Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145469	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paris Health and Rehab Center	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)
F 0550 Level of Harm - Actual harm Residents Affected - Few	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** 41970 Failures at this level required more than one deficient practice statement. A. Based on observation, interview and record review the facility failed to protect a resident's right to be free from restricted access from areas of the facility without clinical justification. These failures affect one (R9) out of three residents reviewed for seclusion in a sample list of 16 residents. These failures resulted in R9 expressing fear of being yelled at by staff and threats of room move to a locked down Dementia unit if R9 walked the length of her own hallway. Findings include: The facility policy titled Abuse Policy revised 1/9/24 documents the Administrator and/or designee is the Abuse Coordinator for this facility. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment. It is the responsibility of all facility staff to ensure that all residents remain to be free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. Unreasonable confinement or Involuntary Seclusion means the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will, or the will of the resident's legal representative. Emergency or short term monitored separation from other residents will not be considered involuntary seclusion and may be permitted if used for a limited period of time as a therapeutic intervention to reduce agitation until professional staff can develop a plan of care to meet the resident's needs. R9's undated Face Sheet documents medical diagnoses as Cerebral Infarction, Peripheral Vascular Disease, History of Right Artificial Hip Joint, Seizures, Intellectual Disabilities, Alzheimer's Disease, Psychosis, Pulmonary Hypertension, Intervertebral Disc Degeneration, and Congestive Heart Failure. R9's Minimum Data Set (MDS) dated [DATE] documents R9 as cognitively intact and uses a walker for ambulation. (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 0550 Level of Harm - Actual harm Residents Affected - Few	On 12/13/14 at 1:20 PM, R9 walked the entire length of North Hall in the facility, rounded the corner to walk the length of the back hall and then turned around when she reached the end of the South Hall where R14 resides. R9 then retraced her steps down the back hall and back down the North Hall. R9 stated I can't go down there, or I will get into trouble with that mean lady Administrator (V1). I don't want to get yelled at anymore. On 12/12/24 at 1:00 PM, V1, Administrator, stated V1 told R9 to not walk down the back half of R9's hallway due to a complaint that R9 was standing in the hallway staring in (R14's) room. V1 stated I absolutely told (R9) to not walk down her hallway. (R9) could go to the nurse's station but no further. What am I supposed to do when there is a family member complaining about (R9) staring in (R14's) doorway? (V55) (R14's) Power of Attorney (POA) is just going to keep complaining so I made it clear to (R9) she can't go down there anymore. On 12/12/24 at 9:35 AM, V16, Certified Nursing Assistant (CNA) stated (R9) can only walk to the nurse's station and not any farther per (V1). I am not sure why but (R9) never walks down the rest of the hall. (R9) walks all around the halls but not down the other half of her own hall. On 12/12/24 at 10:35 AM, V2, Director of Nurses (DON), stated a family member of another resident (R14) complained that R9 would walk by R14's room and stare in. V2 stated V2 was not aware if R9 ever entered R14's room but would stop and stare in. V2 stated the staff are busy down R9's hall and do not have time to monitor R9 to make sure she is not staring into someone else's room so V1 told R9 that she cannot walk down that half of the hall. V2 stated R9 and R14 live on opposite ends of the same hallway. V2 stated V1 stated R9 was allowed to walk to the nurse's station on her hall but not any further. On 12/12/24 at 10:45 AM, V4, Social Service Director (SSD), stated on 12/6/24 at lunch time V1 asked V2 and V4 to witness a conversation with R9. V4 stated V23 Director of Business Development was already sitting in the conference room working for the day. V4 stated V1 yelled at R9 until she cried. V4 stated V4 could see R9 become visibly upset when V1 was yelling at her. V1 asked R9 if she wanted to live in the Dementia unit again and R9 replied No! I hated it back there! V1 Administrator then told R9 You better get your act together or you will be moving back to the Dementia unit. V4 stated after this incident was over R9 walked back to her room with V4. V4 stated once R9 got to her room, she began sobbing saying Why does (V1) talk so mean to me? (V1) yelled at me about walking down my own hallway. I won't ever walk down that part of the hall again! On 12/12/24 at 1:10 PM, R9 stated V1 had come to R9 and told R9 that she was not supposed to walk past the nurse's station on her own hallway due to R14's wife complained that R9 was staring into R14's room. R9 stated R9 didn't think anything of that so she continued to walk all around the facility including past R14's room. R9 stated R9 might have stopped in front of R14's room but did not recall staring in at anyone, just admiring the room. R9 stated R14's room has a private bathroom and more space than her room and would like to move into R14's room. R9 stated (V1) called me into that room by (V1's) office (conference room) to yell at me. (V1) threatened to move me back to the Dementia unit. I lived there once before, and it was awful. You are locked up back there. (V1) told me if I don't behave, she was sending me back there. I remember crying in that room and I was very upset. I went back to my room and had a good cry. I am never going down that hall again! I don't ever want to be treated like that again! (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 12/13/24 at 12:45 PM, V23 Registered Nurse (RN), stated R9 walks from the nurse's station on South Hall where R9 resides, past her room, past the front offices, down North Hall and the back hall and then turns around when R9 reaches the other end of South Hall. V23 stated R9 will not walk by R14's room. V23 stated R9 has followed that same path every time for the last few weeks. On 12/18/24 at 1:45 PM, V43, Medical Director, stated V43 is very familiar with R9. V43 stated R9 walks up and speaks to V43 every time he visits the facility. V43 stated R9 has a fragile demeanor due to her Intellectual Disability and Mental Health history. V43 stated R9 should be walking around the entire perimeter of the facility in order to maintain her current mobility. V43 stated R9 had a Right total hip replacement in May 2024, and it is imperative to her recovery. V43 stated there is no reason why R9 cannot walk down the length of her own hallway and every hallway in the facility. V43 stated I am not sure why the facility thought restricting (R9's) access to open areas would help resolve the issue. The last I checked, this is a free country. (R9) has every right to all of the resident designated areas in that facility. If you restrict that access, you are basically secluding the resident. We should never do that unless it's in case of an emergency. B. Based on observation, interview and record review the facility failed to ensure one (R6) resident was assisted to smoke breaks out of three residents reviewed for smoking in a sample list of 16 residents. Findings include: The facility policy titled Resident Rights revised 7/11/22 documents employees shall treat all residents with kindness, dignity and respect. R6's undated Face Sheet documents medical diagnoses as Dementia with Agitation, Chronic Obstructive Pulmonary Disease (COPD), Macular Degeneration, Systolic Heart Failure, Non ST Elevation R6's Minimum Data Set (MDS) dated [DATE] documents R6 as severely cognitively impaired. R6's Smoking assessment dated [DATE] documents R6 requires supervision while smoking. R6's Careplan initiated 7/22/24 does not document a focus area, goal nor intervention for R6 smoking. On 12/12/24 at 9:52 AM, a sign was posted on the wall at the nurses station that reads smoking times are at 9:00 AM, 1:00 PM, 4:00 PM and 7:00 PM. This same sign stated that Certified Nurse Aides (CNA) and Activity staff are not responsible for assisting residents to designated smoking area and that residents had to get to the designated smoking on their own or they would not be allowed to smoke. On 12/13/24 at 2:23 PM R6 was laying in his bed in his room. R6 stated he would like to have a cigarette but no one has asked him to go outside today. R6 stated I wouldn't stay long because it is cold but I could go out for a few minutes. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 12/12/24 at 10:13 AM, R6 stated he smokes outside with staff. R6 stated the facility allows him to smoke four times per day having two cigarettes each time. R6 stated the staff ask him twice per day and not the four times like they should. R6 stated sometimes it is too cold out but the staff still only ask him if he wants to smoke twice per day and not four times per day. R6 stated I would rather have one cigarette four separate times than have two cigarettes two times. Then I have to wait all night to have another one. That is a very long wait! On 12/12/24 at 2:42 PM, R6 stated he has not been asked to go outside to smoke today. R6 stated I would like a cigarette. I haven't had one since yesterday afternoon. On 12/13/24 at 1:40 PM, V27 Activity Director, stated the residents are allowed to smoke two cigarettes with staff supervision at 9:00 AM, 1:00 PM, 4:00 PM and 7:00 PM. V27 stated there are two residents (R6, R7) who reside on the Dementia unit who smoke. V27 stated the Dementia unit staff are responsible for making sure (R6, R7) get their smoke breaks. On 12/13/24 at 1:50 PM, V25, Dementia Unit Coordinator, stated R7 is always escorted up front to smoke with the other group from the main part of the facility. V25 stated R6 has had behavioral problems with some of those other smokers so R6 smokes with supervision but not in a group of residents. V25 stated R6 should be offered smoking times as scheduled like everyone else but sometimes there is a problem getting staff from the main building to help out when they can. V25 stated if the Dementia unit staff are busy providing cares to other residents and no one else steps in to supervise R6 while he smokes, then R6 doesn't get to smoke. V25 stated that is not fair to R6. On 12/13/24 at 8:30 AM, R6 stated I sure would like a cigarette. I haven't had one in two days. On 12/17/24 at 9:45 AM, R6 was sitting up in his wheelchair next to the nurses station. R6 stated I would like to go smoke. It's cold out so I will only stay outside for one cigarette. I haven't had a cigarette in five or six days. No one will take me out. On 12/17/24 at 1:55 PM, V2, Director of Nurses (DON), stated the facility is a smoking facility and every resident who wants to smoke should be allowed to at the designated times. V2 DON stated sometimes the staff might not be able to get to take R6 out to smoke at the exact moment R6 wants to go but there should be staff available within a short amount of time to supervise R6 smoking. V2 stated R6 should be offered alternate times to smoke. V2 stated anyone [AGE] years of age or older can supervise a resident smoking. V2 DON stated allowing R6 to smoke could help alleviate behaviors and was an intervention to a prior incident.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to provide privacy for one (R5) resident during incontinence care out of three residents reviewed for incontinence care in a sample list of 16 residents. Findings include: The facility policy titled Resident Rights revised 7/11/22 documents employees shall treat all residents with kindness, dignity and respect. R5's undated Medical Diagnosis List documents R5's medical diagnoses as Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-dominant side, Parkinson's disease, Paroxysmal Atrial Fibrillation, Seizures and Vascular Dementia. R5's Minimum Data Set (MDS) dated [DATE] documents R5 as severely cognitively impaired. This same MDS documents R5 is dependent of staff for toileting, dressing, bathing, personal hygiene and requires maximum assistance for bed mobility and transfers. On 12/12/24 at 1:30 PM, V8, Certified Nursing Assistant (CNA), assisted R5 to the toilet. V8 applied gloves and walked R5 from his wheelchair to the toilet in the bathroom (several feet). V8 pulled down R5's pants and incontinence brief leaving R5 exposed from the waist to ankles. V8 did not close the bathroom door, the room door nor did V8 pull the privacy curtain between R5 and his roommate (R11). R11 was sitting in his wheelchair in their (R5, R11) shared room when V8 was assisting R5 to the toilet. R14 walked by in the hallway, paused to look over into R5's bathroom and kept walking down the hallway. V12, CNA, walked into R5's room, stood in the area just outside R5's bathroom as R5 was fully exposed. V12 stood there for several minutes watching V8 assist R5 to the bathroom. V12 then stated to V8 I just wanted to tell you, I am done with my break and left R5's room. V8 did not change gloves during the entire procedure. On 12/12/24 at 1:42 PM, V8 stated V8 should have provided privacy to R5 when assisting R5 to the toilet. On 12/12/24 at 2:40 PM, V2, Director of Nursing (DON), stated staff should always provide privacy when providing perineal care. V2 stated V8, CNA, should have closed the bathroom door and/or the room door and changed her gloves during the procedure. V2 stated V12, CNA, should not have walked into R5's room unannounced. V2 stated That would be embarrassing. Our staff know better. That is 101 of CNA care. Privacy is one of the basic things everyone learns. I will start some training on this right away.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to honor two (R11, R16) resident's right to refuse treatment out of three residents reviewed for electronic monitoring device systems in a sample list of 16 residents. Findings include: The facility policy titled Wandering/Elopement Policy revised 3/13/24 documents the facility will not use an (electronic monitoring device) on a resident who is able to give consent based on cognitive level without further assessment to protect the resident's right to personal autonomy. 1.) R11's undated Face Sheet documents R11 as his own responsible party. This same face sheet documents R11's medical diagnoses as Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right dominant side, Diabetes Mellitus Type II, Asthma, Vascular Dementia without behaviors, Bipolar Disorder, Anxiety, Depression, Seizures and Adjustment Disorder with Depressed Mood. R11's Minimum Data Set (MDS) dated [DATE] documents R11 as cognitively intact. This same MDS documents R11 requires moderate assistance with bathing, dressing, personal hygiene, is independent in walking ten feet and requires supervision with walking 50 feet and 150 feet. R11's Physician Order Sheet (POS) dated December 2024 documents a physician order starting 7/30/24 for staff to check the (electronic monitoring device) placement every shift. R11's Elopement Risk assessment dated [DATE] documents R11 as a high risk for elopement. This same assessment documents If Interdisciplinary Team (IDT) determines a (electronic monitoring device) is appropriate, complete physical restraint assessment and obtain consent. (R11) wears a (electronic monitoring device), there is an alarm on his door to notify staff when he leaves his room. R11's Nurse Progress Note dated 11/22/24 at 2:58 PM documents (R11) kindly asked this nurse to cut off (electronic monitoring device). Explained to (R11) that I cannot cut that off and that it needs to stay on for safety precautions. (R11) unhappy with response and said ok and went back to room. On 12/11/24 at 2:50 PM, R11 was sitting in his wheelchair in his room. R11 had an electronic monitoring device bracelet applied to his Right Ankle. On 12/17/24 at 3:00 PM, R11 is sitting in his room in his wheelchair wearing an electronic monitoring device on his Right Ankle. R11 stated I don't want to wear this thing (pointing to his electronic monitoring device). This place is like a concentration camp. I can't do anything. All I want to do is go outside and get some fresh air. I walked outside this morning and was told to get back inside or they (facility) would call the police on me. Just for walking outside! Tell me that isn't imprisonment! 2.) R16's undated Face Sheet documents R16 as his own responsible party. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16's Minimum Data Set (MDS) dated [DATE] documents R16 as cognitively intact. This same MDS documents R16 as independent in transfers and walking up to 150 feet. R16's Nurse Progress Notes dated 12/10/24 at 5:10 PM documents (Electronic monitoring device) not in place. (R16) had cut it off and it was in his bedside table cabinet. Spoke to (R16) about keeping it on for safety. Applied new band to sensor and reapplied on (R16's) Right Ankle R16's Care plan intervention dated 4/6/23 documents an electronic sensor was placed to alert staff of exit attempt. R16's undated Electronic Medical Record (EMR) does not document a Physical Restraint Assessment nor Consent for the use of an electronic monitoring device. On 12/17/23 at 2:15 PM, R16 stated They (facility) put this G****** f******(expletives) on me. I want it off. I am not an animal. They (facility) treats me like a dog on a chain. If I want to leave, I should be able to. I really don't want to leave, I just want to go outside. They (facility) won't let me go outside. I take this d*** (expletive) thing off (showing electronic monitoring device on his Right ankle) every chance I get but they (facility) just keeps putting it back on. On 12/18/24 at 10:30 AM, V38, Regional Clinical Nurse, stated R11 and R16 are both alert, oriented and ambulatory. V38 stated This facility only has one door that has the electronic monitoring device system. That is the front door. There is no reason for (R11, R16) to wear such a device. I can't find a Physical Restraint Assessment nor a consent. Both (R11, R16) wanted them removed and so they were removed.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to protect one (R9) resident's right to be free from mental abuse by a staff member (V1) out of three residents reviewed for mental abuse in a sample list of 16 residents. This failure resulted in R9 being yelled at and threatened by staff, crying, expressing humiliation, and fear of participating in activities. Findings include: The facility policy titled Abuse Policy revised 1/9/24 documents the Administrator and/or designee is the Abuse Coordinator for this facility. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment. It is the responsibility of all facility staff to ensure that all residents remain to be free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. It is all staff's responsibility to report any allegation or witnessed abuse immediately to the Administrator (Abuse Coordinator). The facility will report all allegations of abuse timely to the proper authorities to include State Agency, Ombudsman, Power of Attorney (POA) and Physician. R9's undated Face Sheet documents medical diagnoses as Cerebral Infarction, Peripheral Vascular Disease, History of Right Artificial Hip Joint, Seizures, Intellectual Disabilities, Alzheimer's Disease, Psychosis, Pulmonary Hypertension, Intervertebral Disc Degeneration, and Congestive Heart Failure. R9's Minimum Data Set (MDS) dated [DATE] documents R9 as cognitively intact and uses a walker for ambulation. On 12/12/24 at 10:35 AM, V2, Director of Nurses (DON), stated V1, Administrator, asked V2 to be present for a conversation with R9. V2 stated V4, Social Service Director (SSD), was also present. V2 stated V1 did raise her voice at R9. V2 stated V1 was not cursing or screaming at R9. V2 stated R9 looked upset while V1 was raising her voice at R9. V2 stated a family member of another resident (R14) complained that R9 would walk by R14's room and stare in. V2 stated Sometimes you have to be stern with these residents. You have to set firm boundaries. (V1) said to (R9) I don't want to have to put you back on the Dementia unit. Do you like your freedom? V2 stated (R9) replied yes and was upset. V2 stated (R9) cries all the time when she gets in trouble, so I don't know if she was crying that day. (R9) could have been crying. I don't really remember because (R9) is so sensitive she cries a lot anyway. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 12/12/24 at 10:45 AM, V4, Social Service Director (SSD), stated on 12/6/24 at lunch time, V1 asked V2 and V4 to witness a conversation with R9. V4 stated V23, Director of Business Development, was already sitting in the conference room working for the day. V4 stated V1 yelled at R9 until she cried. V4 stated V4 could see R9 become visibly upset when V1 was yelling at her. V1 asked R9 if she wanted to live in the Dementia unit again and R9 replied No! I hated it back there! V1 then told R9 You better get your act together or you will be moving back to the Dementia unit. V4 stated after this incident was over R9 walked back to her room with V4. V4 stated once R9 got to her room, she began sobbing saying Why does (V1) talk so mean to me? (V1) yelled at me about walking down my own hallway. I won't ever walk down that part of the hall again! On 12/12/24 at 10:50 AM, V45, Anonymous, stated V1 yells at residents. V45 stated V1 has a loud voice naturally but the yelling is not meant for residents due to hearing impairment, V1 just yells at everyone. V45 stated V1 will slam her fist down on a table, yell from her office out into the hallway or just yell down the hall at staff in front of residents. V45 stated I heard (V1) yelling at (R9) the day (12/6/24) (V1) brought (R9) into the conference room. I heard (R9) crying outside the conference room door when it was done. (V1) was yelling so loud you could hear her in the dining room down the hall. The residents in the dining room were looking around like who is yelling like that? On 12/12/24 at 1:10 PM, R9 stated V1 had come to R9 and told R9 that she was not supposed to walk past the nurse's station on her own hallway due to R14's wife complained that R9 was staring into R14's room. R9 stated R9 didn't think anything of that so she continued to walk all around the facility including past R14's room. R9 stated R9 might have stopped in front of R14's room but did not recall staring in at anyone, just admiring the room. R9 stated R14's room has a private bathroom and more space than her room and would like to move into R14's room. R9 stated (V1) called me into that room by (V1's) office (conference room) to yell at me. (V1) yelled so loud everyone could hear it. (V1) did not use any curse language. (V1) was yelling at me because I walked down my own hallway. (R14) lives on my hallway too. I don't mean to bother (R14), I just like his room. (V1) threatened to move me back to the Dementia unit. I lived there once before, and it was awful. You are locked up back there. (V1) told me if I don't behave, she was sending me back there. I don't know why (V1) had to yell at me in front of all those people. That was humiliating. I remember crying in that room and I was very upset. I went back to my room and had a good cry. (V4) was there with me. (V4) was very kind and helped me calm down. I am never going down that hall again! I don't ever want to be treated like that again! On 12/13/24 at 3:00 PM, V28, Registered Nurse (RN), stated R9 used to attend activities all of the time and has recently stopped going. V28 stated V28 has encouraged R9 to participate in activities but R9 declines stating she doesn't want to get into trouble. On 12/13/24 at 3:15 PM, V27 stated V27 was walking in the hallway adjacent to the conference room '30 feet' away. V27 stated V27 heard V1 yelling inside the conference room. V27 stated V27 did not know until later that a resident (R9) was in the conference room with V1, V2 , V4 and V23. On 12/18/24 at 1:52 PM, V43, Medical Director, stated staff should never raise their voices when talking to residents. V43 stated Verbal and Mental abuse is a very serious issue. (V1) should have addressed the issue of where (R9) can walk or not in a better way. (V1) should never have raised her voice at (R9). There is no need to use a firm tone with (R9) or any other resident. (R9) will not respond to that. (R9's) temperament can be fragile and the facility staff should be trained on how to address issues without abusing residents.

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 12/18/2024
NAME OF PROVIDER OR SUPPLIER Paris Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1011 North Main Street Paris, IL 61944	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on interview and record review the facility failed to report an allegation of mental abuse of one (R9) resident by a staff member to the Physician, Ombudsman and State Agency timely. These failures affect one (R9) out of three residents reviewed for abuse in a sample list of 16 residents. Findings include: The facility policy titled Abuse Policy revised 1/9/24 documents the Administrator and/or designee is the Abuse Coordinator for this facility. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment. It is the responsibility of all facility staff to ensure that all residents remain to be free from abuse, including injuries of unknown origin, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. It is all staffs responsibility to report any allegation or witnessed abuse immediately to the Administrator (Abuse Coordinator). The facility will report all allegations of abuse timely to the proper authorities to include State Agency, Ombudsman, Power of Attorney (POA) and Physician. R9's undated Face Sheet documents medical diagnoses as Cerebral Infarction, Peripheral Vascular Disease, History of Right Artificial Hip Joint, Seizures, Intellectual Disabilities, Alzheimer's Disease, Psychosis, Pulmonary Hypertension, Intervertebral Disc Degeneration, and Congestive Heart Failure. R9's Minimum Data Set (MDS) dated [DATE] documents R9 as cognitively intact and uses a walker for ambulation. The Final Report and Conclusion of Incident dated 12/15/24 documents R9 was involved in a staff (V1) Administrator to resident (R9) allegation of mental abuse. On 12/12/24 at 10:50 AM, V4 Social Service Director (SSD), stated on 12/6/24 R9 was mentally abused by V1 when V1 escorted R9 into the facility conference room and proceeded to yell at R9. V4 stated R9 was visibly upset over being yelled at. V4 stated V4 did not report V1 yelling at R9. V4 stated V4 would normally report to V1 but V1 was doing the yelling. V4 stated I had no idea who to tell. If the person in charge is the one yelling at a resident who do I call? (V2, Director of Nursing/DON) was also in the room and did not report anything. So all I did was help (R9). On 12/12/24 at 1:02 PM, V1, Administrator, stated this incident was never reported to the State Agency. On 12/17/24 at 2:00 PM, V2, DON, stated V2 should have made a report of staff to resident abuse after witnessing V1 raise her voice to R9 on 12/6/24 in the conference room. V2 stated Once I look at it from (R9's) perspective, it is pretty clear. (R9) was upset because (V1) was using such a firm tone and did raise her voice. This should have been reported immediately. I would have just called (V24, Regional Clinical Nurse). (continued on next page)

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	145469	A. Building B. Wing	12/18/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/18/24 at 1:50 PM, V43, Medical Director, stated V43 was not notified of any allegation of staff to R9 abuse from 12/6/24. On 12/18/24 at 2:25 PM, V42, Ombudsman, stated V42 is the regular Ombudsman assigned to this facility. V42 stated V42 was not notified of any allegation of abuse regarding R9 or any other resident.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review the facility failed to prevent cross contamination during incontinence care and failed to provide timely incontinence care for one (R12) resident out of three residents reviewed for incontinence care in a sample list of 16 residents. Findings include: The undated facility policy titled Handwashing/Hand Hygiene documents staff will use an alcohol based hand rub before moving from a contaminated body site to a clean body site during resident care. R12's undated Face Sheet documents medical diagnoses of Aphasia following Cerebral Infarction, Adult Failure to Thrive, Hypertension and Right Hand Contractures. R12's Minimum Data Set (MDS) dated [DATE] documents R12 as severely cognitively impaired. This same MDS documents R12 as being dependent on staff for transferring, bed mobility, toileting, dressing bathing and personal hygiene. On 12/13/24 at 11:15 AM, V31, Certified Nursing Assistant (CNA) assisted R12 to R12's dining room table. On 12/13/24 from 11:15 AM-12:50 PM, R12 sat in her wheelchair in the dining room. On 12/13/24 from 12:50 PM -2:40 PM, R12 sat in her wheelchair outside her room with no staff interventions. On 12/13/24 at 1:13 PM and 2:03 PM R12 called out to staff saying I hurt. I want to lay down. On 12/13/24 at 2:41 PM, V31, CNA, provided R12 with incontinence care. R12's incontinence brief was thoroughly saturated with yellow/brown substance with a foul odor. The absorbent material inside R12's incontinence brief had broken apart forming three large clumps saturated with urine. R12's buttocks were dark red with lines from where R12 had been sitting on the incontinence brief. V31 did not change gloves throughout the entire procedure. V31 washed R12's perineal area with gloved hands, pulled the garbage bag back away from the garbage can to retrieve a new garbage bag, opened the garbage bag, placed the soiled washcloth inside the garbage bag and then proceeded to clean R12's perineal area without changing gloves or using any kind of hand hygiene. V31 did not provide any barrier cream for R12's reddened buttocks. On 12/13/24 at 3:00 PM, V31 stated V31 should have changed her gloves after reaching into the garbage can for a garbage bag. V31 stated cross contaminating R12's perineal area could cause an infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/13/24 at 3:30 PM, V2 Director of Nurses (DON), stated staff should always wash their hands and change gloves when they are contaminated during incontinence care. V2 stated residents who are incontinent should be provided incontinence care at least every two hours. V2 stated V2 will start educating floor staff to be sure this doesn't happen again.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970 Based on observation, interview and record review, the facility failed to maintain safe functioning equipment. These failures affect two residents (R3, R5) out of three residents reviewed for equipment in a sample list of 16 residents. Findings include: 1.) R3's undated Face Sheet documents medical diagnoses of Morbid Obesity, Chronic Respiratory Failure, Diabetes Mellitus, Chronic Pain, Combined Systolic and Diastolic Heart Failure, and Chronic Obstructive Pulmonary Disease (COPD). R3's Minimum Data Set (MDS) dated [DATE] documents R3 as cognitively intact. This same MDS documents R3 is dependent on staff for transfers using a total body mechanical lift. On 12/13/24 at 2:10 PM, V29 and V30 Certified Nursing Assistant (CNA) assisted R3 from her wheelchair to her bed using a total body mechanical lift. V30 CNA exited R3's room stating the total body mechanical lift broke during R3's transfer. V30 stated R3 was in the sling and had been raised up in the air over R3's bed when the total body mechanical lift would not lower R3 into her bed. V30 stated V30 had to use the emergency release knob to get the machine to lower R3. V30 stated We (V29, V30) got (R3) into bed but she still had to drop from the sling onto the bed. That machine (total body mechanical lift) just stopped working again. On 12/11/24 at 11:42 AM, R3 stated the remote control to her bed was broken so the staff put duct tape around it to hold it together. It would spark sometimes. I am on oxygen and if that would spark around my oxygen, I am a goner. The maintenance man (V3) ordered me a new one and replaced it when the new one came in but I had to live for a few weeks wondering if every time I moved my bed up and down I would catch fire. On 12/11/24 at 2:10 PM, V13, Maintenance Assistant, stated R3's bed remote was not working as it should. V13 stated the facility ordered a new one because the old bed remote was not repairable. V13 stated (V3) Maintenance Director had a hard time finding one online that would work due to the age of R3's bed being older. V13 state R3 did have to wait weeks for a replacement bed remote. On 12/11/24 at 11:45 AM, V5, Registered Nurse (RN), stated each hall has their own (total body mechanical lift). V5 stated there was a day when the staff tried to use the total body mechanical lift on R3 and it threw a wrench symbol and did not move up or down and the legs would not move outwards. R5 stated the problems with that total body mechanical lift were noticed prior to having a R5 in it and the machine was placed in the back hall for maintenance to fix with a note on it. V5 stated staff borrowed another lift to use that day. On 12/13/24 at 2:30 PM, R3 stated See what I mean? This place has a lot of equipment that doesn't work. It needs replaced. I could have fallen. I was scared wondering how the staff were going to get me out of that d*** (expletive) thing. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) R5's undated Medical Diagnosis List documents R5's medical diagnoses as Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-dominant side, Parkinson's disease, Paroxysmal Atrial Fibrillation, Seizures and Vascular Dementia. R5's Minimum Data Set (MDS) dated [DATE] documents R5 as severely cognitively impaired. This same MDS documents R5 is dependent of staff for toileting, dressing, bathing, personal hygiene and requires maximum assistance for bed mobility and transfers. R5's Careplan intervention dated 2/13/24 documents R5's siderails should be assessed quarterly and as needed (PRN). On 12/11/24 at 1:30 PM, V8, CNA, confirmed through demonstration that R5's siderail was stuck in the up position. On 12/11/24 at 12:29 PM, V11 (R5's) wife stated R5's siderail on his bed has been stuck in the up position since August. V11 stated R5 was sent to the hospital in August with Pneumonia and when the Emergency Medical Technicians (EMT's) came, they had to move R5's bed 180 degrees to be able to transfer R5 out of his bed onto the gurney due to R5's siderail would not go down. V11 stated V11 has asked several people to get it fixed and it is still broke. V11 stated They (facility) should have fixed it a few months ago. On 12/11/24 at 1:33 PM, V8, CNA, stated R5 attempts to get out of bed by himself using the siderail as a tool to get up. V8 stated R5 forgets to ask for help. V8 stated R5's siderail not functioning properly could result in an injury for R5. On 12/12/24 at 9:00 AM, V1, Administrator, stated there have been no reports of R5's broken siderail to V1. V1 stated That is important. We (facility) will get that fixed right away.