

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 02/26/2025
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on interview and record review the facility failed to administer one (R4) resident's physician ordered Insulin for eight days and failed to notify R4's Physician of medication error out of three residents reviewed for Quality of Care in a sample list of ten residents.</p> <p>Findings include:</p> <p>R4's undated Face Sheet documents R4 admitted to the facility on [DATE] with medical diagnoses of Diabetes Mellitus Type II, Dementia, Pubis Fracture, Thyrotoxicosis, Hearing Loss, Lumbar Vertebrae Compression Fracture, Localized Skin Infection and Atherosclerotic Heart Disease.</p> <p>R4's Minimum Data Set (MDS) dated [DATE] documents R4 as moderately cognitively impaired.</p> <p>R4's Physician Order Sheet (POS) dated January 2025 documents a physician order starting 1/21/25 and ending 1/28/25 to administer Levemir 100 units/milliliter (ml) give 18 units subcutaneously every bedtime for Diabetes Mellitus Type II (DM). This same POS documents a physician order starting 1/22/25-2/18/25 to monitor R4's blood glucose three times daily. This same POS documents a physician order starting 1/29/25 and ending on 2/18/25 to administer Lantus Insulin Pen-injector 100 units/ml Insulin Inject 18 unit subcutaneously at bedtime related to Diabetes Mellitus Type II.</p> <p>R4's Medication Administration Record (MAR) dated January 2025 documents R4's physician ordered Levemir 18 units every bedtime was ordered from 1/21/25-1/28/25 but was not administered from 1/21-1/28/25 due to 'medication not available'. R4's MAR documents blood glucose levels ranging from 166-562 during that same timeframe.</p> <p>R4's Physician Notification Form dated 1/27/25 documents V12 Physician was informed that Levemir Insulin will need addressed by (V12) Physician due to Levemir is not manufactured any longer since December 2024. This same form is signed by V12 Physician with a note that reads Change it to Lantus with same dose on 1/28/25.</p> <p>R4's Nurse Progress Notes dated 1/21/25-1/28/25 do not document notification of V12 Physician of Levemir Insulin not being administered.</p> <p>(continued on next page)</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 2/21/25 at 1:00 PM V2 Director of Nurses stated R4's Levemir Insulin was not administered from 1/21/25-1/28/25 due to Levemir is no longer being manufactured. V2 DON stated the facility pharmacy notified the facility on 1/27/25, to inform V12 Physician that Levemir is not long being manufactured.</p> <p>On 2/21/25 at 3:15 PM V12 Physician stated the facility should have notified him of R4's Levemir not being available so that he could have changed R4's Insulin order more timely. V12 Physician stated the facility nursing staff should inform the Director of Nurses (V2 DON) if a medication like Insulin is not available so that V2 can make the proper calls to the Physician and pharmacy to adjust the resident's Diabetic management accordingly.</p> <p>The facility policy titled Non-Controlled Medication Orders effective September 2018 documents the prescriber is contacted by nursing for direction when the medication is not or will not be available for administration in accordance with facility policy.</p> <p>The facility policy titled Medication Error Policy/Procedure revised July 16, 2023 documents medication errors shall be documented as required. A medication error shall be defined as any variation in administration of medication from the physicians' orders and/or facility policy. It is the responsibility of the nursing personnel to report and record any and all medication errors. It is the responsibility of nursing to assure Physician and Power of Attorney are notified of medication errors. It is the responsibility of the Director of Nurses to follow up on any suspected or reported medication errors.</p>		

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<p>F 0761</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35347</p> <p>Based on observation, interview, and record review, the facility failed to store a Schedule II Controlled medication (Morphine Sulfate) in a locked location by leaving the medication on top of the medication cart in plain view, unsupervised, and readily accessible to wandering residents on a dementia care unit. This failure resulted in facility staff observing R1 at the medication cart with the bottle of Morphine placed to R1's lips, when staff removed the bottle, no medication remained in the bottle and then staff later observed R1 unresponsive with a decreased respiration rate followed by staff administering Narcan (an emergency medication that rapidly reverses life-threatening opioid overdoses) and sending R1 to the hospital emergency room for evaluation and treatment. This failure affects one resident (R1) of four reviewed for medication storage in the sample list of ten</p> <p>The Immediate Jeopardy began on 1/28/2025 when a bottle of liquid Morphine was left unattended on top of a medication cart and staff found R1 with the bottle up to R1's lips. V1 (Administrator) was notified of the Immediate Jeopardy on 2/19/2025 at 10:57AM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 1/28/2025 and the deficient practice corrected on 1/29/2025 prior to the start of the survey and was therefore Past Noncompliance.</p> <p>Findings include:</p> <p>R1's Medical Diagnosis list (printed 2/14/2025) documents R1 diagnoses include: Dementia with Psychotic Disturbance, Major Depressive Disorder, and Other Conduct Disorders (a mental health condition characterized by persistent and severe antisocial and aggressive behaviors that violate social norms and rules).</p> <p>R1's Clinical Census sheet (printed 2/20/2025) documents R1 has resided on the facility's Dementia care unit since admission to the facility.</p> <p>R1's comprehensive assessment (1/8/2025) documents R1 does not require staff assistance for eating or drinking, does not use any mobility devices (such as a cane, walker, or wheelchair), and has daily wandering behavior in the facility.</p> <p>On 2/11/2025 at 1:55PM, the nurses' station at the facility Dementia care unit consisted of chest-height countertops and cabinetry arranged in an oval shape in the center of the care unit. Standard swinging doors the same height as the countertops were located at each end (East and West) of the station for staff to enter the work area. Standard lever style door handles were located at the top of each door. Numerous residents (unidentified) were congregating around the station and a medication cart was also stored inside of the station in plain view.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's nursing care plan in effect on 1/28/2025 (printed 2/20/2025) documents R1 walks independently and also wanders in the facility. The same record documents the focus area Potential Risk of Elopement Cognitive deficit, History of wandering, Walks about aimlessly w/o (without) purpose with the goal (R1) will remain safely in facility through review date with a target date of 5/6/2025. The plan lists the following facility interventions/tasks to achieve the goal: Monitor whereabouts regularly, recognize any unsafe conditions or escalating patterns, and provide re-direction and diversion as needed.</p> <p>On 2/11/2025 at 1:55PM, V3 (Licensed Practical Nurse) reported R1 has a history of wandering and will wander into the nurses' station if the doors at each end are open. V3 reported R1 had previously drank from staff beverages located inside of the nurses' station. V3 reported R1 also recently drank fingernail polish remover during an activity on 1/19/2025 and coughed all over getting the solution on R1's shirt and staff had to call the Poison Control telephone hotline for emergency medical instructions to care for R1. V3 reported R6 is another resident who wanders and will attempt to manipulate the door handles located at each door leading into the nurses' station and other residents also will sometimes reach over the top of the doors to attempt to unlock the handles.</p> <p>On 2/13/2025 at 11:11AM, V4 (Licensed Practical Nurse) reported R1 does wander in the Dementia care unit and reported R1 has a history of getting inside of the nurses' station on the unit. V4 reported the unit has several residents who like to wander and residents will pull on and shake the doors at the nurses' station. V4 stated Residents will shake the doors, we need more secure doors because of the wandering residents and the (door) handle on the East side doesn't lock and it doesn't have a sliding lock anymore. V4 reported if staff leave a soft drink beverage at the nurses' station, R1 will absolutely drink it. V4 reported R1 does not normally spill any drinks on R1's self when R1 is drinking a beverage.</p> <p>On 2/11/2025 at 2:15PM, V5 (Certified Nurse Aide) reported R1 does not normally spill any liquids when drinking and is not normally messy when drinking.</p> <p>On 2/11/2025 between 1:50-2:05PM, a medication cart remained stored inside of the Dementia care unit nurses' station. R1 was present and ambulating independently outside of the station in a random pattern before sitting down on a nearby chair. Facility staff then handed R1 an insulated water bottle with a flip top and R1 began drinking independently from the water bottle. R1 did not dribble or spill any of the water when R1 was taking sips from the bottle. When the surveyor attempted to speak to R1, R1 began screaming and was unable to coherently answer any questions.</p> <p>The facility incident investigation (undated) documents on 1/28/2025, V4 (Licensed Practical Nurse) accidentally left a bottle of liquid morphine (an opiate medication used to treat moderate to severe pain) out in the open and V7 (Certified Nurse Aide) and V10 (Certified Nurse Aide) observed R1 with the bottle in R1's hand and then up to R1's mouth. The same record documents V7 retrieved the bottle of liquid Morphine from R1 and observed the bottle was empty.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 2/23/2025 at 11:11AM, V4 (Licensed Practical Nurse) reported accidentally leaving a bottle of liquid morphine out on top of the medication cart on the facility Dementia care unit on the late afternoon of 1/28/2025. V4 reported opening a new bottle of liquid Morphine Sulfate (30 milliliters total volume at a concentration of 10 milligrams/5 milliliters) at around 3:05-3:06PM and administering 0.25 milliliters to R3 and then replacing the bottle and remaining Morphine (29.75 milliliters of remaining liquid equating to 59.5 milligrams of medication) back inside of the locked medication cart. V4 reported later retrieving the bottle of Morphine and placing the bottle into a small biohazard bag because the bottle was not contained in a cardboard box as is usual when the medication was received from the facility pharmacy provider. V4 reported then placing the bag containing the Morphine bottle on top of the medication cart at about 5:00PM, with the cart located in the Dementia care unit nurses' station, followed by V4 leaving the Dementia care unit.</p> <p>R3's Physician Orders (printed 2/11/2025) document an order for Morphine Sulfate, 0.25 ml by mouth every 4 hours as needed for severe pain with a start date of 1/25/2025 and end date of 2/3/2025.</p> <p>R3's Medication Administration Record (1/28/2025) documents V4 administered 0.25 milliliters of Morphine Sulfate to R3 at 3:07PM.</p> <p>R3's Controlled Drug Administration Record (January 2025) documents the facility received a 30 milliliter bottle of Morphine Sulfate (10 milligram/5 milliliter solution) and V4 administered 0.25 milliliters to R3 on 1/28/2025 at 3:07PM leaving 29.75 milliliters of solution remaining in the bottle.</p> <p>The facility incident investigation (undated) documents on 1/28/2025 V5 (Certified Nurse Aide) was walking to the dining room on the Dementia unit to help serve resident supper meals and observed R1 with a bottle of something in R1's hand. The investigation documents V7 and V10 were serving resident meals in the dining room at the time and V7 observed R1 in a common area with a bottle up to R1's mouth. The record documents V7 then grabbed the bottle away from R1 and observed the bottle was empty and then asked V5 what was in the bottle and V5 reported the bottle contained Morphine and contacted V4 (Licensed Practical Nurse) who was located outside of the Dementia care unit on a break to report the concern (R1 having potentially drank Morphine Sulfate from an unsecured medication bottle). The record documents V4 then immediately returned to the unit and staff called emergency medical services to transport R1 to the hospital emergency room for evaluation and treatment. The investigation documents the incident was a Medication Incident and documents Medication (Morphine Sulfate) as Administered Dose 59.5mg (milligrams) and Medication as Administered Name (R1).</p> <p>On 2/11/2025 at 2:15PM, V5 (Certified Nurse Aide) reported standing at the entrance of the Dementia unit dining room adjacent to the nurse's station on the evening of 1/28/2025 and observing R1 standing beside the medication cart which was located inside of the nurse's station. V5 reported observing R1 with something in R1's hand that V5 initially thought was a candy bar and then realizing R1 had a bottle in R1's hand and then asked nearby staff (V7 Certified Nurse Aide) what R1 had in R1's hand. V5 reported staff then realized R1 had a bottle of Morphine in R1's hand and the bottle was empty and R1 just had the bottle up to R1's mouth. V5 reported V7 then called V4 (Licensed Practical Nurse) back to the Dementia care unit. V5 reported staff did not see any spilled liquid Morphine on R1 anywhere and did not see any spilled Morphine on the medication cart and also looked at nearby surfaces including the interior of a nearby trash can to see if R1 poured or spilled the Morphine out and they did not find any evidence of the Morphine in the environment and concluded R1 drank the entire bottle of Morphine.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 2/13/2025 at 11:11AM, V4 (Licensed Practical Nurse) reported receiving a call from V5 on 1/28/2025 informing V5 that staff found R1 with a bottle of Morphine Sulfate up to R1's mouth on the Dementia unit. V4 reported V5 stated please tell me this (Morphine) bottle was empty (prior to staff observing R1 placing the bottle to R1's lips). V4 reported returning to the Dementia care unit after receiving the call and helping staff look around to see if R1 had spilled instead of drank the liquid Morphine. V4 stated We looked around and went to trash can and didn't find any moisture anywhere (to indicate R1 spilled part or all of the Morphine instead of ingesting the contents of the bottle).</p> <p>The facility Physician Notifications form (a facsimile sent to R1's attending medical provider, V12, after the incident on 1/28/2025) documents R1 was sent to the hospital emergency room after accidentally ingesting another residents liquid morphine.</p> <p>R1's Progress Notes (1/28/2025 at 5:15PM) document: Incident Note: Medication error occurred. Resident refused V/S. Only able to obtain respiratory rate. Facility protocol followed.</p> <p>The facility Medication Incident report (undated) documents the facility sent R1 to the hospital emergency roianom on [DATE] at 5:50PM.</p> <p>The emergency medical services (EMS) Patient Care Report (0263) documents facility staff called EMS on 1/28/2025 to transport R1 to the hospital emergency room due to R1 possibly ingesting 29.75 milliliters of liquid Morphine. The report documents the dispatch reason as Overdose/Poisoning/Ingestion and documents R1 was not cooperative and would not walk to the EMS cot to be transported by ambulance to the hospital so EMS staff carried R1 by R1's extremities to the cot. The report documents R1 had constricted pupils at the time of transportation to the hospital. The report documents R1 was taken to the hospital emergency room at 5:37PM.</p> <p>The hospital emergency department report (1/28/2025) documents R1 arrived at the hospital awake and irritated and V27 (Registered nurse) at the emergency room contacted the facility to get information about R1. The report documents V31 (former Director of Nursing) reported to V27 that R1 got 29.75ml (milliliters) of morphine at 1715 and the bottle was completely empty when the nurse found it and she called 911. The same report documents the bottle of Morphine had a concentration of 2 milligrams per milliliter and was sitting on top of the medication cart unattended (at the nursing home). The report documents R1 arrived at the hospital emergency room via ambulance with a chief complaint of accidental overdose, was evaluated, and then sent back to the nursing home with the medication Narcan (an emergency medication that rapidly reverses life-threatening opioid overdoses) and printed patient care instructions titled Opioid Overdose: Care Instructions. The report does not document the hospital emergency room attempted to obtain any laboratory specimens from R1 at the time of R1's visit to the emergency room to directly screen for Morphine (opiate) ingestion. The report documents V28 (emergency room physician) signed R1's discharge instructions at 6:32PM.</p> <p>Progress notes (1/28/2025) document R1 returned to the facility from the hospital at 7:09PM via emergency medical services.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 2/7/2025 at 2:43PM, V6 (Registered Nurse) reported starting a work shift at 6PM on 1/28/2025 on the Dementia care unit where R1 resided. V6 reported R1 had already been sent to the emergency room at the hospital and V4 (Licensed Practical Nurse) had reported to V6 during shift change report that R1 had gotten ahold of some Morphine that facility staff left unsupervised and staff were not sure if R1 drank or spilled the Morphine but staff could not find evidence the Morphine was spilled. V6 reported the hospital called emergency room called V6 around 6:30-6:45PM about sending R1 back to the facility. V6 reported emergency medical services brought R1 back to the facility and R1 was at R1's baseline but a bit more lethargic. V6 reported around 10:00PM, R1's oxygen saturation fell off to around 88% and R1's respiration rate started becoming lower and lower and R1 was less responsive. V6 reported when R1 is normally in R1's room, staff can not go into R1's room without R1 screaming and V6 stated you certainly can't check her vitals (without R1 screaming). V6 reported when V6 was in R1's room taking R1's blood pressure, R1 looked at V6 but was silent. V6 reported a Certified Nurse Aide (unidentified) was doing a fifteen minute check on R1 later and reported to V6 that R1's respiration rate was at 13 and so V6 went to R1's room immediately. V6 reported observing R1's respiration rate decrease to 10 and that R1 does not have any history of having a low respiration rate. V6 reported then calling 911 to get emergency medical services to transport R1 to the hospital emergency room a second time and then administering 4mg (milligrams) of Narcan to R1 as R1 seemed less and less responsive.</p> <p>Progress Notes (1/28/2025) document R1 was sent back to the emergency room at 10:41PM due to decreased respirations.</p> <p>The emergency medical services (EMS) Patient Care Report (0265) documents facility staff called EMS on 1/28/2025 to transport R1 to the hospital emergency room due to a report of a resident who is unresponsive, but breathing and Respirations down to 11. 1 dose of Narcan has been administered and Staff reports that during their assessment they found pt's (patient's) respirations to be between 11-13 breaths per minute. After noting this change in pt (patient) condition staff administered 4mg (milligrams) of nasal Narcan. EMS assessed pt respirations and found them to be at 18 breaths per minute. The report documents the dispatch reason as Breathing Problem. The report documents R1 was taken to the hospital emergency room at 10:48PM.</p> <p>The hospital emergency department report (1/28-1/29/2025) documents R1 presented to the hospital emergency department due to the chief complaint of possible overdose and R1 was uncooperative and yelling at hospital staff in the emergency department. The record documents nursing home staff reported completing fifteen minute checks on R1 when R1 was found unresponsive with a respiration rate of 11 and an oxygen saturation of 88% followed by nursing home staff administering Narcan to R1.</p> <p>The emergency department report documents R1 received an intravenous catheterization in R1's arm at 11:30PM on 1/28/2025 which R1 pulled out of R1's arm at 11:47PM followed by the notes bleeding controlled at this time and ER MD notified. The same report documents hospital staff inserted a second intravenous catheter into R1's arm at 12:10AM on 1/29/2025. The report also documents hospital emergency room staff performed a urinary catheterization on R1 at 11:27PM on 1/28/2025 to obtain a urine specimen for a urinary drug screen and at 11:47PM, the screen resulted positive for the presence of Morphine (an opiate) in R1's urine.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The emergency department notes document on 1/28/2025 at 11:50PM, V28 (Emergency department physician) stated R1's urine drug screen was positive for opiates but R1 did not currently have any opiates on R1's medication list and that V29 (Hospitalist) was concerned R1's positive urine drug screen may be an actual (Morphine) ingestion and the hospital will observe R1 in the Emergency Department overnight.</p> <p>On 2/13/2025 at 11:45AM, V9 (facility Quality Assurance Pharmacist) looked at R1's medication records and reported R1 was opiate naive prior to the incident (had not been taking any opiates recently) and if R1 had ingested the bottle of liquid Morphine containing 59.5 milligrams, V9 would expect to see traditional signs of opioid overuse, especially respiration rate depression and mental status changes. V9 reported additional signs would include lethargy and trouble concentrating. V9 reported expecting the onset of liquid Morphine to be within 30-60 minutes but possibly longer. V9 reported it would be reasonable for R1 to not show signs of opiate overdose for some time after ingestion depending on food in R1's stomach and other factors. V9 reported death is possible with opioid overdose and other possible outcomes include temporary or permanent harm.</p> <p>On 2/14/2025 at 11:26AM, V9 reported typical dosing for Morphine Sulfate at a concentration of 2 milligrams/milliliter is as low as a few milligrams for an opiate naive patient and reported standard dosing for a patient without previous use would be 5 milligrams or lower per dose.</p> <p>R1's Medication Administration record (January, 2025) does not document R1 was taking any opiate medications at the time of the incident on 1/28/2025.</p> <p>On 2/14/2025 at 12:21PM, V12 (R1's attending medical provider at the facility) reported if R1 was positive for opiates on a urinary drug screen, then R1 must have ingested some of the liquid Morphine. V12 reported facility staff leaving the Morphine out on the medication cart unsupervised was a high risk for residents.</p> <p>V12's (R1's attending medical provider in the facility) Progress Note (1/30/2025) documents V12 discussed in great detail with nursing home staff that they should not leave any medication unattended to prevent future incidents with any resident. The note documents V12 recommended to provide all staff necessary education and discussed this with V1 (Administrator) and V31 (former Director of Nursing) and they agreed.</p> <p>The Immediate Jeopardy that began on 1/28/2025 was removed on 1/28/2025 when the facility removed the bottle of Morphine Sulfate from R1's possession and sent R1 to the hospital emergency room for evaluation. The deficient practice was corrected on 1/29/2025 after the facility took the following actions:</p> <ol style="list-style-type: none"> 1. R1 was evaluated and sent to the Local emergency room for evaluation on 1/28/25 at 5:50p.m. When EMS personnel arrived, they attempted to administer Narcan to R1 prior to transferring R1 to the local emergency room . 2. V4, Licensed Practical Nurse, was suspended on 1/28/2025 pending a comprehensive investigation of the incident. <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. Upon Return to the facility on [DATE], R1 was placed on 15-minute checks and increased assessment and monitoring with hourly vital signs/Level of Consciousness for eight hours and then every shift times two days.</p> <p>4. Upon Return to facility, R1 had a change in condition. V6, Registered Nurse, administered Narcan to R1, called 911, and sent R1 back to the Local emergency room for Evaluation at 10:41p.m.</p> <p>5. R1 returned from the hospital on 1/29/25 at 7:35a.m. Upon return to the facility, R1 was placed on 15-minute checks and increased assessment and monitoring with every 4 hour vital signs for 2 days.</p> <p>6. All licensed nursing staff were educated on Storage of Controlled Substances, Medication Administration, Accidents and Incidents, and Change of Condition Policies prior to their next scheduled shift either in person or via phone by V31 (former Director of Nursing), V2 (former Nurse and current Director of Nursing), (former Registered Nurse and current Director of Nursing), and V36 (Licensed Practical Nurse) completed 1/29/25.</p> <p>7. V2 (former Registered Nurse and current Director of Nursing) contacted V37 (R1's Power of Attorney) for notification on 1/28/25 at 6:01p.m.</p> <p>8. V2 (former Registered Nurse and current Director of Nursing) contacted V12 (R1's Physician) for notification on 1/28/25 at 7:15p.m., V31 (former Director of Nursing), and the facility pharmacy provider on 1/29/25 for assistance with Medication Audits.</p> <p>9. V30 (Maintenance Director) completed a sweep of the Dementia Unit to ensure that all items that are liquid and hazardous products were locked up or put away out of reach on 1/28/25.</p> <p>10. The Facility Corporate team (V32 Chief Nursing Officer, V33 Regional Clinical Consultant, V34 Chief Executive Officer, V35 Regional Director of Operations) reviewed and revised policies and procedures related to Medication Administration, Medication Storage, Accidents and Incidents, and Change of Condition. (Completed 1/29/25)</p> <p>11. The Director of Nursing or designee will complete audits three times weekly for a period of 8 weeks in the following categories: (Initiated 1/29/25) Medication Administration Policy, Storage of controlled substances, Accidents and Incidents, and Change of Condition. Results of the above reviews will be discussed at a weekly quality assurance meeting for a period of 4 weeks and will provide additional education as needed and implement interventions for improvement until resolution.</p>		

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 02/26/2025
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 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41970</p> <p>Based on observation, interview and record review, the facility failed to follow two (R4, R9) residents physician ordered diets, and failed to initiate a nutritional careplan for one resident (R4) out of three residents reviewed for Dietary Services in a sample list of ten residents.</p> <p>Findings include:</p> <p>R4's undated Face Sheet documents R4 admitted to the facility on [DATE] with medical diagnoses of Diabetes Mellitus Type II, Dementia, Pubis Fracture, Thyrotoxicosis, Hearing Loss, Lumbar Vertebrae Compression Fracture , Localized Skin Infection and Atherosclerotic Heart Disease.</p> <p>R4's Minimum Data Set (MDS) dated [DATE] documents R4 as moderately cognitively impaired. This same MDS documents R4 requires supervision with oral hygiene and eating.</p> <p>R4's Hospital Record dated 1/21/25 documents discharge instructions for R4 to receive a Diabetic diet.</p> <p>R4's Physician Order Sheet (POS) dated January 2025 documents a physician order starting:</p> <p>-1/22/25 and ending 2/17/25 for R4 to receive a Regular diet, Full Liquids texture, Thin/Regular (TNO) consistency.</p> <p>-2/17/25 and ending 2/20/25 for R4 to receive a Diabetic Consistent Carbohydrate (CCHO) diet, Full Liquids texture, Thin/Regular (TNO) consistency.</p> <p>-2/20/25 with no end dated for R4 to receive a Diabetic Consistent Carbohydrate (CCHO) diet, Regular (RG7) texture, Thin/Regular (TNO) consistency.</p> <p>R4's Dietary Profile dated 1/23/25 documents R4 is on a regular diet.</p> <p>On 2/19/25 at 1:20 PM V21 Certified Dietary Manager (CDM) stated R4 was admitted to the facility on [DATE] with orders from the hospital to be placed on a Diabetic diet. V21 stated the nurse on duty (V4) Licensed Practical Nurse (LPN) submitted a diet slip to the dietary department that instructed the dietary department to serve a regular diet with regular texture and thin liquids. V21 CDM stated the dietary department has been serving R4 a regular diet, not a diabetic nor a carbohydrate controlled diet as ordered since her admission on 1/21/25.</p> <p>On 2/21/25 at 3:00 PM V12 Physician stated R4 should have been on a Diabetic diet and/or Carbohydrate controlled diet to help manage her Diabetes.</p> <p>2. R9's undated Face Sheet documents medical diagnoses as Wedge Compression Fracture of First Lumbar Vertebrae, Diabetes Mellitus Type II, Dementia, Heart Failure, Dysphagia, Anemia and Cardiac Pacemaker.</p> <p>(continued on next page)</p>		

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 02/26/2025
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 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R9's Minimum Data Set (MDS) dated [DATE] documents R9 as severely cognitively impaired. This same MDS documents R9 requires set up assistance for eating meals.</p> <p>R9's Care plan intervention dated 3/8/2022 instructs staff to serve R9 her diet as ordered by her Physician.</p> <p>R9's Physician Order Sheet (POS) dated February 2025 documents a physician order starting 2/13/25 with no end date for R9 to receive Consistent Carbohydrate (CCHO) diet, Pureed texture, Thin/Regular consistency.</p> <p>On 2/20/25 at 11:56 PM V15 Certified Nurse Aide (CNA) served R9 her lunch. R9's meal ticket included on her lunch tray documents Diet: Regular, Texture: Pureed, Iced Tea: One cup. R9's meal was pureed breaded catfish, pureed mixed vegetables, pureed rice pilaf and pureed pear crisp. R9's dish of pureed pear crisp was a full portion. V15 CNA sat with R9 to assist R9 in eating her lunch. R9 ate approximately 75% of her main meal and 100% of her dessert.</p> <p>On 2/20/25 at 11:40 AM V26 Agency Registered Nurse (RN) stated R9 has a physician order for a pureed Carbohydrate controlled diet with thin liquids. V26 stated R9 has Diabetes Mellitus and should be on a Diabetic diet. V26 RN confirmed R9 had a full cup of dessert.</p> <p>On 2/20/25 at 2:00 PM V24 Regional Registered Dietician (RD) stated V20 Regional Dietician is unavailable for interview this week. V24 stated every resident who is admitted to the facility should have a physician ordered diet. V24 stated R4's diet was documented in R4's hospital discharge orders as a diabetic diet. V24 stated there was a transcription error as the facility entered the wrong diet into the Electronic Medical Record (EMR) and then also wrote R4's diet incorrectly on the diet communication form that the nursing department submits to the dietary department. R24 stated the diet communication form documented R4 was to be on a regular diet with regular textures and thin liquids. R24 stated R4's EMR documents R4's diet as a full liquid diet. V24 stated the nursing department should have transcribed the hospital discharge orders correctly and the dietary department should have ensured the orders the nursing department submitted were correct. V24 Regional RD stated R9's diet order entered into R9's EMR is correct as listed : Carbohydrate controlled, pureed texture and thin liquids. V24 stated the facility should serve the residents the physician ordered diets. V24 stated serving R4 and R9 a regular diet could have caused high blood sugar, hospitalization , diabetic coma or even death.</p> <p>On 2/19/25 at 1:40 PM V2 Director of Nurses (DON) stated R4's physician order for a full liquid diet was entered incorrectly. V2 DON stated R4 has been receiving a diet with regular textured foods since admission. V2 DON stated R4's order should have been entered as written from R4's hospital discharge records. V2 DON stated R9's diet order was transcribed correctly into R9's EMR but the dietary department served R9 the wrong diet. V2 DON stated serving R4 and R9 who both have Diabetes Mellitus Type II a regular diet instead of their physician ordered Diabetic diets could cause either resident (R4, R9) to have high blood sugar, require additional Insulin or even hospitalization .</p>		