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	02/18/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility reported a census of 91 residents, with one main kitchen and eight kitchenettes. Based on observation, interviews and record review, the facility failed to prepare and serve food in accordance with food safety requirements regarding adequate temperatures and sanitary food storage. Findings included:-Observations in the [NAME] House kitchenettes revealed the following: [NAME] House 1212: On 02/16/26 at 08:39 AM a mustard bottle and two jars of cocktail sauce were opened and undated. [NAME] House 1215: On 02/17/26 at 08:19 AM, Certified Nurse Aide (CNA) HH brought pureed sausage and gravy to the resident. Upon request, CNA HH checked the temperature which measured was 65 degrees Fahrenheit (F). CNA HH took the plate of food and placed it in the microwave. Recheck of the temperature measured 165 degrees F. CNA HH served the resident and told the resident to be careful with her plate because it was hot. The resident stirred her food and stated it was too hot for her to eat. [NAME] House 1202: On 02/17/26 at 11:19 AM, kitchen staff delivered the lunch meal in foil-covered pans. One large pan with smaller foil-covered pans inside was placed on counter. Certified Medication Aide (CMA) S drained a pot of spaghetti noodles, and at 11:42 AM, served the residents plates of spaghetti with sauce, steamed vegetables and a breadstick without measuring temperatures on the cooked food items prior to serving. On 02/17/26 at 12:02 PM, observation in a dry storage panty revealed an undated plastic zipper bag of dry, ground oatmeal labeled pureed, an opened and undated canister of oats and an open and undated bag of potato chips. On 02/17/26 at 11:57 AM, observation revealed one plated pureed meal on the counter, uncovered and unattended while staff ate with the residents. On 02/18/26 at 11:11 AM, kitchen staff arrived with the delivery of a pureed entree for one resident, and a large clear bag of uncut vegetables. The entree was chicken pot pie entree with garden salad and pumpkin spice blondie for dessert. CNA II prepped the salad by cutting the vegetables, then rechecked the entree temperatures. CNA II attempted to measure the temperature of the chicken pot pie but was dissatisfied with amount of time to obtain the measurement, so CNA II attempted to recalibrate the thermometer by placing it in a plastic cup of water with one ice cube. She then removed the entree from the oven and used the thermometer to check the internal temperature.The temperature measured 130 degrees F. so she placed the entree back into the oven at 11:51 AM. Using the same thermometer, CNA II then assessed the temperature of the pureed entree (chicken pot pie) which measured 100 degrees F. Without sanitizing the thermometer, CNA II placed it under running hot water then wiped it off with a kitchen towel that was previously used to wipe spots on the counter and a serving spoon. CNA II then returned to preparing the salad. On 02/18/26 at 12:27 PM, CNA II rechecked the temperature on the non-pureed entree which measured 165 degrees. Observation of the pureed entree revealed the food item was dry, crusty and dark on top with a temperature of 161 degrees F. CNA II placed it back in the oven and resumed serving other residents. Review of the temperature and sanitation logs for one kitchenette (1215) revealed the following: Temperature logs lacked evidence the evening meal temperatures were assessed and documented on 02/01/26-02/02/26, 02/04/26-02/07/26, 02/09/26, 02/11/26-02/13/26. No temperatures were documented in the temperature logbook for breakfast or lunch meals on 02/06/26. No temperatures documented for refrigerator/freezer, on first shift, (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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/06/26, 02/09/26 and 02/11/26. No temperatures documented for refrigerator/freezer, on second shift, 02/01/26-02/02/26, 02/04/26-02/07/26, 02/09/26, 02/11/26-02/13/26. On 02/06/26-02/09/26, the sanitation checks were documented as not working. Sanitizer bucket tests were not completed/documented, for the same dates. During an interview on 02/17/26 at 08:19 AM, CNA HH stated she put cold milk in the pureed biscuits and gravy and that was why it was cold. She said she would need to heat up the food before serving it to the resident. During an interview on 02/16/26 at 08:45, CNA JJ stated the food should be dated when opened, and all food and refrigerator and freezer temperatures should be documented each shift. She stated she does not know why the temperature checks were not completed on second shift but said she does it when she works. On 02/17/26 at 12:00 PM, CMA S stated the resident who received the pureed plate which had sat on the counter was fed after the other residents who were able to come to the dining table themselves. On 02/17/26 at 10:55 AM, Dietary BB stated she expected temperature logs to be completed on each shift by the CNA or CMA who was working in each kitchen. On 02/18/26 at 12:10 PM, CNA II stated she would start plating the food for the residents once the temperatures of the chicken entrees reached 165 degrees. On 02/18/26 at 12:30 PM, CNA II stated she was aware the temperature of the entree needed to be 165 degrees F or higher and acknowledged that after using several thermometers, the temperature of the entree was still not at the appropriate temperature even after several different interventions. During an interview on 02/19/26 at 03:25 PM, Dietary BB stated food opened in the kitchen or kitchenettes should be placed in a ziplocked bag and dated with open and calculated expiration date. She said things like chips would have a 3-day expiration written on the bag, as well as the date it was opened. Dietary BB stated all lunch and supper menu items were prepared the day before and delivered in the mornings on the day they were to be heated and served. She stated the CNA or CMA who heated the hot food entree referred to the temperature guide which was hanging in each kitchen on the refrigerator. Dietary BB clarified all pureed entrees arrived to the kitchenettes hot after an initial temperature of 165 degrees F was achieved because pureed food was considered leftover. She said the temperature was verified as safe in the main kitchen prior to delivering it to the kitchenette, and the food had a holding temperature of 135 degrees F, which was to be rechecked by staff prior to serving. She said food should not be served if the temperature goes below 135 degrees F. The facility's policy Food Safety Requirements, last revised 01/2024, documented it was the policy of this facility to provide safe and sanitary storage, handling, and consumption of all foods including those brought to residents by family and other visitors. The objective and intent of the requirement was to ensure the facility follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling processes.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. The facility identified a census of 91 residents. The sample included 19 residents with five residents sampled for unnecessary medications. Based on observation, interview, and record review, the facility failed to inform R59 or the resident's representative about the risk and benefits of taking a psychotropic (alters mood or thoughts) medication. Findings included:- R59's Electronic Medical Record (EMR) revealed the following diagnoses: dementia (a progressive mental disorder characterized by failing memory and confusion) with behavioral disturbances, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R59's 11/13/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of four, indicating severely impaired cognition. The MDS documented R59 took antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), and antianxiety (a class of medications that calm and relax people) medications. R59's Psychotropic Drug Use CAA documented R59 took routine antipsychotic, antianxiety, and antidepressant medication. Risks include decreased mental alertness, fatigue, drowsiness, dizziness, changes in appetite, and weight gain. R59's 02/10/26 Quarterly MDS documented R59 could not participate in the BIMS assessment. R59 had memory problems and severely impaired decision-making skills. R59 took antipsychotic and antidepressant medications. R59's Physician's Orders documented hydroxyzine (antihistamine used for its psychotropic qualities) 25mg; take one tablet by mouth every six hours as needed for restlessness related to anxiety disorder, end date 02/21/26; ordered on 01/21/26. R59's Physician's Orders documented hydroxyzine 25mg; take one tablet by mouth in the afternoon for anxiety; ordered on 12/12/25. R59's Physician's Orders documented Seroquel (antipsychotic) 50 mg; take one tablet by mouth every morning and at bedtime for agitation related to dementia with behavioral disturbances; ordered on 12/17/25. R59's Physician's Orders documented trazodone (antidepressant) 50mg; take one half a tablet at bedtime for insomnia; ordered on 01/09/26. R59's EMR documented an informed consent for Seroquel and hydroxyzine, but lacked evidence of informed consent regarding the trazodone. On 02/16/26 at 01:38 PM, R59 sat at the dining room table yelling, Help, help! There were handwritten notes from her daughter on the table in front of her, directing her not to yell for help. The notes encouraged her to ask the staff for what she wants. Staff occasionally responded to her and asked her what she needed. On 02/18/26 at 10:12 AM, Licensed Nurse (LN) I stated when a resident got an order for an antipsychotic medication, the nurse told the Director of Nursing (DON) before starting it. LN I stated that staff talked to the family, and they signed a consent form prior to starting the new medications. LN I was unsure if this was the case for new antidepressant medications, but after asking the DON, stated the facility did have a consent form for antidepressant medications. On 02/18/26 at 02:23 PM, Administrative Nurse D stated the facility should get consent for all psychotropic medications prior to starting the medications. Administrative Nurse D verified that the facility had previously only obtained consent for antipsychotic medications but had started including all psychotropic medications. The facility did not provide a policy for psychotropic consents.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. The facility identified a census of 91 residents. The sample included 19 residents with five reviewed for unnecessary medications. Based on interview and record review, the facility failed to ensure Resident (R) 8 was free from unnecessary psychotropic medications and/or chemical restraints when they failed to ensure both of R8's as needed (PRN) lorazepam (antianxiety medication) had a 14 day stop date or a specified duration with a supporting physician rationale. Findings included:-R8's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) and anxiety disorder. R8's Significant Change Minimum Data Set, dated 02/13/26, documented the resident had a Brief Interview for Mental Status (BIMS) score of two, which indicated severe cognitive impairment. The MDS noted R8 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (medication used to treat depression), and an antianxiety medication. R8's Care Plan, dated 11/12/24, documented the resident had behaviors including verbal and physical aggression, yelling obscenities, and hitting. The plan directed staff the resident would see the provider for mental health medication management services. R8's EMR recorded the following physician's orders:Lorazepam 0.5 milligrams (mg), give one tablet by mouth at bedtime for anxiety, dated 12/29/25.Lorazepam 0.5 mg, give one tablet by mouth PRN every six hours for anxiety, dated 12/29/24. The order lacked a stop date or specified duration with a rationale.Ativan (lorazepam) give one 0.5 mg tablet by mouth every four hours PRN for restlessness/anxiety, dated 02/05/26. The order lacked a stop date or specified duration with a rationale. In an interview on 02/18/26 at 12:20 PM, Administrative Nurse D stated R8 had two orders for PRN lorazepam due to the recent addition of hospice orders to his existing orders. Administrative Nurse D verified that neither order had the required 14-day stop date or a specific duration and said the recent pharmacy review Performance Improvement Plan (PIP) will help the facility ensure PRN medications that require stop dates will be quickly identified. The facility policy did not provide a policy for PRN psychotropic medications.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 91 residents. The sample included 19 residents with three in the sample reviewed for hospitalization. Based on observation, interview and record review the facility failed to provide a written bed hold policy at the time of transfer for Resident (R) 10. Findings included:- R10's Electronic Medical Record (EMR) recorded a Significant Change Minimum Data Set (MDS) dated [DATE], which documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS noted R10 received an anticoagulant (blood-thinning medication) routinely. Nurse's Progress notes, dated 02/11/26 at 10:30 PM, documented the facility transferred R10 to the hospital for a critical lab value of potassium (an electrolyte in the blood). R10's EMR lacked evidence that a written bed hold policy was provided at the time of the transfer. On 02/18/26 at 10:45 AM, Concierge GG stated the facility did not provide the written bed hold policy on 02/11/26 because R10 returned to the facility within 24 hours. On 02/18/26 at 12:10 PM, Administrative Staff A stated that any time a resident transferred out of the facility to the hospital, a bed hold policy should be sent out with them. The facility's Bed Hold Prior to Transfer policy, dated 01/2024, indicated that prior to transferring a resident to the hospital or the resident goes on therapeutic leave, the facility will provide written information to the resident and/or the resident representative regarding bed hold. The duration of the state bed-hold, if any, during which the resident is permitted to return and resume residence in a nursing facility

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. The facility reported a census of 91 residents; 19 residents were selected for review. Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set to reflect the condition for Resident (R) 59's falls. Findings included:- R59's Electronic Medical Record (EMR) revealed the following diagnoses: dementia (a progressive mental disorder characterized by failing memory and confusion) with behavioral disturbances, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R59's 11/13/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of four, indicating severely impaired cognition. The MDS documented R59 had one fall. R59's 11/13/25 Falls Care Area Assessment (CAA) documented R59 had a history of falls. R59's 02/10/26 Quarterly MDS documented R59 could not participate in the BIMS assessment. R59 had memory problems and severely impaired decision-making skills. The assessment inaccurately documented that R59 had two or more non-injury falls, no falls with major injury, and no falls with injury (except major) Review of the Resident Assessment Instrument (RAI- a comprehensive, standardized tool used in long-term care facilities to assess residents, guide care planning, and monitor quality of care.) documented falls with major injury, which included, but is not limited to, traumatic bone fractures, joint dislocations/ subluxations, internal organ injuries, amputations, spinal cord injuries, head injuries, and crush injuries. The RAI documented non-major injury includes, but is not limited to, skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.) R59's Event Note, dated 11/17/25 at 06:30 AM, documented a fall. R59 received a laceration to her left eyebrow and had complaints of pain in her left hand and wrist. An X-ray was ordered of the left shoulder, left hand, and wrist due to pain and weakness. R59's Fall note, dated 12/09/25 at 02:23 PM, documented a fall with no injuries. R59's Fall note, dated 12/22/25 at 09:11 PM, documented a fall with no injuries. R59's Nursing Note, dated 12/23/25 at 05:06 AM, documented R59 did not sleep the night and yelled out the entire shift. R59's Nursing Note, dated 12/23/25 at 07:09 PM, documented that the X-ray results showed a nondisplaced fracture of the right fourth and fifth rib. R59'3 Physician/Practitioner Progress Notes, dated 12/24/25 at 06:45 AM, documented a fall on 12/22/25 where an x-ray was obtained due to pain in the right ribs. X-ray showed a fracture to the right fourth and fifth rib. R59's Fall note, dated 02/05/26 at 07:00 AM, documented a fall with no injuries. R59's Nursing note, dated 02/05/26 at 03:30 PM, documented R59 was complaining of shoulder pain and had decreased range of motion. Staff received a new order for a shoulder x-ray. R59's Nursing note, dated 02/06/26 at 03:07, documented that the X-ray results showed no fractures. R59's Fall note dated 02/10/26 at 06:45 PM documented a fall with no injuries. On 02/16/26 at 01:38 PM, R59 sat at the dining room table yelling, Help, help! There were handwritten notes from her daughter on the table in front of her, directing her not to yell for help. The notes encouraged her to ask the staff for what she wants. Staff occasionally responded to her and asked her what she needed. On 02/18/26 at 12:27 PM, Administrative Nurse E stated she sees that the MDS was coded incorrectly, and she will complete a modification of the MDS. It is important that the MDS accurately represents the residents. On 02/18/26 at 02:23 PM, Administrative Nurse D stated she expected the MDS to be completed in a timely and accurate manner. The facility did not provide a policy.

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	175385	A. Building B. Wing	02/18/2026

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. The facility had a census of 91 residents; the sample included 19 residents. Based on observation, interview and record review, the facility failed to provide consistent activities for Resident (R) 7. Findings included:- The Electronic Health Records (EHR) for R7 included diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), paralysis of vocal cords and larynx (a disorder where one or both vocal cords cannot move properly due to interrupted nerve impulses, causes hoarseness, breathing difficulties, and swallowing issues), tracheostomy status (opening through the neck into the trachea through which an indwelling tube may be inserted), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R7's Annual Minimum Data Set (MDS), dated for 0130/26, documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated cognitively intact. The assessment documented that R7 used a wheelchair for mobility and was dependent on staff for all activities of daily living (ADL). The Functional Abilities (Self-care and Mobility) Care Area Assessment (CAA), dated 01/30/26, documented R7 was totally dependent on staff for all ADLs. R7's Care Plan, dated 11/06/25, documented R7 preferred independent activities in her room, and her preferred activities included bingo, being around animals, baking, being around family, and watching TV. R7's EHR, including Progress Notes, lacked documentation that activities were offered to R7 or R7 had participated in any activities. Observed on 02/17/26 at 11:00 AM, R7 was in her room watching TV. She reported she had not been offered any activities that day. Observed on 02/18/26 at 01:37 PM, R7 remained in her room watching TV. She reported she had not been offered any activities to participate in that day. On 02/16/26 at 11:36 AM, R7 reported staff did not offer her activities. She said she stayed in her room and had to determine her own activities. On 02/17/26 at 03:07 PM, Certified Nurse Aide (CNA) M stated residents who stayed in their rooms were not offered activities to do in their room, but they were offered the opportunity to get up and participate in group activities. On 02/17/26 at 03:30 PM, Licensed Nurse (LN) H stated she would offer some type of activity to the residents who remained in their rooms, if time permitted. On 02/18/26 at 10:10 AM, Activity Z stated activities were always offered to those residents who remained in their rooms and their activity preference was charted quarterly but not charted any other time. Activity Z also said R7 frequently refused activities and preferred her own individual activities, but it was not charted anywhere whether an activity was offered or refused. The facility policy Life Enhancement and Activity Programming, dated 01/2024, documented the facility would provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility reported a census of 91 residents with 19 residents selected for review. Based on observation, interview, and record review, the facility failed to follow fall prevention interventions to prevent falls for Resident (R) 59. Findings included:- R59's Electronic Medical Record (EMR) revealed the following diagnoses: dementia (a progressive mental disorder characterized by failing memory and confusion) with behavioral disturbances, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R59's 11/13/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of four, indicating severely impaired cognition. The MDS documented R59 had one fall. R59's 11/13/25 Falls Care Area Assessment (CAA) documented R59 had a history of falls. R59's 02/10/26 Quarterly MDS documented R59 could not participate in the BIMS assessment. R59 had memory problems and severely impaired decision-making skills. The assessment inaccurately documented R59 had two or more non-injury falls and no falls in major injury (includes, but is not limited to, traumatic bone fractures, joint dislocations/ subluxations, internal organ injuries, amputations, spinal cord injuries, head injuries, and crush injuries) and no falls with injury that is not major (includes, but is not limited to, skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain). R59's Care Plan, dated 07/31/25, documented R59 was at risk for falls related to weakness and poor safety awareness due to dementia. Interventions included Dycem (a non-slip mat used for stabilization and gripping to prevent slipping) in the recliner, initiated on 02/11/26. Also, an intervention for staff to offer a weighted blanket when R59 appears anxious or restless was initiated on 12/10/25. On 02/16/26 at 01:38 PM, R59 sat at the dining room table yelling, Help, help! There were handwritten notes from her daughter on the table in front of her, directing her not to yell for help. The notes encouraged her to ask the staff for what she wants. Staff occasionally responded to her and asked her what she needed. On 02/17/26 at 8:08 AM, R59 was seated at the table. Certified Nurse Aide (CNA) HH was pureeing food in the blender. R59 was agitated and hollering at the sound of the blender On 02/17/26 at 08:16 AM, R59 was hollering she was cold, and staff got her a non-weighted blanket. On 02/17/26 at 11:10 AM, R59 continued to be in the dining room at the table covered up, and yelling out. On 02/17/26 at 01:57 PM, R59 sat in the common area with the same non-weighted blanket over her. On 02/17/26 at 02:54 PM, CMA T and CNA HH assisted R59 out of the recliner to the wheelchair. There was no Dycem in the recliner or in her wheelchair as care planned. On 02/17/26 at 01:57 PM, CMA T stated R59 does not have a weighted blanket, and the houses do not have weighted blankets; they only have them in the main building, and that is why she couldn't get her one. On 02/18/26 at 09:24 AM, CNA O stated staff tried to distract R59 when she got restless; staff tried to keep her calm. CNA O was not aware of specific fall interventions for R59 but said they can look at the tablet to know how to care for a resident. On 02/18/26 at 10:12 AM, Licensed Nurse (LN) I stated she did not know what the interventions were, but she could find out. She went to the care plan and brought up the interventions. LN I stated she expected staff to follow the care planned interventions. On 02/18/26 at 02:23 PM, Administrative Nurse D stated she expected the staff to follow all interventions as they are in the care plans. Administrative Nurse D said she would look into why the interventions were not followed and have the appropriate interventions available for the staff to use. Administrative Nurse D stated the daughter might have removed the weighted blanket from her room. The facility's Falls Management policy, dated 01/2024, documented the interdisciplinary team will implement interventions based on individual needs, communicate the interventions to the care-giving teams, and provide training as needed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. The facility identified a census of 91 residents. The sample included 19 residents with three residents reviewed for respiratory care. Based on observation, interview, and record review, the facility failed to ensure emergency equipment was readily available in the event of an accidental extubation (removal of a medical tube) of Resident (R)7's tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted) cannula. Findings included:- The Electronic Health Records (EHR) for R7 included diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), paralysis of vocal cords and larynx (a disorder where one or both vocal cords cannot move properly due to interrupted nerve impulses, causes hoarseness, breathing difficulties, and swallowing issues), tracheostomy status (opening through the neck into the trachea through which an indwelling tube may be inserted), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). R7's Annual Minimum Data Set (MDS), dated for 0130/26, documented a Brief Interview for Mental Status (BIMS) of 13, which indicated cognitively intact. The assessment documented R7 used a wheelchair for mobility and was dependent on staff for all activities of daily living (ADL). The assessment also documented R7 had shortness of breath or trouble breathing when lying flat. The Functional Abilities (Self-care and Mobility) Care Area Assessment (CAA), dated 01/30/26, documented R7 as totally dependent on staff for all ADLs. R7's Care Plan, dated 02/07/25, documented R7 had a tracheostomy and instructed staff to monitor and document R7's level of consciousness, mental status, and lethargy as needed. Staff were also instructed to monitor and document R7 for restlessness, agitation, confusion, increased heart rate, and bradycardia (low heart rate, less than 60 beats per minute). Observed on 02/16/26 at 11:51 AM, there was no emergency tracheostomy kit, including a replacement cannula or Ambu bag (a handheld, manual, self-inflating resuscitator used to deliver positive pressure ventilation to patients with inadequate or no breathing) visible in R7's room. Observed on 02/17/26 at 09:20 AM, there was no emergency tracheostomy kit or Ambu bag visible in R7's room. On 02/17/26 at 01:23 PM, Certified Nurse Aide (CNA) N stated she would immediately get the nurse if R7 had a respiratory distress situation or the tracheostomy tube came out. On 02/17/26 at 01:26 PM, Licensed Nurse (LN) G stated that the two things which should be readily available for a tracheostomy resident were suction and oxygen. LN G then said the Ambu bag was in the oxygen storage room, and there was no other tracheostomy tube available. R7's tracheostomy tube was a special, metal one, and only one was ordered. On 02/17/26 at 01:50 PM, Administrative Nurse D confirmed there was no Ambu bag in R7's room; she did find the emergency tracheostomy kit after several minutes of searching in a plastic shelving unit on the windowsill of R7's room. On 02/17/26 at 02:08 PM, Administrative Nurse D stated the emergency tracheostomy kit had been taped to the wall next to R7's bed and the Ambu bag had been placed in the room. The facility policy Special Needs, dated 01/2024, documented the facility would provide the necessary care and treatment, including medical and nursing care, consistent with professional standards of practice and in accordance with physician orders.

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	02/18/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 91 residents. The sample included 19 residents with two residents reviewed for dialysis (blood purifying treatment given when kidney function is not optimum). Based on observation, record review, and interviews, the facility failed to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for Resident (R) 6 and R13. Findings included:1. R6's Electronic Medical Record (EMR) documented a diagnosis of chronic kidney disease, stage 5 (the final, most severe stage of chronic kidney disease where kidney function drops to less than 15%, indicating kidney failure) and dependence on renal (kidney) dialysis. R6's Annual Minimum Data Set (MDS), dated [DATE], documented R6 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R6 had impairment to one side of her body, upper and lower extremities, and received dialysis services. R6's Care Plan, with an initiated date of 11/16/21, documented R6 had dialysis on Monday, Wednesday, and Friday. An intervention with an initiated date of 11/16/21 documented the facility was to establish a means of communication between the dialysis facility and themselves. R6's EMR under the Orders tab revealed physician orders: Dialysis on Monday, Wednesday, and Friday at 07:00 AM with a start date of 04/23/25. Complete Dialysis Post-Observation form (found in PCC under forms tab) upon return from dialysis, dated 04/23/25. Complete Dialysis Pre-Observation includes vital signs. Fill out the dialysis communication form to send with the resident, dated 04/23/25. R6's EMR under the Forms tab revealed the post-dialysis form was not completed on 02/13/26, and the pre-dialysis and post-dialysis forms were not completed on 02/16/26. Review of R6's dialysis binder revealed the post-dialysis observation form was not completed on 02/13/26 and 02/16/26. Observed on 02/17/26 at 12:16 AM, staff delivered R6 her lunch meal tray. 2. R13's EMR documented a diagnosis of end-stage renal disease (ESRD-a terminal disease of the kidneys) and dependence on renal dialysis. The Annual MDS, dated [DATE], documented R13 had a BIMS score of 15, which indicated intact cognition. The MDS documented R13 required some assistance with activities of daily living (ADL) and received dialysis services. The Nutritional Status Care Area Assessment (CAA) dated 09/15/25, documented R13 was on dialysis three times a week. R13's Care Plan with an initiated date of 03/27/24, documented R13 had ESRD with dialysis. An intervention with an initiated date of 03/03/23 documented R13 received dialysis every Monday, Wednesday, and Friday; staff was instructed to monitor for changes in mental status, dated 11/30/22. R13's EMR under the Orders tab revealed physician orders: Dialysis on Monday, Wednesday, and Friday with a start date of 04/21/25. Complete Dialysis Post-Observation form (found in PCC under form tab) upon return from dialysis. Review the Dialysis Communication form for any recommendations or new orders placed on 04/22/25. Post Dialysis Vital Signs every Monday, Wednesday, and Friday; ordered on 01/09/26. R13's Dialysis Post-Observation form did not show new vital signs, and the order for vital signs to be obtained after dialysis was not completed on 02/11/26 or 02/13/26. R13's Resident Specific Post-dialysis information (Completed by the facility upon return) information was not filled into the dialysis communication form on any day from 12/01/25 to 0218/26. Observed on 02/16/26 at 11:32 AM, R13 sat in his recliner in his room. R13 had recently returned from dialysis. R13 stated the facility checked his vital signs prior to dialysis, but they do not check them or do anything after dialysis. On 02/18/26 at 09:51 AM, Licensed Nurse (LN) G stated the post-dialysis form was not done on 02/13/26, and she confirmed the pre- and post-dialysis assessment was not in the EMR. On 02/18/26 at 12:12 PN, Administrative Nurse D stated the facility communicated with the dialysis treatment center by performing pre- and post-dialysis observation assessments on the dialysis residents with the form in the EMR and putting those forms in each resident's dialysis binder. Administrative Nurse D further stated that the pre- and post-dialysis observation assessment form was the key communication tool and must be completed. The facility policy Special Need-Dialysis Transportation, dated 01/2024, (continued on next page)

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	175385	A. Building B. Wing	02/18/2026

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented a dialysis documentation form would accompany the resident to all appointments and documentation would occur according to protocols.

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. The facility reported a census of 91 residents; the sample included two residents reviewed for bed rail safety. Based on interview, observation, and record review, the facility failed to obtain informed consent from the residents or the resident's legal representative for installation of bedrails for Resident (R) 53 and for R86. Findings included:1. The Electronic Health Records (EHR) for R53 included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (severe functional limitations, including balance issues, reduced mobility, and possible communication difficulties, requiring a multidisciplinary rehabilitation approach), visuospatial deficit and spatial neglect following cerebral infarction (often disabling, cognitive impairment following stroke, characterized by a failure to detect, report, or orient to stimuli on the side opposite the brain injury). R53's Admit Minimum Data Set (MDS), dated 12/24/25, documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severe cognitive impairment. The assessment documented R53 required partial to moderate assistance with activities of daily living (ADL). R53's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 12/24/25, documented R53 had a BIMS score less than 13 and had a presence of inattention, disorganized thinking, and an altered level of consciousness. R53's Communication CAA, dated 12/24/25, documented R53 had an impaired ability to make herself understood through verbal and non-verbal expression; the assessment also documented R53 had an impaired ability to understand others through verbal content. R53's Care Plan, dated 12/25/25, documented R53 chose to use one to two quarter bed rails to complete bed mobility and repositioning. R53's EHR lacked evidence of an order for R53 to have bed rails and lacked a signed, informed consent for bed rails. Observed on 02/16/26 at 12:54 PM, R53 had upper side rails on each side of her bed. 2. The EHR for R86 included diagnosis of morbid (severe) obesity (a chronic, life-threatening disease defined by a Body Mass Index [BMI] of 40 or higher, or 35-39.9 with significant obesity-related health conditions), and unilateral primary osteoarthritis of the left knee (a degenerative, age-related joint disease causing cartilage breakdown in only the left knee, leading to pain, stiffness, and reduced mobility). R86's Significant Change MDS, dated 12/04/25, documented a BIMS score of 15, which indicated intact cognition. The assessment documented R86 had impairment in both lower extremities and that she used a wheelchair for mobility. R86 required set-up or clean-up assistance for personal and oral hygiene and was dependent on staff for toileting and lower body dressing. R86's Cognitive Loss/Dementia CAA, dated 12/04/25, documented she had the presence of behavioral symptoms (verbal, physical, or other), and that R86 had rejected care at least one day out of seven. R86's Functional Abilities (Self-Care and Mobility) CAA, dated 12/04/25, documented R86 required set-up or clean-up assistance for personal and oral hygiene and was dependent on staff for toileting and lower body dressing. R86's Care Plan, dated 12/15/26, documented R86 chose to use one to two quarter bed rails to complete bed mobility and repositioning. R86's EHR lacked evidence of an order for R86 to have bed rails and lacked a signed informed consent for bed rails. Observed on 02/16/26 at 12:41 PM, R86 had upper side rails on each side of her bed. On 02/17/26 at 01:36 PM, Licensed Nurse (LN) G stated a resident must be able to turn and assist themselves before getting any type of bed rail, but no formal consent is required. On 02/17/26 at 01:46 PM, Administrative Nurse D stated consents were not required for bed rails because the facility did not use bed rails; they were called mobility assist rails. Administrative Nurse D confirmed that there were no informed consents for bed rails. The facility policy Bed Rails/Mobility Assist Devices, dated 01/2024, documented that if a side rail or mobility assist device was used, the facility would ensure correct installation, correct use, and maintenance of side rails, and would review the risk and benefits of side rails with the resident or resident representative and obtain informed consent prior to installation.