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	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of Paris	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to document wound assessments for two (R2, R3) of three residents reviewed on a sample list of five residents.1. R2's Care Plan, Undated, documents on 8/2/24 high risk for pressure ulcers was added, and on 10/9/24, actual pressure ulcers of sacrum, right ischium, left heel, right lateral ankle, right heel, left dorsum foot, left gluteal fold and left gluteus was added. R2's Care Plan also documents Pressure Ulcers to be assessed weekly by licensed nurse, monitor for signs of infection daily, increased warmth, redness, swelling, pain, drainage, and odor. Notify physician if not healing.R2's Treatment Administration Record (TAR) dated November and December 2025 documents order for daily foot checks related to a history of ulcers. Document color, temperature, edema, and pedal pulses. On 11/2/25 and 11/25/25, there is missing documentation. On 11/26/25-12/4/25 and 12/30/25-12/31/25 edema bilaterally was documented.R2's progress notes do not document edema, open area, treatment, or notification of physician.R2's TAR dated November and December 2025 document order of daily skin checks. Document C-clear, R-red, O-open, P-pressure, and S-skin tear. On 11/2/25 and 11/25/25, there is missing documentation. On 11/1/25, 11/3/25-11/13/25, 11/16/25-11/21/25, 11/24/25, 11/26/25-12/24/25, and 12/26/25-12/31/25, O for open is documented. On 12/11/25 and 12/19/25, O-open, R-red, P-pressure is documented.R2's Skin Observation Tool dated 10/25/25 documents R2 has skin issues to right hip, sacrum both unstageable, left gluteal fold and both heels pressure. No further documentation.R2's Skin Observation Tool dated 12/7/25 documents sacrum pressure unstageable, Right heel pressure stage 2, left heel pressure stage 2, right iliac crest pressure unstageable, redness to groin and under bilateral breasts, left gluteal fold pressure stage 3, and left foot second toe pressure stage 2. Document does not include measurements or descriptions of wounds.R2's Wound Clinic Visit Notes dated 11/7/25 document R2's wounds and measurements as follows:Coccyx Pressure Stage 4 - 2.7 centimeters (cm) x 4.5cm x 2.82cmRight Ischial Tuberosity Pressure Stage 3 - 1.7cm x 1.5cm x 1.13cmLeft Posterior Heel Diabetic Ulcer Grade 1 - 0 x 0 x 0Right lower lateral ankle Diabetic Ulcer Grade 1 - 0 x 0 x 0Left Ischial Tuberosity Pressure Stage 3 - 1.3cm x 2cm x 0.15cm.No exposed bone to Coccyx area.R2's Wound Clinic Visit Notes dated 12/5/25 document R2's wounds and measurements as follows:Coccyx Pressure Stage 4 - 2cm x 4.8cm x 2.13cmRight Ischial Tuberosity Pressure Stage 3 - 1.7cm x 1.1cm x 1.52cmLeft Posterior Heel Diabetic Ulcer Grade 1 - 0.3cm x 0.7cm x 0.1cmRight lower lateral ankle Diabetic Ulcer Grade 1 - 0.6cm x 0.3cm x 0.13cmLeft Ischial Tuberosity Pressure Stage 3 - 1.2cm x 2cm x 0.24cm.Fibrin present on wound beds, exposed bone to Coccyx area, tunneling present to right ischial tuberosity.R2's Wound Clinic Visit for 1/7/26 was missed due to refusal of transportation by R2.On 1/8/26 at 1:35PM, R2 stated the facility takes care of her wounds and she does go to an outside clinic for wound treatment but is trying to switch somewhere closer. R2's family does not want the in-house wound physician to treat R2, but it is unclear why. R2 denied pain during wound care but did state it can cause discomfort from time to time. Observation of R2's wound care was completed on 1/8/26 at 1:35PM. Measurements were taken at time and are as (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follows:Right hip 1.5cm x 1cm x2cmLeft gluteal fold 2.5cm x 1.5cm x 0.2cmRight gluteal fold 2.5cm x 2.5cm x 0.2mSacrum 3.5cm x 2.5cm x 3.5cmRight outer heel 1cm x 2.5cmLeft heel 0.5cm x 0.6cmRight upper thigh 1.5cm x 1cmPeri area red and excoriatedBilateral breast folds red and excoriatedNo odors noted, R2's bedding clean and free of debris, stains, and holes. Wounds appear clean, no signs of infection observed.2. R3's undated Care Plan documents impaired skin integrity, and at risk for injury related to dementia.R3's Physician Order Sheet (POS) dated 1/8/26 documents order for wound care to left lateral ankle, daily foot exams, weekly skin checks, and preventative measures for coccyx skin breakdown.R3's Physician Wound Visit dated 10/26/25 documents left lateral ankle wound measuring 0.8 centimeters (cm) x 0.9cm with moderate exudate and erythema surrounding wound edges.R3's electronic medical record does not document any skin assessments completed by nursing staff.On 1/8/26 at 10:00 AM, R3 wound dressing change was observed. R3's wound was closed at that time. R3 denied pain or issues with wound site. On 1/7/26 at 10:00AM, V7 LPN stated that R1 is given all treatments with two staff members present due to R1's frequent accusations toward staff.On 1/7/26 at 11:00AM, V2 DON stated they do not write individualized documentation of wounds, they just upload notes from wound clinic visits. V2 stated nurses are not documenting on wounds as they should.Facility Pressure/Skin Breakdown-Clinical Protocol Policy dated January 2017 documents the nurse shall assess and document/report a full assessment of skin condition including but not limited to location, stage or partial/full thickness, length, width and depth, presence of exudates or necrotic tissue, signs/symptoms of infection, and impact of comorbid conditions on wound healing.