STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175385	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paramount Community Living and Rehab Inc	200 SW 14th Newton, KS 67114

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - Review of Resident (R) 37's medical record revealed diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear, chronic kidney disease, congestive heart failure (a condition with low heart output and the body becomes congested with fluid), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The resident required extensive assistance of staff for dressing and personal hygiene. The Cognitive Loss Care Area Assessment (CAA), dated 07/25/23, assessed the resident's risk factors of skin breakdown, weight loss and fluid imbalance. The ADL (Activity of Daily Living) Functional/Rehabilitation CAA dated 07/25/23 did not trigger. The Care Plan reviewed 03/20/24, instructed staff the resident had a functional deficit with ADLs due to dementia(progressive mental deterioration characterized by confusion and memory failure), The resident required moderate assistance with dressing. The care plan instructed staff to ensure the resident wore appropriate footwear, as she preferred tennis shoes. Interview, on 03/25/24 at 02:10 PM, with a family member revealed R37 preferred to wear support hose and had multiple pairs of them in her drawers. The family member stated the resident often does not have them on and she assists R37 in putting them on when visiting the resident. Observation, on 03/26/24 at 11:38 AM, revealed Certified Medication Aide (CMA) M ambulated with the resident to the bathroom. The resident lacked support hose. Interview with CMA M at that time revealed the night shift washed the support hose and dried them on the towel rack in the bathroom, and they were wet this morning, but dry at this time. CMA M did not know the resident had several pairs of the compression hose in her drawers. Observation revealed several pairs of support hose in her drawer beneath the closet. Interview, on 03/28/24 at 10:00 AM, with Administrative Nurse D, revealed the resident did not have a physician order for the support hose, but could wear them as her preference and this should be indicated on the care plan. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175385	A. Building B. Wing	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paramount Community Living and Rehab Inc	200 SW 14th Newton, KS 67114

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy for Resident Rights, undated, included: The facility places a strong emphasis on individual dignity and self-determination for all residents. The policy instructed staff to encourage residents to dress per their individual preferences. The facility failed to ensure staff dressed R37 in support hose as her preference to promote her sense of well-being. - R60's physician orders revealed the following diagnoses that included diabetes mellitus type two (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin), neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), and history of urinary tract infection (infection of any part of the urinary system). The admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of eight, indicating moderate cognitive impairment. The resident was dependent on staff for all activities of daily living (ADLs) and used a wheelchair for mobility. The resident had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) and was incontinent of bowel. The resident had a diagnosis of neurogenic bladder and chronic urinary tract infection and received an antibiotic. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 11/03/23, R60 required assistance for ADLs to keep clean and dry with bowel needs. R60 had a urinary catheter due to urinary retention. R60's Care Plan dated 10/31/23 revealed the resident had an 18 French, five cubic centimeter (cc) balloon indwelling catheter for neurogenic bladder. Staff were to position the catheter bag and tubing below the level of the bladder and attach the leg bag when out of bed. The resident has bowel incontinence related to immobility and required routine check and change incontinent care, dated 12/04/23. Observation, on 03/25/24 at 12:10 PM, revealed Certified Nursing Aides (CNA) V and CNA UU transferred R60 to the bed with the use of a total body lift. The resident had a bowel movement, and staff removed the brief. At 12:24 PM, CNA VV walked into R60's room without knocking on the door when the resident was fully exposed during incontinent care and did not excuse herself. She stayed to collect pizza orders from staff in the room. The resident remained exposed during the conversation. On 03/25/24 at 12:30 PM, CMA VV reported she reported she knew better and was not thinking and knew she should have knocked before entering as well as she should have left the room as soon as she entered and saw the resident's genitals exposed. On 03/28/24 at 08:00 AM, Administrative Nurse D reported all staff whether nursing or not, should knock on the resident's door and wait for permission to enter. At no time would it be appropriate to enter a resident's room unannounced during resident care, much less to take a staff member's pizza order. The facility's policy for Resident Rights, undated, included the facility places a strong emphasis on individual dignity and self-determination for all residents. The facility failed to maintain R60s dignity by staff entering the room unannounced during personal (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Paramount Community Living and Rehab Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SW 14th Newton, KS 67114	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care, and remained in the room when the resident was exposed. The facility reported a census of 92 residents with 22 residents sampled, including five residents reviewed for dignity. Based on observation, interview and record review, the facility failed to show respect and dignity to four Residents (R)31, regarding standing over the resident while feeding him and R 78, regarding the failure to use a dignity bag on the catheter collection bag, R 60, regarding not knocking on door before entering resident's room while cares were being given and R 37, regarding the facility not allowing the resident to wear compression stockings (specially made, snug-fitting, stretchy socks that gently squeeze the leg to promote circulation). Findings included: - Review of Resident (R)31's Physician Order Sheet, dated 03/21/24, documented the resident had a diagnosis of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The Significant Change Minimum Data Set (MDS), dated [DATE], lacked documentation of the resident's cognition. He was dependent on staff for all activities of daily living (ADL). The Nutritional Status Care Area Assessment (CAA), dated 02/06/24, triggered but was not completed. The Modification of Admission/Medicare 5-Day MDS, dated 01/15/24, documented the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. He was dependent on staff for all ADLs. The care plan for ADLs, revised 01/02/24, instructed staff the resident required substantial assistance of one for eating. On 03/26/24 at 11:49 AM, the staff served lunch to the resident in the dining room. Certified Nurse Aide (CNA) OO began to feed the resident his meal while standing over the resident, leaning in slightly toward and over the resident, as the resident was fed. On 03/26/24 at 01:10 PM, CNA OO stated he did not sit down next to the resident while he fed him his lunch because he did not want to. He liked to stand while feeding the residents. On 03/28/24 at 09:51 AM, Administrative Nurse D stated it was the expectation for staff to sit down next to a resident while assisting them with their meals and not to stand up over the residents. The facility policy for Resident Rights, undated, included: The facility places a strong emphasis on individual dignity and self-determination for all residents. The facility failed to show respect and dignity to this dependent resident while feeding him his meal. - Review of Resident (R)78's electronic medical record (EMR) revealed a diagnosis of neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying). The Modification of admission Minimum Data Set (MDS), dated [DATE], documented the resident had a (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. She required extensive assistance of two staff for toileting and had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 08/06/23, documented the resident had an indwelling urinary catheter. The Quarterly MDS, dated 01/23/24, documented the staff assessment for cognition revealed the resident was independent with daily decision making. She was dependent on staff for all activities of daily living (ADLs) and had a urinary catheter. The care plan for the urinary catheter, dated 08/01/23, instructed staff to keep the catheter bag and tubing below the level of the bladder. On 03/25/24 at 10:35 AM, the resident sat in her wheelchair in her room. The catheter bag hung below the seat of her wheelchair and lacked a dignity bag. On 03/26/24 at 08:14 AM, the resident rested in bed in her room with the door open. The resident's catheter bag hung from the bed frame and lacked a dignity bag. On 03/26/24 at 08:14 AM, Certified Nurse Aide (CNA) T stated the resident did not have a dignity bag for her catheter bag because they (CNA T) could not find one. CNA T stated catheter bags typically would be in a dignity bag. On 03/26/24 at 08:19 AM, Certified Medication Aide (CMA) MM stated the resident did not have a dignity bag for her catheter bag. CMA MM stated she was unsure as to why the resident did not have a dignity bag. On 03/27/24 at 01:38 PM, Administrative Nurse D stated it was the expectation for staff to always use a dignity bag for all residents who have a catheter bag. The facility policy for Urinary Catheter Care, dated 02/2017, included: To protect the dignity of residents who need an indwelling catheter, drainage bags will be placed in a dignity bag. The facility failed to utilize a dignity bag to hold the catheter bag of this dependent resident with an indwelling urinary catheter.

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NAME OF PROVIDER OR SUPPLIER Paramount Community Living and Rehab Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SW 14th Newton, KS 67114	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility reported a census of 92 residents, which included 10 residents residing in one of the six Green Houses. Based on observation, record review, and interview, the facility failed to provide unstained towels and washcloths to the residents in one [NAME] House. Findings included: - Interview, on 03/27/24 at 02:45 PM, with Resident (R)43 revealed certified staff does the laundry, and supplies towels and washcloths to the resident, however the towels are often stained, rough and/or worn. Observation at that time revealed a hand towel with a large gray stain over 3 percent of the towel. Observation, on 03/28/24 at 09:06 AM, revealed eight hand towels and two washcloths with stains of varying sizes with rough coarse texture and several with areas of worn texture. Interview, on 03/28/24 at 09:06 AM, with Certified Medication Aide/Certified Nurse Aide (CMA/CNA) AA, revealed all staff on all shift's complete laundry tasks and stained linen should be thrown away, and when the supply is low, more can be ordered. Interview, on 03/28/24 at 10:45 AM, with Administrative Staff A, revealed she expected staff to throw out stained linen and order more linen when needed. The facility policy Resident Rights revised 10/22, instructed staff to provide a safe, clean, comfortable, and homelike environment. The facility failed to ensure staff provided unstained, normal textured towels and washcloths to the residents in this [NAME] House to promote a sense of well-being.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 92 residents with 22 selected for review. Based on observation, interview, and record review, the facility failed to develop comprehensive care plans for four of the 22 residents reviewed. Resident (R)37 for use of support hose, R35 for fluid restriction, R78 for type of music, TV shows and religious preferences and R242 for shaving preferences. Findings included: - Review of Resident (R) 37's medical record revealed diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear, chronic kidney disease, congestive heart failure (a condition with low heart output and the body becomes congested with fluid), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). The admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The resident required extensive assistance of staff for dressing and personal hygiene. The Cognitive Loss Care Area Assessment (CAA), dated 07/25/23, assessed the resident's risk factors of skin breakdown, weight loss and fluid imbalance. The ADL (Activity of Daily Living) Functional/Rehabilitation CAA dated 07/25/23 did not trigger. The Care Plan reviewed 03/20/24, instructed staff the resident had a functional deficit with ADLs due to dementia(progressive mental deterioration characterized by confusion and memory failure).The resident required moderate assistance with dressing. The care plan instructed staff to ensure the resident wore appropriate footwear, as she preferred tennis shoes. The care plan lacked the resident's preference for wearing support hose. Interview, on 03/25/24 at 02:10 PM, with a family member revealed R37 preferred to wear support hose and had multiple pairs of them in her drawers. The family member stated the resident often does not have them on and she assists R37 in putting them on when visiting the resident. Observation, on 03/26/24 at 11:38 AM, revealed Certified Medication Aide (CMA) M ambulated with the resident to the bathroom. The resident lacked support hose. Interview with CMA M at that time revealed the night shift washed the support hose and dried them on the towel rack in the bathroom, and they were wet this morning, but dry at this time. CMA M did not know the resident had several pairs of the compression hose in her drawers. Observation revealed several pairs of support hose in her drawer beneath the closet. Interview, on 03/28/24 at 10:00 AM, with Administrative Nurse D, confirmed the resident preference for support hose was not on the care plan, and not listed as a Task for certified staff to complete. The facility policy Standards of Care and Care Planning Practice dated 04/01/23, instructed staff (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the care plan should reflect resident centered items that are unique to that resident's care. The facility failed to include R37's preference for wearing support hose in her comprehensive care plan to promote a sense of well-being. - R35's physician orders revealed the following diagnoses included orthostatic hypotension (blood pressure dropping with change of position), essential (primary) hypertension (elevated blood pressure), viral hepatitis C (inflammatory condition of the liver), chronic obstructive pulmonary disease (COPD, a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), chronic kidney disease, and fluid overload (increase in the volume of extracellular and/or intravascular fluids). The Annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 09, indicating moderate cognitive impairment. The resident used a wheelchair or walker for mobility. The quarterly MDS dated [DATE], revealed no significant changes in status. The Dehydration/ Fluid Maintenance Care Area Assessment (CAA), dated 10/12/23, revealed R35 was on a fluid restriction, and nursing staff were to monitor the resident was drinking fluids. Review of the care plan dated 01/23/24, lacked guidance related to the resident's fluid restriction. The physician's order dated 04/23/23 revealed the following: The resident has a daily 2000 milliliter (ml) fluid restriction. Fluids include anything that is liquid at room temperature. During the day shift, the resident may have 480 ml at breakfast and 360 ml at lunch from dietary. The resident may have 360 ml during the shift from Nursing. A total for dayshift would be 1200 ml. During the evening shift, the resident may have 360 ml at supper from dietary. The resident may have 240 ml during the shift from nursing. A total for evening shift would be 600 ml. During the night shift, the resident may have 180 ml from nursing. A total for night shift would be 180 ml. Observation on 03/25/24 at 01:40 PM revealed the resident sat in his chair in his room with feet elevated. On 03/25/24 at 01:40 PM, the resident reported he was on an 1800 ml fluid restriction, but the staff did not bother him a whole lot because he has been on it a long time and just knows what he can drink and if he wants extra, he will just get it. On 03/26/24 at 11:55 AM, Certified Nursing Assistant (CNA) SS reported she did not know how staff monitored the resident's fluid restriction. She thought it was probably up to dietary to restrict his fluids and thought he usually had a coffee cup and a glass of fluid at each meal. She was unable to determine the amount of fluid would total for a cup of coffee and a glass of fluid. She reported (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was no intake sheet to chart his fluids, but as long as he had no fluid in his room, nursing did not need to monitor his fluid intake. On 03/26/24 at 12:10 PM, Licensed nurse (LN) I reported she was not sure what the fluid restriction was. She knew they have a chart in the kitchen to tell how much each size glass held. There was no intake sheet that she was aware of and thought dietary measured the fluids. She reported staff did not monitor the resident's fluid intake. On 03/27/24 at 10:30 AM, Administrative Nurse F reported she would expect the resident's fluid restriction to be included on the care plan. On 03/27/24 at 04:30 PM, Administrative Staff A reported the facility had a new MDS staff but had to learn the process to get the assessments to reflect the resident's status. they know the MDS, care plan piece is not where it needs to be. On 03/25/24 a policy for Care Plans was requested and was referred to the MDS manual for instruction. The facility failed to include R35's fluid restriction for staff guidance on the comprehensive care plan. - Review of Resident (R)78's electronic medical record (EMR) included a diagnosis of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord). The Modification of the admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. It was very important for her to listen to music she liked, participate in religious services and do her favorite activities. She required total staff assistance with transfers, locomotion on and off the unit, and she had impaired range of motion (ROM) on bilateral (both) upper and lower extremities. The Activities Care Area Assessment (CAA), dated 08/06/23, documented the resident was at risk for decreased socialization and worsening depression. The facility would encourage active participation in facility functions to engage in sensory stimulation. The Quarterly MDS, dated 01/23/24, documented the staff assessment for cognition revealed the resident was independent with daily decision making. She was dependent on staff for all activities of daily living (ADL). The care plan for activities, revised 08/01/23, instructed staff the resident was dependent on staff for participation in activities. Her favorite activities included visiting, watching group activities, watching TV and listening to music. The care plan lacked the genre of music the resident enjoyed, TV shows she like to watch and lacked the resident's religion. Review of the resident's Activities admission Data Collection, dated 08/01/23, documented it was very important for her to listen to the music she liked, participate in religious services and to do her favorite activities. The primary respondent for the assessment was the resident. Review of the resident's Activities readmission Data Collection, 02/21/24, lacked activity (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preferences. Review of the facility's activity calendar revealed an activity of morning music would occur every morning at 09:30 AM and religious services would occur each Sunday morning at 09:30 AM and 11:00 AM. Review of the resident's EMR, from 03/01/24 through 03/27/24, revealed she participated in a social on three occasions and had visitors on two occasions. No other activities documented. On 03/26/24 at 08:14 AM, Certified Nurse Aide (CNA) T and Certified Medication Aide (CMA) MM entered the resident's room to prepare the resident for the day. The resident's room lacked a device to listen to music and her TV was not turned to a music station. On 03/27/24 at 09:48 AM, the resident sat in her wheelchair in the commons area facing the TV. The TV, which was tuned to a soap opera, had no volume. On 03/28/24 at 09:01 AM, the resident sat in her wheelchair in her room with CNA X. The TV was turned off and no music played in the resident's room. On 03/28/24 at 09:01 AM, the resident stated she prefers to listen to rap music. She stated she was a Baptist but had not been able to participate in a Baptist service for a long time. On 03/26/24 at 03:09 AM, CNA PP stated she was unsure of what the resident liked to watch on TV but staff would put her in the commons area in front of the TV so she was able to watch whatever was on at that time. On 03/27/24 at 08:14 AM, CNA T stated the resident's family would turn the TV on to a music station when they visited, but CNA T was unsure of what music the resident preferred. On 03/28/24 at 07:38 AM, Activity Staff Z stated the staff were responsible for activities in the green houses. On 03/28/24 at 09:01 AM, CNA X stated she was unsure of what music the resident preferred. On 03/28/24 at 09:51 AM, Administrative Nurse D stated it was important for the care plan to include the types of music and TV shows the resident enjoyed and should also include her religion. The facility policy for Standards of Care and Care Planning Practice, dated 04/01/23, included: Care plans should reflect resident-centered items that are unique to that resident's care. The facility failed to complete a person-centered comprehensive care plan to meet this dependent resident's activity preferences. - The Physician's Order Sheet (POS), dated 03/21/24, documented Resident (R)242 had a diagnosis of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The Annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed severe impairment. The resident was dependent on staff for all activities of daily living (ADL). (continued on next page)

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	175385	A. Building B. Wing	03/28/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Functional Abilities Care Area Assessment (CAA), dated 01/15/24, did not trigger. The Medicare 5-day MDS, dated 03/16/24, documented the staff assessment for cognition revealed severe impairment. He was dependent on staff for all ADLs. The care plan for ADLs, revised 01/30/24, instructed staff the resident was dependent on staff for all ADLs. The care plan lacked staff instruction on facial shaving. Review of the resident's electronic medical record (EMR), from 02/27/24 through 03/26/24, revealed the resident was dependent on staff for personal hygiene, including shaving. On 03/25/24 at 01:50 PM, the resident sat in his room in his wheelchair. He was unshaven with scraggly overgrowth of facial hair. On 03/26/24 at 09:55 AM, the resident sat in his wheelchair in the dining room. He remained unshaven with scraggly overgrowth of facial hair. On 03/27/24 at 08:29 AM, the resident sat in his wheelchair in the commons area. He remained unshaven with scraggly overgrowth of facial hair. On 03/26/24 at 01:15 PM, Certified Medication Aide (CMA) NN stated residents were to be shaved on their shower days. On 03/27/24 at 11:13 AM, Certified Nurse Aide (CNA) RR stated residents were to be shaved on their shower days. On 03/26/24 at 12:26 PM, Licensed Nurse (LN) H stated the staff were to shave the residents on their shower days and whenever they wanted to be shaven. On 03/27/24 at 01:38 PM, Administrative Nurse D stated staff instruction for the resident's facial shaving should be included on the care plan. The facility policy for Standards of Care and Care Planning Practice, dated 04/01/23, included: Care plans should reflect resident-centered items that are unique to that resident's care. The facility failed to complete a person-centered comprehensive care plan to meet this dependent resident's preferences for facial shaving.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - Review of Resident (R)20's medical record revealed diagnoses that included deep vein thrombosis (DVT blood clots) in the right and left leg, heart disease, diabetes (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), and unstageable pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction and the wound is covered by a layer of dead tissue). The Quarterly Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. The resident had an unstageable pressure ulcer present upon admission/reentry. The resident had no impairment in function range of motion in her upper or lower extremities and was dependent on staff for Activities of Daily Living (ADL). The Significant Change Minimum Data Set (MDS), dated [DATE], assessed the resident with a BIMS score of nine, which indicated moderate cognitive impairment. The resident had no impairment in her upper or lower extremities, was dependent on staff for ADL, and at risk for pressure ulcers with no current pressure ulcer injury. The Pressure Ulcer Care Area Assessment (CAA), dated 02/05/24, assessed the resident due to impairment with functional mobility, recent acute illness, and incontinence. Licensed staff were to assess R20's skin each week and initiate proper interventions to prevent skin breakdown, and caregivers assist with repositioning as needed. The Care Plan reviewed 02/21/23, instructed staff the resident admitted to hospice. The resident had a potential for impairment of skin integrity related to fragile skin. An intervention added 11/21/23, instructed staff to avoid positioning the resident on her heals and use foam always off-loading boots when in bed due to a deep tissue injury (DTI) to the left heel following hospitalization (11/13-11/20/23). Staff instructed to apply skin prep (a solution when applied that forms a protective waterproof barrier on the skin) to bilateral (both) heels daily. The care plan failed to include the right heel pressure ulcer which developed on 02/09/24 and failed to include updated interventions for off loading devices. On 02/29/24, the physician instructed staff to apply skin prep to bilateral heels daily. A Skin/Wound New Observation note dated 02/09/24, indicated the resident developed a 1.5 by 1 centimeter (cm) deep tissue injury to her right heel. This note indicated staff to continue to utilize the off-loading boots. A Skin/Wound Weekly Observation note, dated 02/13/24, indicated the DTI measured 3.3 cm by 4.5 cm and staff instructed to continue the use of off-loading boots. A Skin/Wound Weekly Observation note, dated 02/20/24, indicated the DTI measured 4 cm by 6 cm, with a mushy feeling. A Skin/Wound Weekly Observation note, dated 03/07/24, indicated the DTI measured 6 cm by 3.5 cm (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175385	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER Paramount Community Living and Rehab Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SW 14th Newton, KS 67114	

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with a depth of 1 cm, with wound edges intact. The note indicated a treatment of skin prep to both heels and float the heel off the bed with pillows. A Skin/Wound Weekly Observation note, dated 03/12/24, indicated the DTI measured 7 cm by 4 cm with no depth. This note indicated the area improved with softness decreased. A Skin/Wound Weekly Observation note, dated 03/19/24, indicated the DTI measured 5.2 cm by 7.4 cm with a dark colored eschar (dead tissue) and no changes in treatment. A Skin/Wound Weekly Observation note, dated 03/26/23, indicated the DTI measured 4.5 cm by 6.3 with 100% eschar with no changes in treatment. An Interdepartmental Team (IDT) Comprehensive Care Review dated 02/15/24, indicated the resident had a new DTI to her right heel with a wound treatment of offloading the heels by floating the heels. An Interdepartmental Team (IDT) note, dated 02/22/24, indicated the right heel decreased in size. An Interdepartmental Team (IDT) note, dated 03/01/24, indicated the right heel as mushy with the appearance of a blood blister. An Interdepartmental Team (IDT) note, dated 03/14/24, indicated the resident had a DTI to the right heel with stable wound margins. The resident had DVT's to both lower legs and was on hospice for end-of-life cares. The resident had a pressure redistributing mattress on her bed and used a pillow to float her heels off the surface. Observation, on 03/26/24 at 09:45 AM, revealed the resident seated in her wheelchair in her room. Certified Medication Aide (CMA) XXX and CMA Y assisted R20 to pivot transfer into her bed. CMA Y placed a pillow under the resident's calves to elevate her heels off the bed. Observation, on 03/26/24 at 10:30 AM, revealed the pillow remained under the resident's calves, but her heels laid directly on the bed. Licensed Nurse (LN) G removed the resident's socks and revealed her right heal with blue black eschar. The left heel skin was pink and intact. Interview, at that time with LN G, revealed staff applied specialized foam boots to R20's bilateral heels and the left pressure ulcer heeled, but she developed a pressure ulcer on her right heel despite the boots. LN G stated the resident could move her foot in the boot causing a shift in the off-loading ability of the boots, so staff used pillows to off load her heels. LN G confirmed the pillow ineffective in keeping the resident's heels offloaded and obtained a blanket for additional off-loading. LN G stated R20 received hospice services, and she would inform hospice of the need for more effective off-loading device. Observation, on 03/26/24 at 02:05 PM, with Administrative Nurse E, revealed the readmitted to the facility with a deep tissue injury to her left heel. The resident had bilateral DVT in her lower extremities. The resident wore specialized pressure relieving boots and with treatments, the left heel injury resolved, however, the right heel injury developed inspire of the pressure relieving boots, so staff used pillows to elevate her heels off the bed. Administrative Nurse E confirmed the pillows may not maintain their buoyancy over time to keep the heels off the bed. Administrative Nurse E measured the right heel blue/black eschar as 4.5 cm by 6.3 centimeters and then applied skin prep to both (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heels. Administrative Nurse E confirmed the care plan lacked updated interventions for the right heel pressure ulcer and need for alternative means to float the resident's heels. Observation, on 03/27/24 at 09:20 AM, revealed the resident sitting up in her bed, eating breakfast. A pillow and blanket positioned under the resident's calves, but her right and left heel lay directly on the surface of the mattress. Interview, at that time with CMA P, revealed the resident did move her feet when in bed. Observation on 03/27/24 at 09:59 AM, revealed Consulting Therapy Staff GG, applied a foam shelf-like positioning device with elevated lateral (outer edges) sides. Consulting Therapy Staff GG stated she was consulted for R20's heel positioning needs due to the development of the DTI to her right heel. Consulting Therapy Staff GG stated she felt this device was a more appropriate device for floating R20's heels. Interview, on 03/28/24 at 10:00 AM, with Administrative Nurse D, stated she would expect licensed nursing staff to revise the care plan to include the development of the right heel pressure ulcer and assess effectiveness of heel floating interventions and initiate alternatives. The facility policy Standards of Care and Care Planning Practice dated 04/01/23, instructed staff instructed staff to ensure that all services are provided to the resident to ensure the care plan is resident centered and specific to the unique needs of each resident. The facility failed to review and revise R20's care plan to include the development of the right heel deep tissue injury and assess the effectiveness of off-loading interventions for the prevention/healing of her deep tissue injury. The facility census totaled 92 residents with 22 residents included in the sample. Based on observation, interview, and record review, the facility failed to revise care plans for two residents. Resident (R)9, related to the failure to care plan a fall with a fractured foot that required a special walking boot, and R9, related to skin care for a pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Findings included: - R9's physician orders revealed the following diagnoses: diabetes mellitus (when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and right great toe fracture (broken toe). The Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident was dependent on a walker or wheelchair for mobility. The resident had no recent falls. Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 15. The resident used a walker and wheelchair for mobility. The resident had a fall with major injury since last MDS. The resident received Physical Therapy and Occupational Therapy (PT, OT) for rehabilitation. The Activities of daily living (ADL) Functional/ Rehabilitation Care Area Assessment (CAA) dated 01/04/24 revealed the resident had impaired balance and transition during transfers, and functional (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impairment in activity. The care plan failed to resvise the care plan to include the fall on 01/28/24 which resulted in a fractured right great toe and use of a walking boot. The physician orders dated 01/29/24 revealed the resident was to wear a surgical boot on the right foot when getting out of bed and off at bedtime, for a fracture of the right great toe. Review of the Reported Incident revealed on 01/28/24 at 03:15 AM, R9 fell from her bed. The fall resulted in a skin tear to her right elbow and a fractured right great toe. R9 was to wear a walking shoe until the fracture healed. Observation on 03/25/24 at 11:45 AM, revealed Certified Nurse Aide (CNA) UU assisted R9 to the dining room. R9 wore the walking boot. On 03/25/24 at 11:50 AM, the resident reported she fell out of bed about 5 weeks ago and had to wear the fracture boot until her fractured toe healed. On 03/27/24 at 10:30 AM Administrative Nurse F reported the care plan should have been revised to include her fall with a fracture and interventions. On 03/25/24, a policy for Care Plans was requested and was referred to the MDS manual for instructions. The facility failed to revise R9's care plan regarding this resident's fall/interventions to guide staff with cares.

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY The facility census totaled 92 residents with 22 residents included in the sample. Based on observation, interview, and record review, the facility failed to monitor one Resident (R)35, for a physician ordered fluid restriction.

Findings included:

- R35's physician orders revealed the following diagnoses included orthostatic hypotension (blood pressure dropping with change of position), essential (primary) hypertension (elevated blood pressure), viral hepatitis C (inflammatory condition of the liver), chronic obstructive pulmonary disease (COPD, a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), chronic kidney disease, and fluid overload (increase in the volume of extracellular and/or intravascular fluids).

The Annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 09, indicating moderate cognitive impairment. The resident used a wheelchair or walker for mobility.

The quarterly MDS dated [DATE], revealed no significant changes in status.

The Dehydration/ Fluid Maintenance Care Area Assessment (CAA), dated 10/12/23, revealed R35 was on a fluid restriction, and nursing staff were to monitor the resident's fluid intake.

Review of the care plan dated 01/23/24, lacked guidance related to the resident's fluid restriction.

The physician's order dated 04/23/23 revealed the following:

The resident has a daily 2000 milliliter (ml) fluid restriction. Fluids include anything that is liquid at room temperature.

During the day shift, the resident may have 480 ml at breakfast and 360 ml at lunch from dietary. The resident may have 360 ml during the shift from Nursing. A total for dayshift would be 1200 ml.

During the evening shift, the resident may have 360 ml at supper from dietary. The resident may have 240 ml during the shift from nursing. A total for evening shift would be 600 ml.

During the night shift, the resident may have 180 ml from nursing. A total for night shift would be 180 ml.

Observation on 03/25/24 at 01:40 PM revealed the resident sat in his chair in his room with feet elevated.

On 03/25/24 at 01:40 PM, the resident reported he was on an 1800 ml fluid restriction, but the staff did not bother him a whole lot because he has been on it a long time and just knows what he can drink and if he wants extra, he will just get it.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/26/24 at 11:55 AM, Certified Nursing Assistant (CNA) SS reported she did not know how staff monitored the resident's fluid restriction. She thought it was probably up to dietary to restrict his fluids and thought he usually had a coffee cup and a glass of fluid at each meal. She was unable to determine the amount of fluid would total for a cup of coffee and a glass of fluid. She reported there was no intake sheet to chart his fluids, but as long as he had no fluid in his room, nursing did not need to monitor his fluid intake. On 03/26/24 at 12:10 PM, Licensed nurse (LN) I reported she was not sure what the fluid restriction was. She knew they have a chart in the kitchen to tell how much each size glass held. There was no intake sheet that she was aware of and thought dietary measured the fluids. She reported staff did not monitor the resident's fluid intake. On 03/27/24 at 10:30 AM, Administrative Nurse F reported she would expect the resident's fluid restriction to be included on the care plan. All staff caring for the resident should be aware of his fluid restriction and how to monitor it. The facility lacked a policy related to fluid restrictions. The facility failed to monitor the physician prescribed fluid intake for this resident that required a fluid restriction.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 92 residents with 22 included in the sample. Based on observation, interview, and record review, the facility failed to ensure infection control techniques for Resident (R)9, regarding oxygen (O2) tubing/cannula storage, for R60, related to urinary catheters and perineal care, R242, related to storage of soiled catheter collection device stored next to personal care items of toothbrush and toothpaste, and R78, related to incontinence cares, to prevent the spread of infections in the facility. Findings included: - R9's physician orders revealed the following diagnoses that included chronic obstructive pulmonary disease (COPD-progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Review of the Quarterly MDS dated [DATE], revealed a BIMS score of 15. R9 received oxygen (O2). The care plan dated 03/17/2023 revealed the resident had COPD and staff were to give oxygen therapy as ordered by the physician. Observation on 03/25/24 at 11:45 AM, revealed Certified Nursing Assistant (CNA) UU entered the resident's room to assist the resident to lunch. CNA UU removed R9's O2 cannula and placed the tubing and nasal cannula directly on the bed. The room lacked a storage container for the O2 cannula. CNA UU removed a trash filled bag out of the trash can, reached into the trash can and obtained a new trash bag out and placed R9's cannula into the trash bag, and laid the cannula back onto the bed. No hand hygiene completed between removing the trash and handling R9's cannula. Observation revealed a second nasal cannula stored directly on R9's walker and was not stored in a container. CNA UU applied the opened, unbagged nasal cannula to R9 and assisted R9 to the dining room. Observation on 03/26/24 at 12:10 PM, CNA SS entered the resident's room to assist the resident to the dining room. She removed R9's O2 cannula and placed the cannula/tubing directly on the bed and placed a magazine on top of the cannula. CNA SS removed O2 tubing/cannula from the walker and placed it on the resident. That cannula was not in a storage bag and was wrapped around the back of the walker with the cannula having contact with the top of the O2 tank. On 03/25/24 at 11:50 AM, CNA UU reported the resident's O2 cannula and tubing should be in a box but did not see one in her room. The resident's walker should have a bag to contain the O2 when not in use. On 03/26/24 at 12:10 PM, CNA SS reported she was not sure what to do with the O2, so she just put it on the bed and laid something on top of it so it would not slide off on the floor. She was unaware anything had to be on the walker for the O2 tubing to be stored in. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/26/24 at 12:20 PM, Licensed Nurse (LN) I reported everyone on O2 should have a three-compartment cart in their room for the O2. She also reported all walkers or wheelchairs that use O2 should have bags with the resident's name and date on it and changed weekly. Observation revealed LN I went into R9's room and found the O2 cart, in a closet behind a wheelchair, with piled clothing and blankets that covered the O2 cart. LNI removed the cart from the closet and placed it into R9's room to be utilized. The facility's policy for oxygen, lacked care of the tubing and cannulas. The facility failed to ensure good infection control techniques by the failure to store oxygen (O2) tubing and nasal cannula in a sanitary manner when not in use. - Resident (R) 60's signed physician orders dated 11/03/23 revealed the following diagnoses included neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), and a history of urinary tract infection (infection of any part of the urinary system). The admission Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The resident was dependent on staff for all daily cares and used a wheelchair for mobility. The resident had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) and was incontinent of bowel. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 11/03/23 revealed staff were to provide assistance to clean and dry the resident for bowel needs and the resident had an indwelling urinary catheter. Observation on 03/25/24 at 12:10 PM, revealed Certified Nursing Assistant (CNA) V emptied the resident's catheter. CNA V donned gloves and retrieved a graduated pitcher from the bathroom and removed the tubing from the catheter bag spigot. She drained the catheter bag and placed the tubing into the spigot of the drainage bag without cleansing the spigot. CNA V failed to remove her soiled gloves and CNA V and CNA UU transferred the resident from a full body mechanical lift to the bed. The resident had a bowel movement and required incontinence cares. CNA UU provided perineal cares and grabbed disposable wipes from the container with the soiled gloves. CNA V and CNA UU failed to remove their soiled gloves and placed a clean brief under the resident. CNA UU then went into the bathroom with the soiled gloves on, retrieved moisture barrier, and applied moisture barrier to the resident. With soiled gloves on, the brief was placed and fastened, and staff positioned the resident onto his side with positioning devices and placed positioning devices under his legs. CNA V then removed her gloves. CNA UU emptied the trash and then removed her gloves. Both CNA's left the resident's room without washing their hands. On 03/25/24 at 12:30 AM, CNA V reported she would usually use alcohol when emptying a catheter but thought there was no available alcohol in the resident's bathroom, so just did not use it. On 03/25/24 at 12:32 PM, CNA UU reported she should have changed her gloves during the incontinent care. On 03/28/24 at 08:00 AM, Administrative Nurse D reported she expected her staff to maintain good hand hygiene with personal care. Staff should change their gloves between dirty and clean. Staff with the clean gloves should handle the wipes and hand to the aide doing the perineal care. When emptying (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175385	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the catheter, gloves are required along with alcohol to the tubing to clean the tubing, to prevent urinary tract infections (UTI's). Hand washing and proper usage of gloves and disinfecting the tubing is a must. The facility's policy for Urinary Catheter Care, dated 02/2017, included: Staff shall use standard precautions while performing urinary catheter cares with residents. Review of the facility's policy for Standards of Care dated 04/01/23, revealed all staff are to maintain standard precautions when providing care to a resident. The facility failed to ensure good infection control techniques by the failure to change gloves between dirty and clean while performing peri-care for R60 and the failure to properly clean the catheter spigot when emptying R 60's indwelling urinary catheter. - Review of Resident (R)78's electronic medical record (EMR) revealed a diagnosis of multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord). The Modification of admission Minimum Data Set (MDS), dated 08/06/23, documented the resident had a Brief Interview for Mental Status (BIMS) score of thee, indicating severe cognitive impairment. She required extensive assistance of two staff for toileting and was incontinent of bowel. The Activity of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 08/06/23, did not trigger. The Quarterly MDS, dated 01/23/24, documented the staff assessment for cognition revealed the resident was independent with daily decision making. She was dependent on staff for all ADLs and was always incontinent of bowel. The care plan for ADLs, dated 08/01/23, instructed staff the resident required assistance with all ADLs. Review of the resident's EMR, from 03/01/24 through 03/27/24, revealed the resident was dependent on staff for bowel incontinence and dressing. On 03/26/24 at 08:14 AM, Certified Nurse Aide (CNA) T and Certified Medication Aide (CMA) MM entered the resident's room to get her ready for the day. The staff completed peri-care due to the resident being incontinent of bowel. The staff then applied a clean brief without changing gloves. CNA T then began to dress the resident, putting her hand through the sleeve of the resident's clean shirt, without changing her gloves. On 03/26/24 at 08:14 AM, CNA T confirmed she had not changed her gloves after performing peri-care following the incontinent BM before she placed a new brief on the resident and began to dress her. CNA T stated she should have changed her gloves but had forgotten. On 03/26/24 at 08:19 AM, CMA MM stated she should have changed her dirty gloves before helping to put a clean brief on the resident. On 03/28/24 at 09:51 AM, Administrative Nurse D stated it was the expectation for staff to change their gloves after providing peri-care and before putting on a clean brief or assisting a resident to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dress. The facility lacked a policy regarding changing gloves following peri-care. The facility failed to use appropriate hand hygiene after performing peri-care for this dependent resident. - Review of Resident (R)242's electronic medical record (EMR) included a diagnosis of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The Annual Minimum Data Set (MDS), dated 01/15/24, documented the staff assessment for cognition revealed severe impairment. He was dependent on staff for all ADLs. The Urinary Incontinence/Indwelling Catheter Care Area Assessment (CAA), dated 01/15/24, documented the resident was dependent on staff for toileting. The Medicare 5-Day MDS, dated 03/16/24, documented the staff assessment for cognition revealed severe impairment. He was dependent on staff for all ADLs. The indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) care plan, revised 03/25/24, instructed staff to position the catheter bag and tubing below the level of the bladder. Review of the resident's EMR revealed the following physician's order: Indwelling urinary catheter for neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), 03/20/24. On 03/26/24 at 01:15 PM, Certified Medication Aide (CMA) NN entered the room to empty the resident urinary catheter. CMA NN drained the urine into a graduate (a vessel used to measure liquids). CMA NN then emptied the urine into the toilet, filled the graduate half-way with water from the resident's bathroom faucet to rinse, poured the rinse water into the toilet then placed the graduate upside down on the back of the toilet on top of paper towels up against the resident's tooth brush, tooth paste and shaving cream. On 03/26/24 at 01:15 PM, CMA NN stated the staff kept the graduate on the back of the toilet with the rest of the resident's things all the time. On 03/27/24 at 01:38 PM, Administrative Nurse D stated the staff should not place the graduate up against the resident's toothbrush and toothpaste. The facility policy for Urinary Catheter Care, dated 02/2017, included: Staff shall use standard precautions while performing urinary catheter cares with residents. The facility failed to use appropriate standard precautions while performing catheter care for this dependent resident with a urinary catheter.