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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676294	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House at Paris Rehab & Nursing	150 S.E. 47th Street Paris, TX 75462

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45810 Based on observations, record review, and interviews, the facility failed to ensure residents had the right to receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 23 residents (Resident #76) reviewed for accommodation of needs. The facility treatment nurse failed to ensure Resident #76's lunch meal was fully accessible for her to eat on 11/04/2024 at the lunch meal, when the Treatment Nurse served Resident #76 her lunch meal and did not remove it off the tray and kept her plate on the warmer and covered with a lid. This failure could have placed resident at risk of having nutritional needs gone unmet. Findings included: Record review of Resident #76's face sheet dated 11/06/2024 indicated she was a [AGE] year-old female who readmitted to the facility on [DATE] with the diagnoses vascular dementia(disease in which it causes memory loss in older adults), glaucoma of left eye severe stage(eye condition that causes blindness), high blood pressure, depression(condition associated with lowering of a person's mood), anxiety(intense worry or fear), and need for assistance with personal care. Record review of Resident #76's quarterly MDS dated [DATE] indicated she was able to make herself understood, she could understand others, and she had impaired vision. The MDS also indicated she had a BIMS score of 8 which meant she had moderately impaired cognition. Record review of Resident #76's care plan revised 08/20/24 indicated Resident #76 had an ADL self-care performance deficit with interventions for supervision and setup for eating. During an observation of lunch in the dining room on 11/04/2024 starting at 12:15 PM, the Treatment Nurse served Resident #76 her lunch meal and did not remove it off the tray and kept her plate on the warmer and covered with a lid. The Treatment Nurse then walked away. Resident #76 said she could not see what was on her plate because she was blind in one eye. The resident next to Resident #76 assisted her by removing the lid off her plate, turning the plate towards and closer to Resident #76, so she could eat. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/04/2024 at 2:27 PM, the Treatment Nurse said she was familiar with Resident #76, but she was not in the dining room a whole lot. The Treatment Nurse said Resident #76 did not have any vision issues. The Treatment Nurse said she was new, and she did not know if she was supposed to uncover the residents' meals, but she was under the impression not to uncover the plates. The Treatment Nurse said she did not know if it was okay to leave the plates on the tray or not. The Treatment Nurse said from her observations at mealtimes sometimes the plates were left on the trays and sometimes they were not. The Treatment Nurse said to her it was not a big deal whether the plate was left on the tray or not. The Treatment Nurse said it was important to uncover the plate for the residents and ask them if they needed assistance. The Treatment Nurse said she had not asked Resident #76 because she knew Resident #76 did not require assistance and she could set up her own tray. The Treatment Nurse said it was important to assist the residents with their meals so they could have the same quality as those who can set up their meals themselves and it would not be fair to them to not have the assistance they require. During an interview on 11/06/24 at 5:46 PM the DON said she expected all of staff in the dining room assisting with meals to set the plates up for the residents and provide salt and pepper, or whatever else the resident may need during that meal. She said the failure placed a risk for residents not eating what they need. The DON said the failure could also cause a decline or weight loss in the residents. The DON said everyone who passed trays in the dining room were responsible. During an interview on 11/06/24 at 6:05 PM the Administrator said whoever passed the trays in the dining room for meal services was responsible for setting up the trays for each resident and ensuring the resident had what they needed. The Administrator said the failure placed a risk for malnutrition and weight loos for the residents. Record review of the policy Resident Rights dated 2/20/2021 indicated: Policy: The facility will inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility . Resident rights. The resident [NAME] the right lo a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 1. Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen of the United States . 4. Respect and dignity. The resident has a right to be treated with respect and dignity, including .c. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review, the facility failed to ensure prompt efforts were made to resolve grievances for 1 of 2 residents (Resident #40) reviewed for grievances. The facility did not ensure a grievance was filed and Resident #40 was appropriately apprised of progress toward resolution when Resident #40's pink pants were not returned from the laundry. This failure could place residents at risk for grievances not being addressed or resolved promptly. Findings included: Record review of a face sheet dated 11/06/2024 indicated Resident #40 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included sequelae of unspecified cerebrovascular disease (medical conditions that affect the blood vessels of the brain and circulation of blood to the brain). Record review of the MDS assessment indicated Resident #40 was understood by others and was able to understand others. The MDS assessment indicated Resident #40 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #40 was dependent for dressing, toileting, personal hygiene, and bathing/showering. During an interview on 11/04/2024 at 2:52 PM, Resident #40 said she had told the laundry aide she was missing a pair of pink capri pants. Resident #40 said the laundry aide told her she did not remember washing that color capri for her, but she would keep her eye out for them. Resident #40 said it had been about a month and the laundry aide had not let her know anything. During an interview on 11/06/2024 at 11:39 AM, Laundry Aide B said Resident #40 had reported to her she was missing a pair of pink pants. Laundry Aide B said it had been a while since Resident #40 reported the missing pants. Laundry Aide B said when the residents were missing clothing, they would look through the clothes, the lost and found, and if she was unable to find the missing item, tell the resident she was still looking for the clothes. Laundry Aide B said she had notified her supervisor, the Environmental Services Manager, that Resident #40 was missing a pair of pink pants. Laundry Aide B said the Environmental Services Manager was responsible for filing a grievance when a resident's clothing was not found. Laundry Aide B said she did not think a grievance had been filed yet. Laundry Aide B said it was important for the residents' clothing to be returned to them because they did not have much, and everybody needed their clothes. Laundry Aide B said it was important for a grievance to be filed in case the clothes were not found, so they could be in the process of replacing them. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/2024 at 11:49 AM, the Environmental Services Manager said if the resident was missing something they would let the Social Worker know for her to file a grievance. The Environmental Services Manager said she did not know anything about Resident #40 missing a pair of pink pants. the Environmental Services Manager said Laundry Aide B usually notified her if something was missing, but she was not aware of Resident #40 missing a pair of pink pants. Therefore, she had not notified the Social Worker for a grievance to be filed. The Environmental Services Manager said it was important for the residents to get their clothing back because they needed them, and it was their personal property. The Environmental Services Manager said it was important for a grievance to be filed so they could work together as a team to recover the lost items, and everyone was aware of it. During an interview on 11/06/2024 at 5:57 PM, the Administrator said if clothes were missing, they would look for them and then write a grievance. The Administrator said if the missing clothes were not found they would replace them. The Administrator said a grievance should have been filed for Resident #40's missing pink pants, and anybody could have filed the grievance. The Administrator said whoever took the residents grievance should write it up and give it to the Social Worker. The Administrator said it was important for the residents to have their clothing returned so they had something to wear. Record review of the facility's, Grievance Policy, revised 07/22/2023, indicated, .Resident concerns should be taken seriously and that the ability to voice a grievance is an important right and protection for residents . The right to file grievances orally, or in writing in the language he/she understands .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on observation, interview and record review the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 23 residents (Resident #63) reviewed for ADL (activities of daily living) care. The facility failed to provide nail care by removing black material from under fingernails for dependent female Resident #63 on 11/04/2024,11/05/2024, and 11/06/2024. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: Record review of the face sheet, dated 11/06/2024, revealed Resident #63 was a [AGE] year old female with diagnoses which included malignant neoplasm of unspecified part of the right bronchus or lung (cancer that forms in tissues of the lungs, usually in the cell lining air passages), chronic respiratory failure with hypoxia (chronic respiratory failure with hypoxia), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (caused by damage to the right side of the brain). Record view of the MDS, dated [DATE], revealed Resident # 63 had a BIMS of 04 indicating severe cognitive impairment. Resident #63 required assistance of two person for dressing, bathing, and personal hygiene ADLs. Record view of the MDS, dated [DATE], revealed Resident # 63 had a BIMS of 04 indicating severe cognitive impairment. Resident #63 required assistance of two person for dressing, bathing, and personal hygiene ADLs. The MDS revealed Resident #63 did not reject care. Record review of care plan, with a revision date of 07/24/2024, indicated Resident # 63 has an ADL self-care performance deficit. Goal: Resident # 63 will maintain a sense of dignity be being clean, dry, odor free and well groomed. Interventions: Resident #63 prefers to have long fingernails. Bathing total care dependent times two person assist, provide shower, shave oral care, hair care, and nail care per schedule when needed. During an observation on 11/04/2024 at 9:48 a.m. Resident # 63 was observed black material under fingernails. During an observation on 11/05/2024 at 9:32 a.m. Resident # 63 was observed black material under fingernails. During an observation on 11/06/2024 at 9:35 a.m. Resident # 63 was observed black material under fingernails. During an interview on 11/06/2024 at 8:58 a.m., CNA K stated it was the CNAs responsibility to ensure the residents fingernails were clean during showers or when needed. CNA K stated it was important to keep resident fingernails clean to keep bacteria down. CNA K stated Resident # 63 could put her hand in her mouth and the bacteria cause sores in her mouth or infection. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/2024 at 2:58 p.m., the DON stated it was the CNAs usual cleaned the resident's fingernails on bath days. The DON stated it was important to keep Resident #63 fingernails clean for infection control and dignity purposes. The DON stated she would monitor by making frequent rounds. During an interview on 11/06/2024 at 4:48 p.m., the Administrator stated he expected the CNAs to keep residents clean and dry. The Administrator stated Resident #63 requires long fingernails and digs in her brief. The Administrator stated there could be a risk to Resident #63 putting dirty fingernails in her mouth. The Administrator stated he would monitor by making rounds. Record review of the facility's policy titled Activities of Daily Living Care Guideline dated 2/11/2021, A resident who was unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities in accordance with the comprehensive assessment to meet the interests and the physical, mental, and psychosocial well-being for 1 of 2 residents (Resident #2) reviewed for activities. The facility failed to ensure Resident #2's Activities Evaluation was accurately completed on 09/09/2024. The facility failed to ensure Resident #2 was provided in-room activities in August 2024, September 2024, and October 2024. This failure could place residents at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being. Findings included: Record review of a face sheet dated 11/06/2024 indicated Resident #2 was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included vascular dementia (a condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain causes problems with reasoning, planning, judgment, and memory) and shortness of breath. Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #2 was sometimes understood by others and understood others. The MDS assessment indicated Resident #2 had a short-term and long-term memory problem. The MDS assessment indicated it was not very important for Resident #2 to have books, newspapers, and magazines to read. The MDS assessment indicated Resident #2 required partial/moderate assistance with eating, oral hygiene, substantial/maximal assistance with personal hygiene, and dependent for bathing/showering. Record review of Resident #2's care plan indicated she was dependent on staff for cognitive stimulation, activity attendance, and social interaction related to cognitive impairment and was at risk for isolation. Resident #2's care plan indicated she would attend/participate in activities of choice 1-3 times weekly through the next review date. Resident #2's care plan indicated interventions to assist/escort the resident to activity functions, converse with resident while providing care, provide a program of activities that is of interest and empowers the resident by encouraging/allowing choice, self-expression and responsibility, provide the resident with assistance as needed during the activity, and the resident's preferred activities are: TV, music, adult coloring, perk word search and family/friend visits. Record review of Resident #2's Activity Evaluation dated 09/09/2024 completed by the Activities Director indicated it was not very important for her to have books, newspapers, and magazines to read. The Activity Evaluation indicated Resident #2 was not interested in reading/audio books. The Activity Evaluation indicated Resident #2 preferred activities in her own room. The Activity Evaluation indicated Resident #2 had poor vision. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the In Room Activity Visit Logs for August 2024, September 2024, and October 2024 indicated: 08/19 Resident #2 with no activity description, no start or end time, and no signature to indicate it was completed. No in-room activities for Resident #2 in September 2024. No in-room activities for Resident #2 in October 2024. During an observation and interview on 11/04/2024 at 9:37 AM, Resident #2 said the staff told her they would read to her, but they had not. Resident #2 said she loved for them to read to her because she was not able to see the books anymore. Resident #2 had books on her overbed table. During an interview on 11/05/2024 at 4:35 PM, the Activities Director said she started in August of 2024. The Activities Director said Resident #2 read her own books, looked at her own pictures, and liked to visit with her family. The Activities Director said Resident #2 was supposed to have in-room activities, and she thought she had been doing these. The Activities Director said she had not tried to read to Resident #2, and she completed activities on her own. The Activities Director said she guessed she had had filled out Resident #2's Activity Evaluation wrong because Resident #2 liked to read. During an interview on 11/06/2024 at 5:48 PM, the Administrator said if Resident #2 liked to be read to, he expected for this to be done for her. The Administrator said the Activities Director was responsible for doing activities and the activities assessments. The Administrator said Resident #2's activities preferences should be included on her care plan as well. The Administrator said this was important to maximize the resident's quality of life. Record review of the facility's policy, Recreational Services, revised 02/2022, indicated, Recreation becomes extremely significant in meeting each resident's needs for quality of life. Well planned programs must be designed to enhance residents' abilities to function at their highest practicable level as well as to allow them to realize their own abilities and their own potential for fulfillment. The process must include assessing the residents' functional abilities, interests and needs, developing mutual agreed upon goals and the use of specialized recreation services as approaches to meet the individualized goals .

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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 46892

Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of the bladder and had an indwelling urinary catheter received appropriate treatment and services for 1 of 2 residents (Resident #72) reviewed for urinary catheters.

The facility failed to ensure CNA H provided proper catheter care to Resident #72 on 11/06/2024.

This failure could place residents at risk of injury, urinary tract infections, and a decreased quality of life.

Findings included:

Record review of a face sheet dated 11/06/2024 indicated Resident #72 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) and urinary retention.

Record review of a Comprehensive MDS assessment dated [DATE] indicated Resident #72 was sometimes able to make herself understood and was sometimes able to understand others. The MDS assessment indicated Resident #72 had a BIMS score of 3, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #72 was dependent on staff for all ADLs. The MDS assessment indicated Resident #72 had an indwelling catheter.

Record review of Resident #72's care plan revised 10/30/2024 indicated she had an ADL self-care performance deficit and was at risk for not having her needs met in a timely manner and required substantial/maximum assistance with toileting. Resident #72's care plan indicated she had a urinary catheter and was at risk for urinary tract infections and injury. Resident #72's care plan indicated catheter care every shift. The care plan indicated Resident #72 required enhanced barrier precautions to wear gown and gloves during high-contact resident care activities.

Record review of Resident #72's Order Summary Report indicated to provide catheter care every shift with a start date of 09/26/2024.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 11/06/2024 starting at 2:12 PM, CNA G and CNA H provided incontinent care to Resident #72. CNA G and CNA H put on PPE and gloves. CNA H cleaned Resident #72's left peri area and wiped down the middle. CNA H did not wipe Resident #72's right peri area and she did not clean the foley catheter tubing (thin, flexible tube used to drain urine out of your body from your bladder). Resident #72 was turned on her side. When she was turned on her side Resident #72 got a hold of her catheter tubing. CNA G cleaned Resident #72's back peri area. CNA G changed gloves and Resident #72 was turned back onto her back. Resident #72 was still holding her catheter tubing. CNA H removed her gloves. Resident #72 was still holding her catheter tubing when they covered her up. After this, CNA H and CNA G decided Resident #72 needed to be pulled up in the bed. When CNA H and CNA G pulled up Resident #72 in the bed she started pulling at the catheter. CNA H intervened and stopped Resident #72 from pulling the catheter further, and they finished repositioning her in the bed. CNA H said she thought she had cleaned both sides of Resident #72's front peri area. CNA H said when cleaning a resident with a catheter she should hold the tubing and wipe down it to clean it. CNA H said she should clean the peri area properly and the catheter tubing properly because they could have bacteria and germs and so the resident would not get an infection. CNA H said when providing care to Resident #72 she should be looking at the foley catheter tubing. CNA H said it was important to pay attention to where the foley catheter tubing was so it would not get pulled out and rupture something. During an interview on 11/06/2024 at 4:38 PM, ADON O said when performing incontinent care, the CNAs should clean from inside/out, clean the foley from top to bottom. ADON O said they should clean the tube, but make sure they do not pull it. ADON O said the CNAs should be aware of where the catheter tubing was at all times, and they should be aware of where the residents' hands and limbs were. ADON O said it was important for them to be aware of where the foley catheter tube was because it could cause trauma, pain, injury, and it was a risk for infection. ADON O said when providing incontinent care, the CNAs should be trying to clean the residents completely. ADON O said it was important to keep the skin clean and to prevent infections. During an interview on 11/06/2024 at 5:22 PM, the DON said during incontinent care the CNAs were supposed to clean both sides on the front peri area, and they should be cleaning the foley catheter tubing when providing incontinent care on someone with a foley catheter. The DON said it was important to completely clean the residents and clean the catheter tubing to prevent urinary tract infections, infections, and skin breakdown. The DON said the CNAs should be paying attention to where the residents foley catheter tubing was located while providing incontinent care. The DON said it was important to prevent trauma and risk for infection. The DON said the CNAs practiced incontinent care on the mannequins, and she randomly observed the CNAs perform incontinent care. The DON said she had not noticed any issues with incontinent care. During an interview on 11/06/2024 at 5:50 PM, the Administrator said he expected for the CNAs to provide proper incontinent care and fully clean the residents. The Administrator said he expected the CNAs to keep the residents from pulling the catheter tubing because this could cause trauma to the urethra (tube connected to the bladder for removal of urine). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled, Urinary Catheter Management, review date 08/20/2021 indicated, Residents with indwelling catheters (urethral or suprapubic) shall receive appropriate care and services to prevent and manage catheter-related complications . Properly position drainage bag and tubing below the level of the bladder and in a dependent position to facilitate flow of urine. Avoid allowing the drainage bag or tubing to touch the floor. Avoid positioning resident on tubing. Do not coil drainage tubing on bed or chair. Avoid loops in tubing: when in bed, hang drainage bag on bed frame (not side rail) towards the foot of the bed; when up in wheelchair or geri-chair, use a leg bag instead of a bedside drainage bag unless contraindicated by resident's condition .Provide perineal/catheter care with a perineal cleanser or mild soap and water at least once daily and promptly after fecal soiling to reduce the potential for bacterial contamination .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676294	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House at Paris Rehab & Nursing	150 S.E. 47th Street Paris, TX 75462

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review, the facility failed to ensure that respiratory care was provided consistent with professional standards of practice for 1 of 2 residents (Residents #2) reviewed for respiratory care. The facility failed to ensure Resident #2 had an order for oxygen. This failure could place residents requiring respiratory care at risk for respiratory complications. Findings included: Record review of a face sheet dated 11/06/2024 indicated Resident #2 was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included vascular dementia (a condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain causes problems with reasoning, planning, judgment, and memory) and shortness of breath. Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #2 was sometimes understood by others and understood others. The MDS assessment indicated Resident #2 had a short-term and long-term memory problem. The MDS assessment indicated Resident #2 required partial/moderate assistance with eating, oral hygiene, substantial/maximal assistance with personal hygiene, and dependent for bathing/showering. The MDS assessment did not indicate Resident #2 used oxygen. Record review of Resident #2's care plan revised 09/17/2024 did not indicate the use of oxygen. Resident #2's care plan indicated she had hospice/terminal prognosis with interventions to coordinate with the hospice to ensure the resident's spiritual, emotional, physical, intellectual, and social needs were met. Record review of Resident #2's Order Summary Report dated 11/04/2024 indicated oxygen at 2-4 liters via nasal canula for shortness of breath or saturation less than 90% as needed with an order date of 10/28/2024 and a start date of 11/04/2024. Record review of Resident #2's progress notes indicated 10/28/2024 hospice here stated oxygen saturation 78 placed on oxygen at 2 liters via nasal canula, signed by RN C. During an observation on 11/04/2024 starting at 9:23 AM, Resident #2 was in bed, an oxygen concentrator with a nasal cannula attached was at Resident #2's bedside, but not in use. LVN E entered the room, checked Resident #2's oxygen saturation and applied the oxygen via nasal cannula at 2 liters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/04/2024 at 2:29 PM, LVN E said she had noticed Resident #2 had oxygen in her room, but when she checked Resident #2's physician's orders she had not seen an order for oxygen. LVN E said she read a note in Resident #2's progress note that indicated she was started on oxygen on 10/28/2024. LVN E said she asked the hospice nurse about the oxygen order, and they said Resident #2 should have had an order from 10/28/2024. LVN E said it was important for Resident #2 to have an order for oxygen, so everyone knew she was supposed to receive oxygen and to ensure she was receiving the amount of oxygen she needed per the doctor's order. During an interview on 11/04/2024 at 3:27 PM, Hospice RN D said she had visited Resident #2 on 10/28/2024 and her oxygen saturation was low, so she placed oxygen on her at 2 liters via nasal cannula. Hospice RN D said she had given RN C a verbal order for oxygen 2-4 liters per min as needed. Hospice RN D said the facility did not have written orders for them to write down physicians' orders, so the hospice nurse went back to the hospice office put in the order and took kit back to the facility the same day. Hospice RN D said she was not able to remember if she had sent an order over to the facility. Hospice RN said it was important for the orders to be communicated so that everybody was aware of what was going on and the resident was given the care they needed. Hospice RN D said Resident #2 not having an order for oxygen could result in her oxygen getting too low. During an interview on 11/06/2024 at 11:18 AM, RN C said the hospice nurse visited Resident #2, and told her that her oxygen saturation was 70 something and she had put oxygen on Resident #2. RN C said since Resident #2 was a hospice patient and the hospice nurse had put oxygen on her, RN C said she had assumed that Resident #2 had an order for oxygen. RN C said the hospice nurse had not given her a new order for oxygen. RN C said she should have checked for an oxygen order and not just assumed Resident #2 had an order for oxygen. RN C said it was important for there to be an oxygen order for the residents to be more oxygenated and to help them stay alive. During an interview on 11/06/2024 at 5:17 PM, the DON said the nurse had taken the verbal order from the hospice company for Resident #2's oxygen, and normally the hospice faxed over the order, and it was placed in the resident's electronic health record. The DON said if the nurses noticed there was not order for oxygen, they should contact the hospice for an order. The DON said the hospice should have provided the order for the oxygen. The DON said it was important for Resident #2 to have an order for oxygen because she could decline and could pass away if her oxygen was too low or have respiratory distress, and so they could practice within their scope of practice. Record review of the facility's policy titled, Respiratory: Oxygen Administration, review date 02/10/2020, indicated, To describe method for delivering oxygen in order to improve tissue oxygenation, prevent hypoxia, decrease work of breathing and prevent shortness of breath with activity . Verify Physician's order . Hook cannula tubing behind ears and under chin .Set flow rate .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observations, interviews, and record review, the facility failed to ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 2 of 2 residents (Resident #15 and Resident #46) reviewed for trauma-informed care 1. The facility did not ensure Resident #46 had an accurate trauma screen that identified possible triggers when Resident #46 had a history of trauma. 2. The facility did not ensure Resident #15's trauma screening was completed with triggers upon admission to the facility. These failures could place residents at an increased risk for severe psychological distress due to re-traumatization. The findings included: 1. Record review of a face sheet dated 11/06/2024 indicated Resident #46 was a [AGE] year-old female originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included major depressive disorder, recurrent (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks), generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), and mild cognitive impairment. Record review of a face sheet dated 10/25/2024 indicated Resident #46 was understood by others and was able to make herself understood. The MDS assessment indicated Resident #46 was independent for eating, toileting, personal hygiene, and required partial/moderate assistance with showering/bathing. The MDS assessment indicated Resident #46 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #46 had anxiety and depression. Record review of Resident #46's care plan revised 10/29/2024 indicated she had alteration in mood related to disease process, diagnosis of depression and anxiety. Resident #46 care plan included interventions to administer medications as ordered, assist the resident to identify strengths, positive coping skills, and reinforce these, monitor/record mood to determine if problems seem to be related to external causes, monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills, and the resident needs encouragement/assistance/support to maintain as much independence and control as possible. Resident #46's care plan did not indicate she had a history of trauma. Record review of Resident #46's Comprehensive Trauma Screening with effective date 04/15/2022 completed by the previous social worker did not indicate Resident #46 had a history of trauma. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/04/2024 at 11:14 AM, Resident #46 said when she was growing up, she was smothered on purpose. Resident #46 said she had post-traumatic stress disorder due to this and she had told the social worker and the staff about it. During an interview on 11/06/2024 at 10:46 AM, the Social Worker said that she was not aware of Resident #46 having a history of trauma. The Social Worker said trauma assessments were done on admission and occasionally if the resident went to the hospital the system would trigger for a trauma assessment to be completed, and she would re-do it. The Social Worker said she had not completed Resident #46's trauma assessment because she was new at the facility (started in February 2024). The Social Worker said addressing trauma informed care was important because it could affect the residents well-being and quality of life, how they interacted with staff and each other and it could affect their sleep. During an interview on 11/06/2024 at 3:24 PM, LVN A said Resident #46 had not told her she was smothered in the past. LVN A said she was aware Resident #46's family member was abusive towards her when she was younger. LVN A said some time back Resident #46 was crying and had reported her family member was abusive to her. LVN A said she had reported it to the previous social worker, and she had talked to her about it. LVN A said it was important for history of trauma and triggers to be identified so that the staff would not trigger Resident #46's anxiety or go in her room and say something that was going to upset her because Resident #46 did have a lot of anxiety. During an interview on11/06/2024 at 4:30 PM, phone interview was attempted to the previous social worker with no answer. During an interview on 11/06/2024 at 5:10 PM, the DON said she was not aware of Resident #46 having any trauma. The DON said she knew Resident #46 was admitted to the facility because she lived in bad apartments with her family member and they were stealing her pills, but she was unaware of any trauma. The DON said if Resident #46 had trauma it should be on her trauma assessment and in her care plan. The DON said the previous social worker would have identified the trauma and put it in the care plan. The DON said it was important for trauma to be identified because the resident's treatment would be different, and they would have to look for mannerisms, behaviors, triggers, and offer psych services, counselor services. The DON said it was important for it to be included on the resident's care plan, so they knew how to care for them. During an interview on 11/06/2024 at 5:44 PM, the Administrator said he expected the Social Worker to address trauma on the trauma assessment and for trauma and triggers to be included in the residents' care plans. The Administrator said the Social Worker was responsible for this. The Administrator said it was important for trauma and triggers to be identified so it could be treated, if necessary. The Administrator said if trauma was not identified it could affect the resident's quality of life mentally. The Administrator said triggers needed to be identified so they could treat and evaluate the resident's mental status. 47612 (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #15's face sheet dated 11/05/2024, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included bipolar disorder current episode mixed severe with psychotic features (characterized by the presence of either delusion or hallucinations or both), Post-traumatic stress disorder, chronic (mental health condition that occurs when symptoms of PTSD last for more than three months after traumatic event), generalized anxiety disorder (a mental disorder that causes people to experience excessive and uncontrollable worry about everyday events and activities). Record review of Resident #15's MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. The MDS indicated Resident #15 had a BIMS score of 14, indicating cognition was intact. The MDS in the section of Social Isolation D0700 indicated Resident #15 always felt lonely or isolated from others. Record review of Resident #15's care plan dated 10/19/2022, revision date 08/09/2024, indicated intervention for PTSD but failed to address trigger for PTSD. During an observation and interview on 11/04/2024 at 3:27 p.m., Resident #15 stated she does not get out of her private room very often. Resident #15 stated she was afraid to get close to people because she would lose them. During an interview on 11/06/2024 at 1:56 p.m., the Social Worker stated she was not sure who was responsible for updating PTSD triggers on the care plan. The Social worker stated Resident # 15 never mentioned any PTSD triggers to her. The Social Worker stated she did not work at the facility for Resident #15 initial trauma assessment and has not done a trauma assessment at this time. The Social worker stated it was important for PTSD triggers to be on the care plan to provide the appropriate cate. During an interview on 11/06/2024 at 2:58 p.m., the DON stated PTSD triggers should be on the care plan. The DON stated the social worker was responsible for the trauma assessments at admission and change of condition. The DON stated Resident #15 was being seen by psychiatric services. Record review of the facility's policy Trauma Informed Care dated 10/24/2022 The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify wat to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to: a. Experiencing a lack of privacy or confinement in a crowded or small space. b. Exposure to loud noises, or bright/flashing lights. c. Certain sights, such as objects that are associated with their abuser. d. Sounds, smells, and physical touch

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on interview and record review, the facility failed to ensure that residents were free of significant medication errors for 2 of 23 residents reviewed for pharmacy services. (Resident # 15 and Resident # 68) The facility failed to ensure Resident #15's Metoprolol and Hydralazine (blood pressure medication) was not administered when her blood pressure was outside of the ordered parameters (systolic blood pressure less than 100 and diastolic blood pressure less than 60) on 10/06/2024. The facility failed to ensure Resident #68's Hydralazine (blood pressure medication) was not administered when her blood pressure was outside of the ordered parameters on 10/24/2024. These failures could place the resident at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: 1. Record review of Resident #15's face sheet dated 11/05/2024, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included bipolar disorder current episode mixed severe with psychotic features (characterized by the presence of either delusion or hallucinations or both), Post-traumatic stress disorder, chronic (mental health condition that occurs when symptoms of PTSD last for more than three months after traumatic event), generalized anxiety disorder (a mental disorder that causes people to experience excessive and uncontrollable worry about everyday events and activities). Essential (primary) hypertension (high blood pressure that doesn't have a single identifiable cause). Record review of Resident #15's MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. The MDS indicated Resident #15 had a BIMS score of 14, indicating cognition was intact. Record review of Resident #15's care plan dated 08/09/2024, indicated Resident #15 has a history of hypertension and was at risk for fluctuations in blood pressure. Interventions administer antihypertensive medications as ordered. Monitor for side effects such. as orthostatic hypotension, headache, vertigo, chest pain, and decreased heart. Record review of Resident #15's physicians order summary dated 11/05/2024, indicated Resident #15 had orders for Metoprolol 50 mg tablet give one tablet two times a day with instructions to hold for SBP less than 100 or DBP less than 60 with a start date of 10/24/2024 and Hydralazine 100mg give one tablet by mouth three times a day with instructions to hold for SBP less than 100 or DBP less than 60 with a start date of 01/10/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #15's medication administration record dated 10/1/2024 - 10/31/2024, indicated Resident # 15 had received Metoprolol 50 mg tablet when her blood pressure was 143/55 on 10/06/2024 with instructions to hold for SBP less than 100 or DBP less than 60 and Hydralazine 100mg when her blood pressure was 143/55 on 10/06/2024 with instructions to hold for SBP less than 100 or DBP less than 60. *On 10/06/2024 at 7:00 a.m., Resident #15's blood pressure was 143/55. The medication administration record had a check mark which indicated Resident #15 was administered Metoprolol 50 mg tablet and Hydralazine 100mg outside the parameters. 2. Record review of Resident #68's face sheet dated 11/06/2024, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included chronic combined systolic (congestive) and diastolic (congestive) heart failure (a condition where the heart muscle was simultaneously impaired in both its ability to contract and squeeze blood out (systolic dysfunction) and its ability to relax and fill with blood properly (diastolic dysfunction), leading to chronic congestion in the body due to poor blood circulation), pulmonary hypertension, unspecified (a serious condition that occurs when blood pressure in the lungs was higher than normal), essential (primary) hypertension (a type of high blood pressure that doesn't have an identifiable cause). Record review of Resident #68's MDS assessment dated [DATE], indicated he was able to make himself understood and understood others. The MDS indicated Resident #68 had a BIMS score of 12, indicating moderate cognitive impairment. Record review of Resident #68's care plan dated 08/28/2024, indicated Resident #68 has a history chronic combined systolic (congestive) and diastolic (congestive) heart failure. Interventions give cardiac medications as ordered. Record review of Resident #68's physician order summary dated 11/05/2024, indicated Resident #15 had orders for Hydralazine 100mg give one tablet by mouth three times a day with instructions to hold for SBP less than 100 or DBP less than 60 with a start date of 06/21/2023. Record review of Resident #68's medication administration record dated 10/1/2024 - 10/31/2024, indicated Resident # 68 had received Hydralazine 100mg when his blood pressure was 99/60 on 10/24/2024 with instructions to hold for SBP less than 100 or DBP less than 60. *On 10/24/2024 at 4:00 p.m., Resident #68's blood pressure was 99/60. The medication administration record had a check mark which indicated Resident #68 was administered Hydralazine 50mg outside the parameters. During an interview on 11/06/2024 at 8:58 a.m., MA L stated she gave the medication to Resident #15 because her systolic blood pressure was 143. MA L stated she was not allowed to contact the doctor when the blood pressure was out of parameter. MA L stated she was supposed to notify the charge nurse, but she could not remember if she notified the charge nurse or not. MA L stated it was important to not give blood pressure medication outside of the parameter because that was what the doctor ordered. MA L stated the risk to Resident # 15 would be her blood pressure dropping to low. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/2024 at 9:10 a.m., LVN M stated she did not give Resident #68 the Hydralazine 50 mg on that day. LVN M stated it was important not to give medication outside of the parameters because the resident's blood pressure could become to low. LVN M stated the risk to the resident giving medication outside of parameters was drowsiness or loss of consciousness. During an interview on 11/06/2024 at 1:56 p.m., the DON stated it was the nurse or the medication aide's responsibility to call the doctor if the residents blood pressure was out of the parameters. The DON stated it was important to get an order from the doctor to hold blood pressure medication when residents blood pressure was out of parameter. The DON stated the risk was the residents blood pressure could bottom out. The DON stated she would monitor by medication administration audits. During an interview on 11/06/2024 at 4:48 p.m., the Administrator stated the person administering the medication was responsible for ensuring the medications were being administered as ordered. The Administrator stated he expected medications to be administered per the physician's orders. The Administrator stated when the blood pressure was outside of parameters the doctor should be notified for orders. The Administrator stated blood pressure medication given outside of parameters could cause all kinds of problems. The Administrator stated he would monitor by reviewing the MAR. Record review of the facility's policy Medication-Treatment Administration and Documentation Guidelines revised on 04/06/2023, indicated Medications are administered according to manufacturer's guidelines unless otherwise indicated by physician order verify and provide medication or treatment focused assessment i.e. BP, wound measurements as indicated by manufacturers guideline or physician orders. Administer the medication according to the physician order

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 45810 Based on observation and interview, the facility failed store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 1 of 4 medication carts. LVN M failed to ensure the 100 Hall medication cart was locked when it was left unattended while she went to the restroom. This failure could place residents at risk of injury. Findings included: During an observation on 11/05/24 at 04:42 PM the hall 100 medication cart was unlocked, unattended, and parked beside the centralized nursing station. During an observation on 11/05/24 at 04:45 PM ADON N walked up to the hall 100 medication cart and locked it. She said the charge nurses were responsible for ensuring their medication carts were locked prior to walking away from them. She said there were all types of risks associated with the cart being left unlocked and unattended. ADON N said some of the risks associated with leaving the medication cart unlocked and unattended included theft of medications, poisoning for residents, and overdose. During an interview on 11/05/24 at 04:48 PM LVN P said she had left the 100 hall medication cart unattended by accident because someone had stopped her and asked her a question when she walked around the nurse's station while headed to the restroom. LVN P said it was her responsibility to ensure the medication cart was locked when left unattended. LVN P said the failure placed a risk for a resident, staff, or visitor to have access to the cart and take whatever they wanted. During an interview on 11/06/24 at 05:44 PM DON she said she expected the carts to be closed, locked, and the keys in their pockets at all times. She said all the charge nurses were responsible for their carts being locked if unattended. The DON said the failure placed a risk for a resident being poisoned, residents getting a hold of sharps, getting needle sticks, and residents getting a hold of medications in the cart. During an interview on 11/06/24 at 06:06 PM the Administrator said the medication carts should be locked at all times when they were not being used. He said the charge nurses were responsible for ensuring the carts were locked when they were unattended. The Administrator said the failure placed a risk for medications to be taken by residents that they were not prescribed to have. He said the failure also placed a risk for staff and visitors getting in the cart and taking the medications. Record review of the policy Medication Storage dated 1/20/2021 indicated: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: It is the policy of this facility to ensure all medications housed on our premises will be stores, dated, and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Policy explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments .b. Only authorized personnel will have access .

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NAME OF PROVIDER OR SUPPLIER Heritage House at Paris Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 150 S.E. 47th Street Paris, TX 75462	

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observations, interviews, and record review, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 8 of 81 residents residents (Residents #68, #79, #3, #11, #62, #48, #45, and #13) and 1 of 3 meals (lunch meal) reviewed for palatability, attractiveness, and appetizing. The dietary staff failed to provide food that was palatable and appetizing temperature for lunch meal observed on 11/5/24. Resident's #68, #79, #3, #11, #62, #48, #45, and #13 complained that food tasted bad, was not cooked properly and was served cold. These failures could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: Record Review of the menu indicated the lunch meal items on 11/5/24 included (A) fried chicken, mash potatoes, spinach, dinner roll and ice cream; (B) steak, egg noodles, green peas, dinner roll and ice cream. During an interview on 11/04/24 9:17 a.m., Resident #68 stated the food was bad every day. During an interview on 11/4/24 at 9:53a.m., Resident #79 stated the food was bad and he did not like his food grinded up. During an interview on 11/04/2024 at 9:58 a.m., Resident #3 stated the food could be better; Resident # 3 stated I feel like I eat a lot of sandwiches all the time. Resident # 3 stated she wanted more of a variety of other foods. During an interview on 11/04/24 10:14 a.m., Resident #11 stated she can't eat rice, corn, berries and gets it on her tray. Resident #11 stated, I had burnt toast this morning and I sent it back. Resident #11 stated the green beans were stringy and felt like she was eating hair. Resident #11 stated her dinner roll was not done yesterday (11/05/24). Resident #11 stated the inside of her dinner roll raw. Resident #11 stated she got cold coffee. During an interview on 11/04/2024 at 10:49 a.m., Resident #62 stated he would not feed the food to a hog. Resident #62 stated most of time the food was not done or was overdone. Resident #62 stated most of the time the pasta noodles were not eatable. During an interview on 11/4/24 at 10:06 a.m., Resident #48 stated he hated getting cold eggs unless the eggs were boiled. Resident #48 stated he liked his eggs over easy and the kitchen fried his eggs too hard. During an interview on 11/04/24 11:23 a.m., Resident #45 food stated the food was horrible, and her family brought her food, or she would starve. (continued on next page)

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Heritage House at Paris Rehab & Nursing	150 S.E. 47th Street Paris, TX 75462

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/5/24 at 10:37 a.m., Resident #13 stated the food was not good and meat was tough. During observation and tasting of lunch meal (A) on 11/5/24 at 12:22 p.m., the Dietary Manager stated the steak needed more seasoning, egg noodles tasted like egg noodles and the peas was warm. The frozen ice cream was not sampled during tasting. During observation and tasting of lunch meal (B) on 11/5/24 at 12:30 p.m., the Dietary Manager stated the fried chicken did not look burnt, but the fried chicken did have a dark color to it. During the tasting, surveyors stated the fried chicken skin tasted burnt and was dark in color. The Dietary Manager stated the mash potatoes was warm but needed a little more seasoning. The Dietary Manager stated the spinach tasted like spinach but could use more seasoning. The frozen ice cream was not sampled during tasting. During an interview on 11/06/24 at 9:15 a.m., The Dietary Manager stated she had been employed at the facility for [AGE] years. The Dietary Manager stated the administrator oversaw her at the facility. The Dietary Manager stated she tasted the foods served at every meal and every meal serving. The Dietary Manager stated she did not test taste the foods on 11/5/24 for lunch because she was cooking and was trying to make sure her staff was on point with everything in the kitchen. The Dietary Manager stated the cooks and aide also tasted the foods prior to serving meals that they prepared. The Dietary Manager stated her cooks and aides have completed in-services on following the recipe recently this year (2024). The Dietary Manager stated she did not exact on the actual month the aides and cooks completed in-services on following the recipe. The Dietary Manager stated she handled food complaints from the residents by communicating with the resident personally. The Dietary Manager stated, For the targeted complainers that she would print the menus for the residents, and she would let the family make their choices on the food's preferences for the resident. The Dietary Manager stated by letting the family make the food choices for the resident that it had had helped her targeted complainers calmed down on the food complaints. The Dietary Manager stated for residents complaining about food, that she would adjust the resident's meal choices based on the notes the resident left for her to read. The Dietary Manager stated it was important to ensure the food was palatable, attractive, and appetizing to the residents to make the residents happy and for the resident nutrition. During an interview on 11/6/24 at 12:04 p.m., the Administrator stated he had been the administrator for 14 months. The Administrator stated he oversaw the Dietary Manager. The Administrator stated he ordered test trays from the kitchen. The Administrator stated he was having lunch from the kitchen today. The Administrator stated the results from his last test tray was good. The Administrator stated the Dietary manager would go and talk to each resident who complain of food when he received food complaints to try to resolve the food complaints. The Administrator stated he handled food complaints by writing grievance on the food complaints from the residents. The Administrator stated he had one resident that always had something to say about everything prepared from the kitchen. Stated he recently talked to one resident who complained about the food and was told from that resident that the food was better and had been good lately. The Administrator stated he did not remember off the top of his head of when the last in-service on following the menu was completed by the dietary staff. The Administrator stated it was important to ensure the food was palatable, attractive, and appetizing for the resident for quality of life, weight loss prevention and for enjoyment. Record review of the facility Policy, titled, Menus and Nutritional Adequacy, revised Dated on 5/30/2012, indicated, Menus are planned to meet the average resident nutritional needs.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47708 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in (1 of 1) kitchen reviewed for dietary services. 1) The Dietary staff failed to label and date all food items. 2) The Dietary staff failed to dispose of expired foods items located in the refrigerator and freezer. These failures could place residents at risk for food contamination and foodborne illness. The findings included: During observations on [DATE] at 9:11 a.m., the following observations were made in the kitchen walk in freezer (1 of 1) (1) zip lock bag of frozen catfish had an open date of [DATE] and an expiration date of [DATE]. (expired) (1) ,d+[DATE]-quart container of celery had a preparation date of [DATE] and an expiration date of [DATE]. (expired) During observations on [DATE] at 9:17 a.m., the following observations were made in the kitchen walk in Refrigerator (1 of 1) (1) container of tomato juice was not labeled and had no preparation date and no expiration date. During an observation and interview on [DATE] at 9:17 a.m., the Dietary Manager stated the container of red juice found in the refrigerator was tomato juice and should have been labeled and dated. The Dietary Manager disposed of the tomato juice found in the refrigerator. During an interview on [DATE] at 9:10 a.m., the Dietary Manager stated she had been employed at the facility for [AGE] years. The Dietary Manager stated the Administrator oversaw her at the facility. The Dietary Manger stated in-services on labeling, dating, and discarding expired foods was last completed within the past month or two. The Dietary Manager stated she was not aware of the items found in the kitchen prior to survey. The Dietary Manager stated she conducted walk throughs every morning, but she did not catch what the surveyor found in the kitchen on [DATE]. The Dietary Manager stated the Administrator did not conduct walk thrus in the kitchen. The Dietary Manager stated it was important for staff to ensure they were labeling, dating, and discarding expired food items for the safety of the residents and so no residents would get sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 12:11p.m., the Administrator stated he had been the administrator for 14 months. The Administrator stated he oversaw the Dietary Manager. The Administrator stated, Yes, all foods were to be labelled dated, and discarded if expired. The Administrator stated, I do not know off the top of my head about the last in-services on labeling, dating and discarding expired foods but the Dietary Manager keep track of all in-services. The Administrator stated, Yes, I conducted walk throughs once a week on Fridays in the kitchen. The Administrator stated he did not have a chance to do walk through this week. The Administrator stated his next walk thru in the kitchen was scheduled for this this upcoming Friday [DATE]. The Administrator stated he was not aware of the expired foods and the tomato juice found in the refrigerator not labeled. The Administrator stated, Yes, I expect the dietary staff to follow kitchen policies and procedures. The Administrator stated, It was important ensure staff were labeling, dating and discarding expired food so staff would not serve foods out of date and possibly spoil. Record review of the facility's policy titled Dry Food and Supplies Storage, revised [DATE] indicated, (7) All storage bags must also be properly sealed and labeled with the common name of the food; (9) All opened products must be resealed effectively and properly labeled, dated and rotated for use. This may require storage in an approved NSF container or food grade storage bag; (10) Use by, Best by, and Sell by, dates should routinely be checked to ensure that items which have expired are discarded appropriately. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of FDA Food code dated 2022 indicated, ,d+[DATE].11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; (2) If made from two or more ingredients, a list of ingredients and sub-ingredients in descending order of predominance by weight, including a declaration of artificial colors, artificial flavors and chemical preservatives, if contained in the FOOD; (3) An accurate declaration of the net quantity of contents. (4) The name and place of business of the manufacturer, [NAME], or distributor; and (5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient. (6) Except as exempted in the Federal Food, Drug, and Cosmetic Act S 403(q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling. (7) For any salmonid FISH containing canthaxanthin or astaxanthin as a COLOR ADDITIVE, the labeling of the bulk FISH container, including a list of ingredients, displayed on the retail container or by other written means, such as a counter card, that discloses the use of canthaxanthin or astaxanthin. Commercially processed food Open and hold cold (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest-prepared or first-prepared ingredient. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 6 residents (Resident #2, Resident #53, and Resident #72) reviewed for infection control. 1. The facility failed to ensure LVN E and CNA F provided proper incontinent care to Resident #2. 2. The facility failed to ensure Resident #53's bagged, dirty briefs were taken out of her bathroom. 3. The facility failed to ensure CNA H provided proper catheter care to Resident #72, and the facility failed to ensure CNA H followed enhanced barrier precautions when she failed to wear gloves as she repositioned and touched Resident #72's sheets. These failures could place residents and staff at risk for cross-contamination and the spread of infection. Findings included: 1. Record review of a face sheet dated 11/06/2024 indicated Resident #2 was an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included vascular dementia (a condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain causes problems with reasoning, planning, judgment, and memory) and shortness of breath. Record review of the Comprehensive MDS assessment dated [DATE] indicated Resident #2 was sometimes understood by others and understood others. The MDS assessment indicated Resident #2 had a short-term and long-term memory problem. The MDS assessment indicated Resident #2 required partial/moderate assistance with eating, oral hygiene, substantial/maximal assistance with personal hygiene, and dependent for toileting and bathing/showering. Record review of Resident #2's care plan revised 09/17/2024 indicated she had an ADL self-care performance deficit and was at risk for not having her needs met in a timely manner. Resident #2's care plan indicated substantial assistance with toileting. Resident #2's care plan indicated she was incontinent of bowel and bladder to check her frequently for wetness and soiling and change her as needed. (continued on next page)

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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 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an observation of incontinent care on 11/04/2024 at 9:46 AM, LVN E and CNA F provided incontinent care to Resident #2. LVN E and CNA F put on gloves, unfastened Resident #2's dirty brief, cleaned her front peri area, Resident #2 was turned on her side. LVN E removed the dirty brief, LVN E cleaned resident back peri area, wiped from front to back but used the same wipe to wipe multiple times, she did this several times while cleaning the back peri area, changed gloves, did not perform hand hygiene in between glove changes, applied clean gloves, tucked in the dirty sheets, changed gloves, did not perform hand hygiene in between glove changes and applied the clean sheets and brief. Resident #2 was rolled to the other side CNA F removed the dirty linens and unrolled the clean sheets from underneath resident. CNA F did not change gloves and perform hand hygiene after removing the dirty linens and before touching the clean sheets. CNA F with her dirty gloves repositioned the resident in the bed. After repositioning Resident #2, CNA F removed the dirty gloves and performed hand hygiene and LVN E removed her gloves and performed hand hygiene.

During an interview on 11/04/2024 at 2:29 PM, LVN E said when performed incontinent care, she should only wipe once and discard. LVN E said this was important for infection control. LVN E said wiping more than once could result in urinary tract infections. LVN E said hand hygiene should be performed before and after care and in between glove changes. LVN E said she had not realized she failed to perform hand hygiene in between gloves changes. LVN E said gloves should be changed after cleaning the front, after cleaning the back, and when gloves were soiled, and when moving from dirty to clean. LVN E said CNA F should have changed her gloves after removing the dirty linens, before applying the clean linens. LVN E said ADON O was responsible for ensuring the CNAs were performing proper incontinent care. LVN E said hand hygiene was important to be done when required for infection control.

During an interview on 11/05/2024 at 3:12 PM, CNA F said gloves should be changed and hand hygiene performed after touching anything contaminated. CNA F said gloves should be changed after removing the dirty linens, before applying the clean linens. CNA F said she had not changed her gloves because she did not think about it. CNA F said it was important to change gloves to prevent contamination.

2. Record review of Resident #53's face sheet dated 11/06/2024 indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life).

Record review of Resident #53's Quarterly MDS assessment indicated she was able to make herself understood and was able to understand others. The MDS assessment indicated Resident #53 had a BIMS score of 10, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #53 was independent for toileting and personal hygiene. The MDS assessment indicated Resident #53 did not exhibit rejection of care or behaviors.

Record review of Resident #53's care plan with a target date of 01/27/2025 indicated she had an ADL self-care performance deficit related to cognitive decline, episodes of incontinence, unsteady gait, and was at risk for not having her needs met in a timely manner. Resident #53's care plan indicated she was independent for toileting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview of Resident #53's bathroom, there were 2 bags on the floor under the sink each bag contained dirty briefs. There was a strong urine odor in Resident #53's bathroom. Resident #53 said she tried to stay out of the bathroom because of the strong urine odor. Resident #53 said she told the nurses about the dirty briefs in the bathroom and they laugh and they do not take them out. Resident #53 said it was like talking to the air. Resident #53 was unable to say how long the bags with the dirty briefs had been in the bathroom, but she said they had been there a while. During an observation and interview on 11/04/2024 3:58 PM with CNA F, Resident #53 had bags with dirty briefs in her bathroom under the sink. CNA F said the CNAs were responsible for taking out the dirty briefs. CNA F said, I haven't gone in there today, I have been busy and did not have time. CNA F said Resident #53's bathroom smelled like urine. CNA F said it was important for the trash bags with briefs to not be left in the bathroom for sanitizing and to prevent contamination. CNA F said the bathroom smelling like urine could make Resident #53 feel like she was not being cared for. 3. Record review of a face sheet dated 11/06/2024 indicated Resident #72 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life) and urinary retention. Record review of a Comprehensive MDS assessment dated [DATE] indicated Resident #72 was sometimes able to make herself understood and was sometimes able to understand others. The MDS assessment indicated Resident #72 had a BIMS score of 3, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #72 was dependent on staff for all ADLs. The MDS assessment indicated Resident #72 had an indwelling catheter. Record review of Resident #72's care plan revised 10/30/2024 indicated she had an ADL self-care performance deficit and was at risk for not having her needs met in a timely manner and required substantial/maximum assistance with toileting. Resident #72's care plan indicated she had a urinary catheter and was at risk for urinary tract infections and injury. Resident #72's care plan indicated catheter care every shift. The care plan indicated Resident #72 required enhanced barrier precautions to wear gown and gloves during high-contact resident care activities. Record review of Resident #72's Order Summary Report indicated to provide catheter care every shift with a start date of 09/26/2024. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 11/06/2024 starting at 2:12 PM, CNA G and CNA H provided incontinent care to Resident #72. CNA G and CNA H put on PPE and gloves. CNA H cleaned Resident #72's left peri area and wiped down the middle. CNA H did not wipe Resident #72's right peri area and she did not clean the catheter tubing. Resident #72 was turned on her side. When she was turned on her side Resident #72 got a hold of her catheter tubing. CNA G cleaned Resident #72's back peri area. CNA G changed gloves and Resident #72 was turned back onto her back. Resident #72 was still holding her catheter tubing. CNA H removed her gloves and covered Resident #72 up, CNA H touched Resident #72's sheets and blankets without gloves. Resident #72 was still holding her catheter tubing when they covered her up. After this, CNA H and CNA G decided Resident #72 needed to be pulled up in the bed. When CNA H and CNA G pulled up Resident #72 in the bed she started pulling at the catheter. CNA H intervened and stopped Resident #72 from pulling the catheter further, and they finished repositioning her in the bed. CNA H said she thought she had cleaned both sides of Resident #72's front peri area. CNA H said when cleaning a resident with a catheter she should hold the tubing and wipe down it to clean it. CNA H said she should clean the peri area properly and the catheter tubing properly because they could have bacteria and germs and so the resident would not get an infection. CNA H said Resident #72 was on enhanced barrier precautions. CNA H said she was able to touch Resident #72's sheets and reposition her without gloves. CNA H said when providing care to Resident #72 she should be looking at the foley catheter tubing. CNA H said it was important to pay attention to where the foley catheter tubing was so it would not get pulled out and rupture something. During an interview on 11/06/2024 at 4:38 PM, ADON O said when providing incontinent care, the staff should wipe and toss, wipe and toss. ADON O said the same wipe should not be used to wipe multiple times because this could cause urinary tract infections. ADON O said anytime they went from dirty to clean, gloves should be changed. ADON O said hand hygiene should be performed in between glove changes. ADON O said if the staff were still cleaning the dirty, they could skip the hand hygiene in between. ADON O said hand hygiene should be performed at the required times to prevent the spread of infection. ADON O said for enhanced barrier precautions the staff did not have to wear glove if they were not touching the resident's skin. ADON O said the staff was able to touch the residents' surroundings with no gloves. ADON O said it was okay for CNA H to reposition and touch Resident #72's sheets without gloves. ADON O said when performing incontinent care, the CNAs should clean from inside/out, clean the foley from top to bottom. ADON O said they should clean the tube, but make sure they do not pull it. ADON O said the CNAs should be aware of where the catheter tubing was at all times, and they should be aware of where the residents' hands and limbs were. ADON O said it was important for them to be aware of where the foley catheter tube was because it could cause trauma, pain, injury, and it was a risk for infection. ADON O said when providing incontinent care, the CNAs should be trying to clean the residents completely. ADON O said it was important to keep the skin clean and to prevent infections. ADON O said the CNAs and any of the staff should have attempted to take out Resident #53's bagged, dirty briefs out of her bathroom. ADON O said the bagged, dirty briefs should not be left on the floor for cleanliness and hygiene, and they were a breeding ground of infection and bugs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676294	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2024
NAME OF PROVIDER OR SUPPLIER Heritage House at Paris Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 150 S.E. 47th Street Paris, TX 75462	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/06/2024 at 5:22 PM, the DON said gloves should be changed when going from dirty to clean. The DON said if the staff was cleaning the dirty, they removed their gloves, applied new ones, and kept cleaning the dirty, they did not have to perform hand hygiene. The DON said the staff should change gloves and hand sanitize after removing dirty linens. The DON said during incontinent care the CNAs were supposed to clean both sides on the front peri area, and they should be cleaning the foley catheter tubing when providing incontinent care on someone with a foley catheter. The DON said it was important to completely clean the residents and clean the catheter tubing to prevent urinary tract infections, infections, and skin breakdown. The DON said the CNAs should be paying attention to where the residents foley catheter tubing was located while providing incontinent care. The DON said it was important to prevent trauma and risk for infection. The DON said the CNAs practiced incontinent care on the mannequins, and she randomly observed the CNAs perform incontinent care. The DON said she had not noticed any issues with incontinent care. The DON said for enhanced barrier protections PPE and gloves should be worn when touching the residents' sheets and covering them up. The DON said it was important to follow the enhanced barrier precautions for infection control and to protect themselves from the quantity of infections going around. During an interview on 11/06/2024 at 5:50 PM, the Administrator said he expected for the staff to use hand hygiene and glove changes as necessary when needed. The Administrator said nursing administration was responsible for ensuring the staff perform proper hand hygiene and glove changes. The Administrator said he expected for the CNAs to provide proper incontinent care and fully clean the residents. The Administrator said he expected the CNAs to keep the residents from pulling the catheter tubing because this could cause trauma to the urethra (tube connected to the bladder for removal of urine). The Administrator said he expected for the staff to follow the enhanced barrier precautions. The Administrator said nursing administration was responsible for overseeing this. The Administrator said not following the enhanced barrier precautions could be a risk for contamination. Record review of the facility's policy titled, Urinary Catheter Management, review date 08/20/2021 indicated, Residents with indwelling catheters (urethral or suprapubic) shall receive appropriate care and services to prevent and manage catheter-related complications .Provide perineal/catheter care with a perineal cleanser or mild soap and water at least once daily and promptly after fecal soiling to reduce the potential for bacterial contamination . Record review of the facility's policy titled, Incontinence Care, review date 02/14/2020 indicated, .put on non-sterile, latex-free gloves .cleanse peri-area and buttocks with cleansing agent wiping from front of perineum toward rectum. Turn patient side to side to cleanse entire affected area, as needed. Rinse with water, if needed or per incontinent product manufacturer's instructions . remove and discard gloves 16. Wash hands 17. Apply clean linen/underpad, brief or other incontinent products, as needed . Record review of the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, accessed on 11/13/2024 indicated, .5a. Hand Hygiene .use an alcohol-based hand rub or wash with soap and water for the following clinical indications: immediately after glove removal . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Heritage House at Paris Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 150 S.E. 47th Street Paris, TX 75462	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the CDC's Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), accessed on 11/13/2024 indicated, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. 3. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: 1. Wounds or indwelling medical devices .

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	676294	A. Building B. Wing	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House at Paris Rehab & Nursing	150 S.E. 47th Street Paris, TX 75462

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46892 Based on interview and record review, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and providing written rationale, by the provider, when an antibiotic was used despite criteria, to determine the appropriate the use of an antibiotic for 1 of 4 residents (Resident #8) reviewed for antibiotic use. The facility failed to ensure Resident #8 had documented signs and symptoms to support the use of prescribed antibiotics. This failure could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections. The findings included: Record review of a face sheet dated 11/06/2024 indicated Resident #8 was an [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #8 was able to make herself understood and was able to understand others. The MDS assessment indicated Resident #8's BIMS score was 11, which indicated her cognition was moderately impaired. The MDS assessment did not indicate Resident #8 used antibiotics. Record review of Resident #8's care plan with a target date of 02/09/2025 did not address the use of antibiotics or cellulitis (skin infection). Record review of Resident #8's Order Summary Report dated 11/06/2024 indicated Doxycycline Monohydrate (antibiotic) 100 mg give 1 capsule by mouth two times a day for cellulitis to left lower extremity for 7 Days was completed with a start date of 10/23/2024 and end date 10/30/2024. Record review of the progress notes, from 10/14/2024 to 10/23/2024, indicated Resident #40 had no documentation of signs or symptoms of an infection to indicate antibiotic use. Record review of the Revised McGeer Criteria for Infection Surveillance Checklist (checklist used to monitor for proper antibiotic use), date of infection 10/23/2024, date reviewed 10/24/2024 for doxycycline twice daily for 7 days for cellulitis, indicated Resident #8 did not meet the criteria for antibiotic use for cellulitis, soft tissue, or wound infection. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/2024 at 4:51 PM, ADON O said she was the infection control preventionist, and she monitored and completed the tracking and tools used to ensure proper antibiotic use. ADON O said she was aware Resident #8 did not meet criteria for antibiotic use. ADON O said she had been working with the nurses to ensure they were properly documenting signs and symptoms of infections and she felt like there had been an improvement. ADON O said if the doctor ordered an antibiotic, they had to follow the doctor's orders. ADON O said she had provided the Medical Director with education regarding proper antibiotic use verbally, but she did not have any documentation of education she had provided to him. ADON O said it was important for the criteria for antibiotic use to be followed to ensure antibiotics were not used improperly. During an interview on 11/06/2024 at 5:38 PM, the DON said she was aware some of the antibiotics used were not meeting criteria. The DON said they were working on the tools for infection surveillance, but if the doctor prescribed an antibiotic, they gave it. The DON said signs and symptoms of infection and location should be documented by the nurses. The DON said it was important for the criteria for antibiotic use to be followed to make sure the residents had a good quality of life, and that the disease process was cured. The DON said giving antibiotics that did not meet criteria could lead to c. diff (c. difficile, bacterial infection usually a result of antibiotic use), super infections, and MRSA (methicillin-resistant Staphylococcus aureus, bacteria resistant to antibiotics). During an interview on 11/06/2024 at 6:00 PM, the Administrator said nurse management was responsible for antibiotic stewardship, and he expected for them to follow the policy and procedure. The Administrator said it was important for the policy and procedure on antibiotic stewardship to be followed so antibiotics were not overused. Record review of the facility's policy titled, Infection Prevention and Control Program, revised 03/26/2024, indicated, . a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility .7. Antibiotic Stewardship: a. An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program. b. Antibiotic use protocols and a system to monitor antibiotic use are implemented as part of the antibiotic stewardship program. c. The Infection Preventionist, with oversight from the Director of Nursing, serves as the leader of the antibiotic stewardship program. d. The Medical Director, consultant pharmacist, and laboratory manager will serve as resources for the antibiotic stewardship program .