift and two direct care staff to transfer the resident. They positioned the sling beneath the residents back and hooked it to the lift. Staff failed to secure the safety belt prior to lifting the resident from the chair with the lift. Upon inquiry, they reported the safety belt was broken and was not able to secure the Velcro around the resident. Staff reported the lift was broken for over a week, but they continued to use it. Furthermore, they stated they had not reported the safety belt as broken.

On 09/11/24 at 09:47 AM, Licensed Nurse (LN) E, reported staff should report any equipment that needed repair to the maintenance department prior to using the equipment. She confirmed the safety belt should be used to ensure the safety of the resident.
On 09/11/24 11:25 AM, Administrative Nurse D stated the safety belt should be used when transferring residents using the sit to stand lift for transfers to prevent injury of the resident and confirmed the lift for the resident had not been reported as broken by the staff until today.

The facility policy titled "Equipment -Maintenance, Repair, and Cleaning," dated 10/11/21, documentation included equipment in need of

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 _____	09/12/2024

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 689	Continued From page 16 repair is communicated to environmental services department. The facility policy "Lifting & Transferring Residents," dated 10/25/23, documentation included the facility will provide a safe work environment for resident care by providing the use of safety materials, equipment, and training designed to prevent injury. The facility failed complete a safe transfer for dependent (R)18 using a sit to stand lift related to the lack of use of the sling's safety belt to ensure the resident's safe transfer.	F 689		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: The facility reported a census of 28 residents. Based on observation, interview, and record review, the facility failed to maintain and/or dispose of garbage and refuse properly in a sanitary condition to prevent the harborage and feeding of pests. Findings included: - On 09/10/24 at 10:13 AM, initial tour with Dietary Staff BB revealed two of four compartments dumpster open with exposed trash and garbage. Additionally, discarded building supplies surrounded the dumpster with grass grown over the edges. Dietary Staff BB confirmed the above findings. She reported the facility staff should dispose of garbage and trash in a closed	F 814		

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 _____	09/12/2024

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 814	Continued From page 17 container to prevent harboring of pests and rodents from nesting around the facility. Dietary Staff BB stated the staff facility used the dumpsters and they should keep all compartment lid closed to contain the garbage and trash when placed in the dumpster. On 09/12/24 at 11:15 AM, during environmental tour with Housekeeping and Maintenance Director U and Consultant GG, revealed the trash dumpster lacked one lid which exposed trash and garbage. The building materials and overgrown grass that surrounded the dumpster remained as noted above. He reported the trash company replaced the dumpster approximately two weeks ago and agreed the dumpster compartment lids should be closed to maintain and/or dispose of garbage and refuse in a sanitary condition. The facility lacked a policy to address garbage and refuse disposal and containment. The facility failed to maintain and/or dispose of garbage and refuse properly in a sanitary condition to prevent the harborage and feeding of pests.	F 814		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by	F 851		

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 _____	09/12/2024

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 851	Continued From page 18	F 851		

CMS.

§483.70(p)(1) Direct Care Staff.
Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(p)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(p)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

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 _____	09/12/2024

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 851	Continued From page 19	F 851		

§483.70(p)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(p)(5) Submission schedule.
The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 28 residents. Based on interview and record review, the facility failed to electronically submit to "Centers for Medicare and Medicaid Services" (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e. "Payroll Base Journal" (PBJ), related to licensed nursing staffing information, when the facility failed to accurately report 24 hour per day Licensed Nurse coverage on 12 dates between 07/01/23 and 09/30/23 and 10 dates between 01/01/24 and 03/31/24.

Findings Included:

- Review of the "Payroll Base Journal" (PBJ) Staffing Data Report for Fiscal year (FY), Quarter 4, 2023 (07/01/23 and 09/30/23) revealed a lack of License Nurse (LN) for 24 hours/seven days a week 24 hour/day on the following dates:

On 07/01/23 , Saturday (SA),

On 07/02/23, Sunday (SU),

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 _____	09/12/2024

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 851	Continued From page 20 On 07/15/23, SA, On 07/22/23, SA, On 07/23/23, SU, On 08/12/23, SA, On 08/13/23, SU, On 08/19/23, SA, On 08/20/23, SU, On 09/03/23, SU On 09/23/23, SA, and On 09/24/23, SU. Review of the "Payroll Base Journal" (PBJ) Staffing Data Report for Fiscal year (FY), Quarter 2, 2024 (01/01/24 and 03/31/24) revealed a lack of License Nurse (LN) for 24 hours/seven days a week 24 hour/day on the following dates: On 02/17/24, SA, On 02/18/24, SU, On 02/24/24, SA, On 02/25/24, SU, On 03/02/24, SA, On 03/03/24 SU, On 03/09/24, SA,	F 851		

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 _____	09/12/2024

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 851	Continued From page 21 On 03/10/24, SU, On 03/16/24, SA, and On 03/17/24, SU. On 09/12/24 at 01:41 PM, interview with Administrative Staff A revealed as far as she knew, the PBJ was submitted correctly and stated the licensed nursed that worked on weekend do not leave the facility or take a lunch break and the facility had 24-hour licensed nurse coverage. The facility policy for "PBJ Reporting Procedure", undated, instructed staff report to PBJ hours to CMS on a quarterly basis and must include the download from Time Tracker (an electronic method to record time worked by staff) to include agency staff. The facility failed to electronically submit to "Centers for Medicare and Medicaid Services" (CMS) with complete and accurate direct staffing information, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (i.e., "Payroll Base Journal" (PBJ), related to licensed nursing staffing information when the facility failed to accurately report 24 hour per day Licensed Nurse coverage on 12 dates between 07/01/23 and 09/30/23 and 10 dates between 01/01/24 and 03/31/24.	F 851		