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	08/22/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to notify residents Family Representatives/Power of Attorney of Physical Abuse allegations for five of nine residents (R3 - R7) reviewed for abuse on the sample list of 18. Findings include:1. R'4s/R3's IDPH resident to resident physical abuse investigation report dated 7/5/25 documents R3 smacked R4's face, and the Power of Attorney was notified, as the facility abuse prevention policy directs.On 8/22/25 at 10:13 am, V24, R3's Power of Attorney (POA)/Family Member reported the facility did call V24 on 7/5/25 and made it sound like another resident (R4) and R3 were just arguing. V24 said there was no mention of anything physical in that call.2. R4/R5 IDPH resident to resident physical abuse investigation report dated 6/21/25 documents R4 swatted R5's back, and the Power of Attorney was notified, as the facility abuse prevention policy directs. On 8/21/25 at 12:35 pm V28, R4's POA/Family Member had great difficulty hearing each question regarding R4's resident to resident altercations. V28, repeated the question regarding the resident to resident altercations back to surveyor correctly, and stated he was unaware of the facility calls about R4's involvement in resident to resident abuse allegations. 3. R4/R6 IDPH resident to resident physical abuse (second) investigation report dated 6/18//25 documents R4 grabbed R6's wrist, and the Power of Attorney was notified, as the facility abuse prevention policy directs.On 8/21/25 at 12:35 pm V28, R4's POA/Family Member had great difficulty hearing each question regarding R4's resident to resident altercations. V28, repeated the question regarding the resident to resident altercations back to surveyor correctly, and stated he was unaware of the facility calls about R4's involvement in resident to resident abuse allegations.On 8/22/25 at 10:20 am V23, R6's POA/Family Member stated she was never called by the facility about resident-to-resident physical abuse of R6. V23, POA stated R6 herself told V23 regarding another resident grabbing R6's wrist. She only knew about it. because R6 told V23 herself. V23 said R6 told V23 it was the same resident that laid in her bed previously and had a bowel movement (R4). V23, also said R6 told V23 that the resident (R4) came in her room, as she does with other resident rooms. V23 said R6 told V23 that R4 grabbed R6's wrist when R6 told (R4) to get out of her room. R6 told V23 that nurses were in the hall, came in the room, and took the other resident (R4) out of R6's room right away. 4. R7's IDPH report dated 8/19/25 documents R7 was handled roughly by an unidentified nursing staff causing a bruise to R7's arm, and the Power of Attorney was notified, as the facility abuse prevention policy directs. On 8/22/25 at 10:07 am V26, R7's Family Member (second emergency contact) said he was never contacted by the facility and V25 (R7's POA), would have told V26 if R7 had made an allegation of staff providing rough care/abuse. On 8/22/25 at 3:08 pm V25 (R7's POA) said she had not been informed by the facility that R7 had made an allegation of rough care by a staff person. V25 said there was no mention of that abuse/rough care allegation, when the facility called V25, and all V25 was told was R7 had a new bruise on her arm. V25 said the facility did not know how the bruise happened. and she expects the facility to tell her the whole story.All of the above reports were documented by V1, Administrator/ Abuse Prevention Coordinator. Each of the above reports document that the Power of Attorney was notified, as the facility abuse prevention policy directs.On 8/22/25 at 12:40 pm V1 Administrator/Abuse Prevention Coordinator said the nurses should be documenting accurately if they aren't getting a hold of a family and the doctor. The nurses are to report to the families about any resident-to-resident altercations/abuse. The facility Abuse Policy dated as revised 01/09/24 documents the following: The Facility will report all allegations of abuse immediately to the Administrator and timely, to the proper authorities to include IDPH (Illinois Department of Public Health), Ombudsman, Local P.D (Police Department), POA (Power of Attorney), and M.D. (Physician) in a timely manner.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect residents' right to be free from witness, resident to resident physical abuse. This failure affects four of nine residents (R3, R4, R5 and R6), reviewed for abuse on the sample list of 18.Findings include:1.) R3's Minimum Data Set (MDS) dated [DATE] documents the following: R3's Brief Interview of Mental Status score of 00 (zero) out of a possible score of 15, which indicates severe cognitive impairment. The same MDS documents R3 has had Verbal behaviors directed towards others (e.g. screaming at others, threatening others, and cursing at others). These verbal behaviors occurred four to six days a week of the lookback period of the MDS assessment.The same MDS documents R3 also had other Behavioral symptoms not directed towards others: (e.g., smearing physical food or symptoms bodily such wastes, as or hitting or verbal/vocal scratching symptoms self, pacing, like rummaging , public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming and disruptive sounds). These other behaviors occurred daily during the lookback period of the MDS assessment.R3's Care Plan dated as last revised 01/22/24 with a target date of 01/10/25 documents the following, (R3) has the potential for abuse/neglect due to invading other's space and property, rummaging through belongings or wandering in and out of other's spaces. She has a history of being physically abused, psychiatric diagnosis or manifestations, including delusions, paranoia and hallucinations, Underlying factors that increase vulnerability; including such as dementia, confusion, poor judgment, wandering and giving away personal property. (R3) will experience no present/future problems related to abuse/mistreatment/violation. Revision on: 01/22/2024, Target Date: 01/10/2025. R4's MDS dated [DATE] documents the following: R4's Brief Interview of Mental Status score of eight out of a possible score of 15, which indicates moderate cognitive impairment . The same MDS documents R4 has had Physical (e.g. Hitting, kicking pushing, scratching, grabbing or abusing others sexually) and verbal behaviors directed towards others (e.g. screaming at others, threatening others, and cursing at others), and Behavioral symptoms not directed towards others: (e.g., smearing physical food or symptoms bodily such wastes, as or hitting or verbal/vocal scratching symptoms self, pacing, like rummaging , public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming and disruptive sounds). These behaviors of verbal and physical, and others behaviors occurred one to three days during the lookback period of the MDS assessment.R4's Care Plan dated as last revised 7/7/25 documents the following: (R4) has a DX (diagnosis) anxiety disorder, unspecified, DX: Dementia in other diseases, unspecified severity, with other behavioral disturbances. The resident is/has potential to be physically aggressive (hitting, kicking, pinching) r/t (related/to) Dementia, History of harm to others, Poor impulse control. The facility's Illinois Department of Public Health initial and final investigation report dated 07/05/25 documents the following: Brief description of the incident/event: It was reported that resident (R4) grabbed resident (R3) by the arm/shirt sleeve. As resident (R3) was trying to get her arm away, she made contact with (R4's) cheek area. The same investigation report documents: Summary of Investigative findings through discussions with Individuals with direct knowledge and review of the resident clinical record, include the report of incident and post-occurrence IDT (Interdisciplinary Team) walking rounds. A comprehensive investigation was initiated, review of video, and found that on 7/5/25 resident (R4) and (R3) were seated next to each other. Resident (R3) had a verbal outburst with a loud noise, which is her baseline. This appeared to startle (R4) and she (R4) was observed to grab (R3's) forearm and then (R3's) shirt sleeve. The staff member did intervene quickly and while attempting to separate the 2 (two) residents, (R3) was flailing her (R3's) arm/hand about, trying to get (R4) to let go of her (R3's) shirt. With this movement (R3's) hand did make contact with (R4's) cheek. Both residents were immediately assessed with no injuries noted. The incident did not appear to be malicious in any manner and more of a matter of the loud verbal outbursts startling(R4) and (R3) not wanting (R4) to be holding/grabbing her arm/shirt. A root cause was identified, and an appropriate intervention has been put into place. Resident (R4) was provided close supervision and the residents were kept separated. Neither resident could recall the incident, and neither resident shows any signs of mental anguish. The facility finds the allegation of willful abuse unsubstantiated related to there being no malicious intent with one resident trying to get the other resident's hand off of her. Follow-Up Actions Taken: The resident plan of care was updated as needed (as noted above R3's and R4's Care Plan were not updated to reflect this report intervention to increase supervision) The same report documents the

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	145469	A. Building B. Wing	08/22/2025

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed repeatedly to operationalize their abuse prevention policy by failing to notify the Ombudsman of abuse allegations. This failure affected seven of nine residents (R3 -R7) reviewed for abuse on the sample list of 18. Findings include:1. R'4s/R3's IDPH resident to resident physical abuse investigation report dated 7/5/25 documents R3 smacked R4's face, and the Ombudsman was notified, as the facility abuse prevention policy directs.2. R4/R5 IDPH resident to resident physical abuse investigation report dated 6/21/25 documents R4 swatted R5's back, and the Ombudsman was notified, as the facility abuse prevention policy directs. 3. R4/R6 IDPH resident to resident physical abuse investigation report dated 6/18//25 documents R4 grabbed R6's wrist, and the Ombudsman was notified, as the facility abuse prevention policy directs. 4. R7's IDPH report dated 8/19/25 documents R7 was handling rough by an unidentified nursing staff named (V11, Nursing staff) causing a bruise to R7's arm, and the Ombudsman was notified, as the facility abuse prevention policy directs. All of the above reports were documented by V1, Administrator/ Abuse Prevention Coordinator. Each of the above reports document that the Ombudsman was notified of the alleged abuse.On 8/21/25 at 11:13 AM V20, Ombudsman discussed the the above alleged abuse investigation reports with the corresponding dates. V20 said V20 reviewed all V20's correspondence with the facility over this time frame and associated dates. V20, Ombudsman stated he was not notified by the facility of any of the above allegations. V20, said V20 reviewed his notes, emails and phone calls. V20 also stated he was in the facility last week and was present during the facility Resident Council Group meeting. V20 stated the facility did not notify V20 in person, of any of the abuse/injury of unknown allegations documented above.The facility Abuse Policy dated as revised 01/09/24 documents, The Facility will report all allegations of abuse immediately to the Administrator and timely to the proper authorities to include IDPH (Illinois Department of Public Health), Ombudsman, Local P.D (Police Department), POA (residents Power of Attorney), and M.D. (Physician) in a timely manner.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based interview and record review, the facility failed to report allegations of resident to resident physical abuse, staff to resident physical abuse, and injuries of unknown origin to the police department and physician, in accordance with the facility policy. This failure affected five of nine residents (R3-R7) reviewed for abuse on the sample list of 18.Findings include: 1. R'4s/R3's IDPH resident to resident physical abuse investigation report dated 7/5/25 documents R3 smacked R4's face, and the local police department and physician were notified. 2. R4/R5 IDPH resident to resident physical abuse investigation report dated 6/21/25 documents R4 swatted R5's back, and the local police department and physician were notified. 3. R4/R6 IDPH resident to resident physical abuse investigation report dated 6/18//25 documents R4 grabbed R6's wrist, and the local police department and physician were notified. 4. R7's IDPH report dated 8/19/25 documents R7 was handling rough by an unidentified nursing staff causing a bruise to R7's arm, and the local police department and physician were notified. All of the above reports were documented by V1, Administrator/ Abuse Prevention Coordinator. Each of the above reports document that the local police department and the physician were notified, as the facility abuse prevention policy directs.On 8/21/25 at 10:20 AM, V19, Supervisor, Local Police Department stated the police department has no records, reports or dispatch calls of the facility contacting them regarding any of the above report.On 8/22/25 at 1:10 PM, V3, Medical Director/Physician (MD) reviewed V3, MD's records, facsimiles and phone calls on each of the above allegations of abuse. V3 said had not been notified of any of the above allegations. V3,MD also said that on-call physicians report all events in the facility to V3, MD. V3 said he does not see any evidence from the on-call providers that reflects they were notified of the above abuse investigations.On 8/22/25 at 12:40 pm V1 Administrator/Abuse Prevention Coordinator stated I called the police, and they asked if I wanted them to come out and I said no. I have nothing to show that I called and I don't keep my phone calls on my cell phone. I have no proof. I will have to get proof from now on. I will get a name or report number from the Police. V1 also stated As far as family and the physician, the nurses should be documenting accurately if they aren't getting a hold of a family and the doctor. That is what I go by in my investigation. I know I talked to (V23 Power of Attorney/R6's Family) about other things. The nurses are to report to the families about any resident-to-resident altercation. I guess I can't prove that either.The facility Abuse Policy dated as revised 01/09/24 documents the following: investigation has been complete. The Facility will report all allegations of abuse immediately to the Administrator and timely to the proper authorities to include IDPH (Illinois Department of Public Health), Ombudsman, Local P.D (Police Department), POA (residents Power of Attorney), and M.D. (Physician) in a timely manner.

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	145469	A. Building B. Wing	08/22/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to complete a thorough investigation by failing to interview families that are frequently in the facility, and other residents residing in the facility, that may have knowledge of alleged abuse. This failure had the potential to affect five of nine residents (R3- R7) reviewed for abuse on the sample list of 18. Findings include:R'4s/R3's IDPH resident to resident physical abuse investigation report dated 7/5/25 documents R3 smacked R4's face. The facility investigation determined this allegation to be unfounded, though no families or other residents were interviewed. 2. R4/R5 IDPH resident to resident physical abuse investigation report dated 6/21/25 documents R4 swatted R5's back. The facility investigation determined this allegation to be unfounded, though no families or other residents were interviewed. 3. R4/R6 IDPH resident to resident physical abuse investigation report dated 6/18//25 documents R4 grabbed R6's wrist. The facility investigation determined this allegation to be unfounded, though no families or other residents were interviewed. 4. R7's IDPH report dated 8/19/25 documents R7 was handling rough by an unidentified nursing staff causing a bruise to R7's arm. The facility investigation determined this allegation to be unfounded, though no families or other residents were interviewed. On 8/22/25 at 8:40 am V1, Administrator confirmed the abuse investigation (R3-R7) provided throughout the survey (8/19/25 - 8/22/25) are complete. V1 then confirmed she did not interview families that visit the facility frequently, or other residents who may have knowledge of alleged abuse incidents. The facility's Abuse Policy dated as revised 01/09/24 documents the following, The facility immediately and thoroughly investigates all allegations of abuse to include but not limited to interviews of residents and staff, visitors, vendors.

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	145469	A. Building B. Wing	08/22/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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	145469	A. Building B. Wing	08/22/2025

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to timely review and revise care plans for four of nine residents (R3, R4, R5, and R6) reviewed for abuse on the sample list of 18. Findings include: R'4s/R3's final IDPH resident to resident physical abuse investigation report dated 7/5/25 documents R3 smacked R4's face. The same report documents R3 and R4's care plan was reviewed/revised. R3's Care Plan dated as last revised 01/22/24 (twenty- four) with a target date of 01/10/25 (twenty -five) documents the following: (R3) has the potential for abuse/neglect due to invading other's space and property, rummaging through belongings or wandering in and out of other's spaces. She has a history of being physically abused, psychiatric diagnosis or manifestations, including delusions, paranoia and hallucinations, Underlying factors that increase vulnerability; including such as dementia, confusion, poor judgment, wandering and giving away personal property. (R3) will experience no present/future problems related to abuse/mistreatment/violation. Revision on: 01/22/2024, Target Date: 01/10/2025. There are no review or revision on R3's Care Plan as indicated above in the investigation report.R4's re-admission Care Plan dated as last revised 7/7/25 documents the following: (R4) has a DX (diagnosis) anxiety disorder, unspecified, DX: Dementia in other diseases, unspecified severity, with other behavioral disturbances. The resident is/has potential to be physically aggressive (hitting, kicking, pinching) r/t (related/to) Dementia, History of harm to others, Poor impulse control. R4's same care plan does not document R4's care plan was reviewed or revised, related to abuse, in a timely manner on 7/5/25 , as documented on the abuse investigation report above. 2. R4/R5 final IDPH resident to resident physical abuse investigation report dated 6/21/25 documents R4 swatted R5's back. The same report documents R4 and R5's care plan was reviewed/revised. R4's re-admission Care Plan dated as last revised 7/7/25 documents the following: (R4) has a DX (diagnosis) anxiety disorder, unspecified, DX: Dementia in other diseases, unspecified severity, with other behavioral disturbances. The resident is/has potential to be physically aggressive (hitting, kicking, pinching) r/t (related/to) Dementia, History of harm to others, Poor impulse control. R4's same care plan does not document R4's care plan was reviewed or revised related to abuse, in a timely manner on 6/21/25, as documented on the abuse investigation report above. R5's Care Plan dated as last revised 01/6/25 documents R5 is at times physically aggressive related to dementia. R5 will not harm self or others through the review date. Target Date for review: 05/06/2025. R5 will have fewer episodes of physical aggression through the review date. R4's same care plan does not document R5's care plan was reviewed or revised, on 6/21/25, as documented on the abuse investigation report above. 3. R4/R6 final IDPH resident to resident physical abuse (second) investigation report dated 6/18//25 documents R4 grabbed R6's wrist. The same report documents R4 and R6's care plan was reviewed/revised. R4's re-admission Care Plan dated as last revised 7/7/25 documents the following: (R4) has a DX (diagnosis) anxiety disorder, unspecified, DX: Dementia in other diseases, unspecified severity, with other behavioral disturbances. The resident is/has potential to be physically aggressive (hitting, kicking, pinching) r/t (related/to) Dementia, History of harm to others, Poor impulse control. R4's same care plan does not document R4's care plan was reviewed or revised related to abuse, on 6/18/25, as documented on the abuse investigation report above. R6's Care Plan dated 12/26/24 with a target date for review/revise of 1/10/25. R6's care plan documents R6 has impaired function/dementia or impaired thought process related to Dementia. The same care plan does not document R4's care plan was reviewed or revised in a timely manner on 6/18/25 as documented on the abuse investigation report above. On 8/21/25 at 3:05 pm V16, Regional Administrator/Licensed Professional Nurse reviewed R3-R7's Care Plans and confirmed R3- R7's care plans have not been updated as they were supposed to be and new interventions should have been documented after each of the abuse allegations.The facility's Abuse Policy dated as revised 01/09/24 documents the following: Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment, and making the necessary changes to prevent future occurrences.

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	145469	A. Building B. Wing	08/22/2025

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation, interview, and record review, the facility failed to provide a full-time director of nurses to oversee and coordinate nursing services provided within the facility. This failure has the potential to affect all 83 residents residing in the facility.Findings include:During the survey 8/19/25 through 8/22/25 there was no Director of Nursing (DON) in the building.On 8/19/25 at 10:10 am V1, Administrator/Abuse Prevention Coordinator stated V2, previous Director of Nursing's last day employed for the facility was Friday 8/15/25. V1 stated she has not hired a Registered Nurse for the DON position, nor does the facility have an Acting DON to provide oversite of the nursing services.The facility resident roster dated 8/19/25 documents 83 residents reside in the facility.

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	145469	A. Building B. Wing	08/22/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed repeatedly to maintain complete and accurate medical records for one of nine residents (R6) reviewed for abuse/injury of unknown origin on the sample list of 18.Findings include:R6's Physician Adult Health Exam, Routine Nursing Home Follow-Up. notes dated 2/20/25, 4/10/25, 4/17/25, 6/19/25 and 7/10/25 document R6 was assessed by V3, Medical Director (Physician). These notes were signed by V3, Medical Director. V3, MD documented R6 'Integumentary (skin)' assessments indicates R6 had left cheek and left, lower rib cage bruises on each of these assessment. On 8/22/25 at 1:10 PM V3, Medical Director reviewed R6's medical record documentation and said he now recognized his documentation was not accurate in V3, MD Nursing home visit notes that he documented on 2/20/25, 4/10/25, 4/17/25, 6/19/25 and 7/10/25. V3 confirmed R6 had a fall in December 2024 and continued with bruises in January but did not have bruising on the above mentioned dates. V3, MD acknowledged this was a documentation error. V3, MD also said V3, MD will add an addendum to each of those progress notes.R6's revised Progress notes dated 2/20/25, 4/10/25, 4/17/25, 6/19/25 and 7/10/25 have the following addendum signed by V3, MD: C: PHC NH (Point Click Care Nursing Home) Addendum: Integumentary: Bruising noted to left cheek and left lower ribs was added to chart due to documentation error. ZOO.DO: Encounter for general adult medical examination without abnormal findings.