

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145469	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Paris Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 North Main Street Paris, IL 61944	
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702</p> <p>Based on observation, interview and record review the facility failed to complete skin assessments and provide hygienic wound care for one of three residents (R1) reviewed for wound care from a total sample list of eight residents.</p> <p>Findings include:</p> <p>The facility provided Pressure Ulcer Policy dated 8/31/23 documents that nurses are to complete skin assessments daily for residents deemed high risk for skin breakdown. When a pressure ulcer is identified, the area will be assessed, a skin assessment completed and physician's orders will be obtained. The physician is to be notified when a pressure ulcer develops, when there is lack of improvement of the wound over time, and when there are signs of wound deterioration.</p> <p>R1's skin assessment dated [DATE] documents R1 is at high risk for skin breakdown.</p> <p>R1's October medical record does not document daily skin assessments.</p> <p>R1's Physician Order dated 10/15/24 documents instructions for staff to cleanse R1's sacrum wound with normal saline, pat dry, and apply foam and a wound vacuum At 125mm/HG (millimeters of Mercury) continuous every day shift every Monday, Wednesday and Friday for wound care.</p> <p>On 10/24/24 at 9:50AM, V5 Wound Nurse prepared to complete R1's sacral wound treatment. V5 gloved and removed the outer dressing from R1's wound and then wearing the same soiled gloves, V5 attempted to remove the sponge from inside R1's stage four tunneling wound by placing her soiled, gloved fingers in the wound. When unsuccessful, V5 took scissors from R1's bedside table and attempted to use the sharp end of the unsanitized scissors to remove the sponge and again could not remove the sponge from the wound. V5 then asked V2 Director of Nursing (DON) to assist. V2 DON used clean tweezers to remove the sponge and stated, I saw this wound on Friday and it has significantly deteriorated. It is deeper and there is tunneling that wasn't there before.</p> <p>On 10/24 24 at 2:25PM, V2 Director of Nursing stated that putting fingers or a pair of scissors in a wound like R1's could cause infection or damage to the wound. V2 stated We need some education.</p>		

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>42702</p> <p>Based on observation, interview, and record review the facility failed to provide a working resident room call light, resulting in a fall for one (R5) of three residents reviewed for falls from a total sample list of eight residents.</p> <p>Findings include:</p> <p>The facility Accidents and Incidents Policy dated 9/7/23 documents that the facility will complete an investigation to determine the root cause of a fall and then implement appropriate interventions to prevent future falls.</p> <p>R5's incident report dated 10/11/24 at 10:25PM documents that R5 was witnessed getting up to go to the bathroom and lost his balance and fell . The root cause was documented as resident impulsivity, drowsiness and gait imbalance. Resident was reminded to use his call light and to use a urinal instead of getting up. The intervention was bed pads placed on the floor next to R5's bed.</p> <p>On 10/17/24 at 11:00AM, R5 stated, I keep falling because my call light doesn't work half the time and I get tired of waiting! I told them when I fell that it didn't work.</p> <p>On 10/17/24 at 11:02AM, R5's call light was pressed three times and lit up once. Additionally, the call light was not in reach of the resident.</p> <p>On 10/24/24 at 1:00PM R5's call light was pressed three times and lit up three time. The button appeared to be a different call light button than the one observed on 10/17/24.</p> <p>On 10/24/24 at 1:25PM, V16 Maintenance Assistant stated that R5's call button wasn't working and he changed it out on 10/21/24.</p> <p>On 10/24/24 at 2:30PM, V2 Director of Nursing stated that the call lights should work at all times and that she did not know why this was not addressed as the intervention sooner.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>42702</p> <p>Based on observation, interview and record review the facility failed to provide hygienic perineal and catheter care for one (R1) of three residents reviewed for perineal and catheter care from a total sample list of eight residents.</p> <p>Findings include:</p> <p>The facility provided, undated, Perineal Care Procedure documents that woman's perineal cleansing begins separating the labia and washing downward, front to back and if the resident has an indwelling catheter, to gently wash the juncture of the tubing from the urethra down the catheter about three inches. After cleaning the front, then wash and dry the rectal area.</p> <p>The facility provided, Indwelling Catheter Care policy dated 10/7/22 documents that the facility shall maintain and care for urinary catheters to prevent catheter-associated urinary tract infections and adhere to the best nursing practice standards.</p> <p>R1's care plan dated 8/23/24 documents that R1 is at high risk for urinary tract infections due to an indwelling urinary catheter and a stage four wound on her sacrum.</p> <p>R1's progress notes document three urinary tract infections since admission. One on 7/24/24, the second on 9/6/24 and the third on 10/8/24. All of which required antibiotic treatment.</p> <p>On 10/24/24 at 9:50AM, V8 Certified Nursing Assistant, assisted by V8 Minimum Data Set Nurse and V5 Wound Nurse, began providing perineal/catheter care for R1 and V8 CNA began at R1's rectal area. V8 cleaned R1's catheter moving from the bottom toward the body and then stated that she was done. When asked about cleaning the front perineal area, V8 CNA stated that she couldn't reach it and that she doesn't usually clean R1's front area, only her backside.</p> <p>On 10/24/24 at 2:00PM, V5 Wound Nurse stated, The pericare and catheter care weren't done correctly. We had done education on making sure that they were wiping the front, but I didn't know that they had gone back to cleaning from the back. They will be educated on this again. It could cause infection.</p>		