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 _____	C 10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	**200 SW 14TH NEWTON, KS 67114**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #165660, # 165956, and # 166254. This 2567 was electronically sent to the facility on 10/21/21.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility reported a census of 23 residents, with three residents sampled for skin conditions. Based on interview and record review, the facility failed to identify and monitor one of the three sampled Resident (R) 1, related to a large bruise to her left breast, to ensure no adverse effects of the bruise. Findings included: - The signed "Physician Order Sheet" (POS), for Resident (R) 1, dated 09/20/21, revealed the following diagnoses; hypertension (elevated blood pressure), anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues), and diabetes mellitus (when the body cannot use glucose, not enough insulin	F 684		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175385	A. BUILDING _____ B. WING _____	C 10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	200 SW 14TH NEWTON, KS 67114

(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 1	F 684		

made, or the body cannot respond to the insulin).

The admission "Minimum Data Set" (MDS), dated 08/25/21, documented the resident admitted on 08/19/21. The resident had a "Brief Interview for Mental Status" (BIMS) score of 15, indicating she had intact cognition. The resident's functional status documented the resident required two-person extensive assist with toileting, one-person limited assist with personal hygiene, and one-person extensive assist with dressing,

The care plan, dated 10/05/21, guided staff that hospice and the facility staff would work together to coordinate for the residents' bathing, ensure the residents' personal hygiene and dressing needs attended to. Report any areas of bruising to the charge nurse immediately for assessment. On 10/09/21, the Skin Integrity care plan, advised staff the resident was at risk for bruising related to lying in the bed. Staff were directed to observe the residents' skin during routine care for bruising and discoloration. Report to the charge nurse for documentation and physician notification as needed.

The Physician Order Sheet dated 09/20/21, included the following order:

Start Date of 08/20/21; Weekly Skin Assessment; one time a week, on bath day.

Review of the Nursing Notes from 08/19/21 through 10/20/21, revealed the resident was admitted to the facility on 08/19/21. The skin assessment included the residents' buttocks, and both heals were clear. The resident had various stages of bruising to her right forearm from multiple intravenous (IV) sites. The resident's left

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 _____	C 10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	200 SW 14TH NEWTON, KS 67114

(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 2	F 684		

and the right second digits remain bent. The admission nursing notes lacked documentation of the left breast bruise.

Review of the "Weekly Skin Check", dated 08/19/21, revealed the resident had bruising to her right forearm from multiple IV sites, however lacked documentation of the resident left breast bruise.

On 08/27/21, review of the Nurse Notes, revealed the resident required hospitalization. During the preparation for transfer, Emergency Medical Services (EMS) arrived to transport the resident to the Emergency Department (ED). EMS informed the facility staff the resident had bruising above her left breast.

Review of weekly skin checks from 09/03/21 through 10/08/21 lacked identification, monitoring, and documentation of bruising to the resident's left breast.

Review of hospital records, revealed on 09/24/21, the resident had multiple bruises in various stages of healing on her arms, and she also had a large area of ecchymosis (bruise) on her left breast.

On 10/13/21 at 01:29 PM, Licensed Nurse (LN) G advised after the resident was admitted to the facility, LN G advised she noticed the resident's bruising to her left breast, however advised she failed to document the bruising in the nursing notes and weekly skin checks.

On 10/20/21 at 12:36 PM, Outside Resource GG advised the resident had a large bruise to her left breast. "The bruise was as large as my hand" and

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 _____	C 10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT COMMUNITY LIVING AND REHAB INC	200 SW 14TH NEWTON, KS 67114

(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 3	F 684		

had various staging of bruising. When Outside Resource GG notified a facility charge nurse, the charge nurse was unaware of the resident's left breast bruise, and the facility staff failed to find documentation and monitoring of the bruising to the resident's left breast.

On 10/20/21 at 04:03 PM, Administrative Nurse D advised upon admission, staff should complete a head to toe skin assessment, that included bruising. Administrative Nurse D advised Certified Nurse Aides should notify the charge nurse with any type of bruising for the nurse to document and monitor.

The Skin Integrity Guideline Policy, dated 2011, documented the Licensed nurse would be responsible for performing a skin evaluation/observation weekly, utilizing the Weekly Skin Check Form.

The facility failed to identify and monitor this resident related to a large bruise to her left breast, to ensure no adverse effects of the bruise.