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| 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 05/07/2025 |
| 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) |
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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642</p> <p>Based on observation, interview and record review the facility failed to ensure a resident was provided adequate assistance and safe equipment, to prevent a fall during a shower. This failure affects one of three residents (R3) reviewed for falls on the sample list of four.</p> <p>Findings include:</p> <p>R3's current diagnoses sheet documents the following: Type II Diabetes Mellitus With Diabetic Polyneuropathy, Personal History of Transient Ischemic Attack, and Cerebral Infarction Without Residual Deficit, Presence of Left Artificial Hip Joint, Unspecified Osteoarthritis, Unspecified and Essential Hypertension.</p> <p>R3's Minimum Data Set (MDS) dated [DATE] documents an admitted as 9/5/23 and that R3 has had one fall with no injury since admission/entry/reentry. The same MDS documents R3's Brief Interview of Mental Status score of 14 out of a possible 15, indicating no cognitive impairment. The same MDS documents R3 uses a walker for mobility and has no upper or lower extremity impairment in range of motion. The same MDS documents R3 requires shower assistance of Partial/moderate assistance - Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.</p> <p>R3's Fall risk assessment quarterly dated 2/13/25 (prior to fall 2/18/25) documents a score of 10, indicating R3 was at high risk for falls.</p> <p>The (Facility) Fall Incident List log dated 01/01/25 - 05/05/25 documents R3 had a fall 2/18/25 at 9:00 pm. The same Fall List documents the fall occurred during transfer in the shower room, with R3 being lowered to the ground by staff member (later identified as V14 Previous Certified Nursing Assistant).</p> <p>R3's Fall Investigation report documents R3's fall occurred on 2/18/25 at 9:00 pm. The fall investigation is signed as investigated by V1, Administrator 5/6/25 (during this survey). The fall investigation documents: Conclusion: Resident slipped while on the shower chair, being lowered to the ground by the CNA. Intervention, place towel on shower chair to prevent resident from slipping as well as on the floor to keep his feet from slipping</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.

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| 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>R3's Current Care Plan documents the following: Self-Care Deficit As Evidenced by: Needs one assistance with Activities of Daily Living and specifies Bathing - One person physical assist required.</p> <p>The same care plan documents R3's care plan was revised with an intervention for the 2/18/25 fall on 5/6/25 (during the survey by V2, Director of Nursing): Fall on 2-19-25 (fall report 2/18/25) Intervention-place towel on floor in front of shower chair and on shower chair to prevent resident from slipping.</p> <p>On 5/6/25 at 3:05 pm V1, Administrator confirmed as part of the Interdisciplinary Team (IDT) V1 assisted in R3's fall investigations 2/18/25 and 4/3/25 V1 confirmed the investigations and as written.</p> <p>On 5/7/25 at 10:55 am R3 stated I recall my falls, I can tell you about each of them. The one I had at home, prior to admitting to the facility, I broke this hip (grabs his left hip), that is why I am here. I have had a couple fall since. Two while trying to make my bed. One, I only hurt my pride. The one about a month ago, I hit my face on my way down to the floor. I went to the ER (hospital emergency room) and they fixed me up. I had a cut above my eye. The doctor cleaned it up and put some kind of adhesive on my skin to keep the cut together. I did not have my walker with me at the time. I was fixing my bed. I will remember not to chance it from here on out. This sign (points to a paper hanging on his wheelchair, Do not forget to use your walker) is my reminder. R3 also stated The fall before that, mid-February, I believe, had nothing to do with my walker. It was the shower chair. It wobbled on the uneven floor. The floor tapers to the drain under the shower chair. The shower chair was not in the locked position, like it usually is. It locks at the bottom on the wheels. The CNAs (Certified Nursing Assistants) have to take care of that. That day, the wheels were not locked. I had a CNA (later identified as V14, Previous CNA) in the room with me. I don't remember her name. She was originally about the distance you are from me now (approximately 4 feet). I was done with my shower. The CNA turned to walk over and get me a towel. She was a good eight feet from me. I stood up from the shower chair, as I usually do, to dry off. The shower chair was not secure. The brakes were not on. The chair abruptly moved backwards, and I fell forward at the same time. The floor was wet, or I may have been able to regain my balance. The CNA turned around and saw me fall. She came over immediately from the towel table, but there was not anything she could do. I was already on the floor. Overall, I was not hurt. I hit the floor hard. I landed on my left hip. The same one I fractured when I fell at home (prior to admission). It hurt bad at first. I had some minor redness at that time. The CNA went and got other people, and a nurse. I can't tell you their names, either. I would know them to see them. A couple days later my hip was black and blue. My hip did not hurt by that time. A couple weeks later, sometime in March, it started hurting. Only when I walked though. It may be because I am getting old. It may not have anything to do with the fall in the shower. I made the association to that fall when I told the doctor (V10, Physician). He ordered an X-ray. The X-ray showed there was no fracture. I have pain medication, I can have. I don't like taking it very often. I ask for it when the hip pain gets bad.</p> <p>This surveyor asked R3 to clarify if the CNA lowered R3 to the floor in the shower room. R3 stated No, she was clear over by the towels. I went down hard, all by myself.</p> <p>(continued on next page)</p> | | |

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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>On 5/7/25 at 11:25 am V16, Certified Nursing Assistant (CNA), had just completed R4's shower. After R4 left the shower room V16, CNA toured the shower room with this surveyor. The shower room was approximately 12 feet wide by 20 feet long. There was a spa-sized bathtub close to the center in the shower room. There was a small table on the left side of the bathtub. On the top of the table, there was a stack of clean bath towels. Approximately 10 feet away from the stacked towels, there was a shower stall. The shower stall was in an alcove inset. The shower stall was approximately five feet wide by five feet long. The shower stall had a free standing, light weight, hard plastic tube shower chair with wheels. The shower chair had a center hole, toileting access at the center of the shower chair seat. The wheels of the shower chair had individual tabs that locked each of the four wheels, when positioned downward. The shower chair sat in the middle of the shower stall floor. The shower stall floor sloped downward from all angles to a shower drain, under the shower chair. V16, CNA confirmed the shower chair was not stable because of the sloped floor. With the shower chair wheels in the locked position the shower chair still moved back and forth, and side to side approximately one half inch. V16, CNA stated I can see how that movement could cause a resident to fall. (R3) is pretty stable getting up, but I always help him just to be safe. If the wheels aren't locked that could cause a problem for anybody. I have only been a CNA since January when I started to work here (in the facility). Nobody had to tell me to lock the shower chair, I knew automatically, that was important to keep the residents safe. I always put a towel down on floor in front of the shower chair. Nobody ever said to put one in the seat. Not for (R3) or any other resident. I will do that from here on out.</p> <p>On 5/7/25 at 11:40 am R4 stated Oh yes, the shower chair moves around and wobbles a little when I get my showers. Some CNAs lock the wheels, and some don't. I feel safe because the CNAs are with me the whole time. I don't stand up on my own. They just pull the shower chair over to the side bar when I'm done getting washed up. The bar is secured well to the wall. I hang on to that and they get me up and dried off. Without the bar, and the CNAs help, I can say I would not feel safe to stand up.</p> <p>On 5/7/25 at 12:50 pm V2, Director of Nursing (DON) stated V2 had not done R3's 2/18/25 fall investigation. V2 stated she was not aware the shower chair wheels weren't locked, and that V14, was not providing R3 assistance to stand.</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642</p> <p>Based on record review and interview the facility failed to maintain a resident's complete and accurate medical record after a fall in the shower room. This failure affects one of three residents (R3) reviewed for falls on the sample list of four.</p> <p>Findings include:</p> <p>R3's Minimum Data Set (MDS) dated [DATE] documents R3's Brief Interview of Mental Status score of 14, out of a possible 15, indicating no cognitive impairment.</p> <p>The (Facility) Fall Incident List log dated 01/01/25 - 05/05/25 documents R3 had a fall 2/18/25 at 9:00 pm. The same Fall List documents the fall occurred during transfer in the shower room, with R3 being lowered to the ground by staff member.</p> <p>R3's Fall risk assessment quarterly dated 2/13/25 documents a score of 10, at high risk for falls. There was no documentation of a fall risk assessment post R3's fall (documented on the above fall log) that occurred 2/18/25.</p> <p>R3's Fall Investigation report documents R3's fall occurred on 2/18/25 at 9:00 pm. The fall investigation is signed as investigated by V1, Administrator on 5/6/25 (during this survey two and a half months post-fall). There is no corresponding documentation of the 2/18/25 fall in R3's medical record.</p> <p>R3's Current Care Plan documents the following: R3's care plan was not revised with an intervention for R3's fall 2/18/25, until 5/6/25 (during the survey).</p> <p>On 5/7/25 at 10:55 am R3 stated he had a fall in mid-February, in the facility shower room. R3 stated the staff member that assisted R3 with the shower, was eight feet away. R3 said the unlocked shower chair, and the wet, uneven shower floor, prevented R3 from stabilizing his gait, that resulted in the fall. R3 also stated he was not lowered to the floor by the CNA (as the fall log above documents). R3 stated No, she was clear over by the towels. I went down hard, all by myself.</p> <p>On 5/7/25 at 12:50 pm V2, Director of Nursing (DON) stated she reviewed R3's chart and could not find any documentation of R3's fall 2/18/25. V2 stated there should have been the initial incident documented, and the nurses follow-up assessments each shift. V2 confirmed there is no documentation that a fall risk was completed after the fall. There is nothing documented in the chart at all.</p> <p>On 5/7/25 at 3:15 pm V17, Regional Director of Operations (RDO) stated V17, V1, Administrator, and V2, DON, were just discussing the absence of documentation in R3's chart, related to R3's fall, 2/18/25. V17, RDO confirmed the facility failure to follow their fall policy for documentation. The nurses did not to follow through with assessments or progress notes, as they were supposed to with falls, and will be in-serviced.</p> <p>(continued on next page)</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The facility policy Subject: Accidents and Incidents Policy dated as revised 09/07/23 documents the following: Purpose: To provide staff with guidelines for investigating, reporting, and recording Accidents and Incidents. Policy: All accidents/incidents involving a resident shall require an incident report. The interdisciplinary team (IDT) will complete an investigation to determine root cause and implement appropriate interventions. Responsibility: It is the responsibility of the Charge Nurse to complete the incident report, notify attending physician and responsible parties and document information accordingly. It is the responsibility of the D.O.N./Designee to investigate and ensure appropriate completion, notification, and follow-up on all accidents and incidents. Investigate and follow up Action: 1. The Charge Nurse must conduct an immediate investigation of the accident/Incident and implement immediate appropriate interventions to affected party. 2. An incident report must be completed. 3. The charge nurse shall communicate the incident and further required documentation to nursing staff. Follow up charting shall continue for 72 hours after incident/accident. 4. The incident report and accompanying documentation will be reviewed by the Director of Nursing/Designee. 5. The Interdisciplinary Team (IDT) will conduct a thorough investigation of the accident/incident. Findings of the investigation, including root cause of the accident/incident and appropriate interventions will be indicated in the incident report and implemented. The MDS nurse shall update the care plan with implemented interventions and communicate interventions with line staff. 7. The Medical Director will review Incidents accident/incidents (sic) during the QAPI process.</p> | | |