

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/04/2026
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 5 (Resident #3) residents reviewed for quality of care. The facility failed to ensure that the Wound Care Treatment Nurse K notified the physician when Resident #3 was noted to have an open wound to the right side of his scrotum on 02/02/2026. This failure could place residents at risk of complications which include worsening existing wounds, development of new wounds, and infection. Findings included: Record review of a face sheet dated 02/04/2026 indicated Resident #3 was an [AGE] year old male admitted to the facility on [DATE] with diagnoses which included venous insufficiency peripheral (lack of oxygen to the extremities) hypertension (high blood pressure), neuromuscular dysfunction of the bladder (nerve damage to the brain, spinal cord, or peripheral nerves disrupts the normal communication between the nervous system and the bladder resulting in urinary incontinence or retention), pressure ulcer of the right heel, non-pressure chronic ulcer of the back, diabetes mellitus due to underlying condition without complications (condition results from insufficient production of insulin, causing high blood sugar due to other conditions), benign prostatic hyperplasia without lower urinary tract symptoms (enlarged prostate), infection and inflammatory reaction due to indwelling urethral catheter. Record review of Resident #3's quarterly MDS assessment dated [DATE], indicated he was able to make himself understood and understood others. The MDS assessment indicated Resident #3 had a BIMS score of 03, indicating his cognition was severely impaired. The MDS assessment indicated Resident #3 had a urinary catheter and was always incontinent of bowel. The MDS assessment indicated Resident #3 was dependent with lower body dressing, taking off footwear and sitting to lying/lying to sitting, and personal hygiene. The MDS indicated Resident #3 was at risk for developing pressure ulcers/injuries and had unhealed pressure ulcers/skin injuries. Record review of Resident #3's comprehensive care plan dated 11/5/2025 and revised on 11/05/2025, indicated Resident #3 was incontinent of bowel/bladder with interventions for weekly skin checks to monitor for redness, circulatory problems, breakdown, or other skin concerns. The care plan indicated to report any new skin conditions to the physician. Record review of Resident #3's order summary report dated 02/04/2026, with active orders as of 08/01/2025, indicated Resident #3 had an order to perform head to toe skin assessment, document any changes in skin integrity in the medical record on Friday for wound prevention/early identification with a start date of 08/01/25. The order indicated to notify the physician with any changes in skin integrity. During an interview on 02/03/2026 at 07:30 AM, Resident #3 said he was experiencing some pain in his down there area the last couple of days. Resident #3 said he was not sure what was going on down there but the nurse and aides had looked at him yesterday and assisted him with the situation and offered him pain medication. Resident #3 said the wound care treatment nurse had not been to see him yet today that he could remember. Record review of Resident #3's progress note dated 02/02/2026 at 05:32 PM did indicate a new open area to right posterior lower leg with hospice physician notified and new order received noted by Wound Care Treatment Nurse K. Record review of Resident #3's progress note dated 02/03/2026 at (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0580 Level of Harm - Actual harm Residents Affected - Few	06:47 AM indicated awaiting a call back from hospice for any new orders. Will refer this area to wound care specialist during rounds on Thursday signed by Wound Care Treatment Nurse K During an interview on 02/03/2026 at 09:10 AM, the Wound Care Treatment Nurse K stated Resident #3 had an area on his penis that looked slightly ulcerated (open painful sore) during wound care on 02/02/2026. The Wound Care Treatment Nurse K stated she called the hospice nurse on 02/02/2026 and did not document it. The Wound Care Treatment Nurse K stated she did not notify the physician because she had notified hospice. During an interview and observation on 02/03/2026 at 09:15 AM, Resident #3 had an open area approximately the size of a nickel on the right side of the scrotum. There was no bandage noted upon removal of Resident #3's disposable brief. The Wound care Treatment Nurse K said the area on Resident #3's scrotum was not as opened yesterday. Attempted telephone call on 02/03/2026 at 09:30 AM to the hospice nurse, left message and requested a call back. Attempted telephone call on 02/03/2026 at 10:00 AM to the hospice nurse, left message and requested a call back. Attempted telephone call on 02/03/2026 at 10:10 AM to the Resident #3's responsible party/family member, left message and requested a call back. During an interview on 02/03/2026 at 10:30 AM, CNA G stated she had assisted the Wound Care Treatment Nurse K on 02/02/2026 for Resident #3. CNA G stated the nickel sized opened area on the right side of Resident #3's scrotum was present at that time. Record Review of hospice progress notes dated 02/04/2026 indicated on Monday, 02/02/2026 SN was notified by Wound Care Treatment Nurse K of redness noted to penis at foley catheter insertion. The hospice progress note did not indicate notification of the new open area to Resident #3's right side of the scrotum. During an interview on 02/04/2026 at 01:06 PM, the physician stated that he had seen Resident #3 on 02/03/2026 after the facility notified him that morning regarding the new development of wound area on the right side of Resident #3's scrotum and diagnosed him with cellulitis (a rare but severe bacterial infection causing rapid swelling, intense pain, warmth and redness) of the penis. The physician stated the area is pus filled abscess that had surfaced and opened. The physician stated that Resident #3 often refused care by the staff, and these types of situations can occur from poor hygiene. The physician stated he did not feel the facility was responsible or had any fault with the development of the abscess. The physician stated he did not feel the resident could endure the treatment needed at bedside to incise the abscess for drainage and had suggested to the family to do the procedure inpatient at the hospital. The physician stated the family had notified him on 02/04/2026 to move forward to transfer the resident for the procedure to the hospital. The physician stated that he was not notified on 02/02/2026 by the facility or hospice of any new wound developments involving Resident #3's penis/scrotum area. The physician stated he expected the facility to notify him so care could be coordinated between entities and advocate for the resident's health and well being as quickly as possible to be proactive in the care. During an interview on 02/04/2026 at 01:40 PM, the DON stated the facility notified the hospice. The DON stated the facility always notifies the hospice if the resident is on hospice because sometimes family members would rather have the hospice physician make the new orders of care and prevent overlapping care. The DON stated she had seen the hospice nurse in the facility that evening on 2/2/2026. The DON said she assumed the Wound Care Treatment Nurse K had notified the hospice nurse that day and was waiting to receive orders. The DON stated she expected all nursing staff to document and report any changes in condition as they are found to prevent any further decline in resident's health and well-being. During an interview on 02/04/2026 at 02:50 PM, the Administrator said he expected the clinical staff to document and report timely to the physician, and family when appropriate - any changes of condition to prevent decline in health status. Record review of the facility's policy titled Notification of Changes with a revised date of 01/10/2020, indicated. To provide guidance on when to communicate acute changes in status to physician/nurse practitioner, and/responsible party. The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or appropriate family member(s) of the following: 3. A significant change in the physical, mental or psychosocial status of the resident. assessment of the skin area is documented in the clinical software.		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 5 (Resident #3) residents reviewed for quality of care. The facility failed to ensure that CNA L notified the charge nurse of Resident #3's open wound on the right side of the scrotum on 02/01/2026. This failure could place residents at risk of complications which include worsening of existing wounds, development of new wounds, and infection. Findings included: Record review of a face sheet dated 02/04/2026 indicated Resident #3 was an [AGE] year old male admitted to the facility on [DATE] with diagnoses which included venous insufficiency peripheral (lack of oxygen to the extremities) hypertension (high blood pressure), neuromuscular dysfunction of the bladder (nerve damage to the brain, spinal cord, or peripheral nerves disrupts the normal communication between the nervous system and the bladder resulting in urinary incontinence or retention), pressure ulcer of the right heel, non-pressure chronic ulcer of the back, diabetes mellitus due to underlying condition without complications (condition results from insufficient production of insulin, causing high blood sugar due to other conditions), benign prostatic hyperplasia without lower urinary tract symptoms (enlarged prostate), infection and inflammatory reaction due to indwelling urethral catheter. Record review of Resident #3's quarterly MDS assessment dated [DATE], indicated he was able to make himself understood and understood others. The MDS assessment indicated Resident #3 had a BIMS score of 03, indicating his cognition was severely impaired. The MDS assessment indicated Resident #3 had a urinary catheter and was always incontinent of bowel. The MDS assessment indicated Resident #3 was dependent with lower body dressing, taking off footwear and sitting to lying/lying to sitting, and personal hygiene. The MDS indicated Resident #3 was at risk for developing pressure ulcers/injuries and had unhealed pressure ulcers/skin injuries. Record review of Resident #3's comprehensive care plan dated 11/5/2025 and revised on 11/05/2025, indicated Resident #3 was incontinent of bowel/bladder with interventions for weekly skin checks to monitor for redness, circulatory problems, breakdown, or other skin concerns. The care plan indicated to report any new skin conditions to the physician. Record review of Resident #3's order summary report dated 02/04/2026, with active orders as of 08/01/2025, indicated Resident #3 had an order to perform head to toe skin assessment, document any changes in skin integrity in the medical record on Friday for wound prevention/early identification with a start date of 08/01/25. The order indicated to notify the physician with any changes in skin integrity. During an interview on 02/03/2026 at 07:30 AM, Resident #3 said he was experiencing some pain in his down there area the last couple of days. Resident #3 said he was not sure what was going on down there but the nurse and aides had looked at him yesterday and assisted him with the situation and offered him pain medication. Resident #3 said the wound care treatment nurse had not been to see him yet today that he could remember. Record review of Resident #3's progress note dated 02/02/2026 at 05:32 PM did indicate a new open area to right posterior lower leg with hospice physician notified and new order received noted by Wound Care Treatment Nurse K. Record review of Resident #3's progress note dated 02/03/2026 at 06:47 AM indicated awaiting a call back from hospice for any new orders. Will refer this area to wound care specialist during rounds on Thursday signed by Wound Care Treatment Nurse K During an interview and observation on 02/03/2026 at 09:15 AM, Resident #3 had an open area approximately the size of a nickel on the right side of the scrotum. There was no bandage noted upon removal of Resident #3's disposable brief. The Wound care Treatment Nurse K said the area on Resident #3's scrotum was not as opened yesterday. During an interview on 02/03/2026 at 10:45 AM, CNA L stated he had worked Sunday, 02/01/2026. CNA L stated that he had noticed the opened skin area on the right side of Resident #3's scrotum. CNA L stated that he had not reported to the nurse because the area had powder and cream on it, and he thought it had already been addressed. CNA L stated he should have reported to the nurse to be sure and to prevent any (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	further decline in Resident #3's condition. During an interview on 02/03/2026, at 11:00 AM, LPN F stated she was not notified of any new areas of concern and had not noticed any opened area to the right side of Resident #3's scrotum over the weekend shift while she worked. LPN F stated Resident #3 was sent out to the hospital on [DATE] at the request of the family and the physician for further treatment of the abscess. Record Review of hospice progress notes dated 02/04/2026 indicated on Monday, 02/02/2026 SN was notified by Wound Care Treatment Nurse K of redness noted to penis at foley catheter insertion. The hospice progress note did not indicate notification of the new open area to Resident #3's right side of the scrotum. During an interview on 02/04/2026 at 01:06 PM, the physician stated that he had seen Resident #3 on 02/03/2026 after the facility notified him that morning regarding the new development of wound area on the right side of Resident #3's scrotum and diagnosed him with cellulitis (a rare but severe bacterial infection causing rapid swelling, intense pain, warmth and redness) of the penis. The physician stated the area is pus filled abscess that had surfaced and opened. The physician stated that Resident #3 often refused care by the staff, and these types of situations can occur from poor hygiene. The physician stated he did not feel the facility was responsible or had any fault with the development of the abscess. The physician stated he did not feel the resident could endure the treatment needed at bedside to incise the abscess for drainage and had suggested to the family to do the procedure inpatient at the hospital. The physician stated the family had notified him on 02/04/2026 to move forward to transfer the resident for the procedure to the hospital. The physician stated that he was not notified on 02/02/2026 by the facility or hospice of any new wound developments involving Resident #3's penis/scrotum area. The physician stated he expected the facility to notify him so care could be coordinated between entities and advocate for the resident's health and well being as quickly as possible to be proactive in the care. During an interview on 02/04/2026 at 01:40 PM, the DON stated the facility notified the hospice. The DON stated the facility always notifies the hospice if the resident is on hospice because sometimes family members would rather have the hospice physician make the new orders of care and prevent overlapping care. The DON stated she had seen the hospice nurse in the facility that evening on 2/2/2026. The DON said she assumed the Wound Care Treatment Nurse K had notified the hospice nurse that day and was waiting to receive orders. The DON stated she expected all nursing staff to document and report any changes in condition as they are found to prevent any further decline in resident's health and well-being. During an interview on 02/04/2026 at 02:50 PM, the Administrator said he expected the clinical staff to document and report timely to the physician, and family when appropriate - any changes of condition to prevent decline in health status. Record review of the facility's policy titled Notification of Changes with a revised date of 01/10/2020, indicated. To provide guidance on when to communicate acute changes in status to physician/nurse practitioner, and/responsible party. The facility will immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or appropriate family member(s) of the following: 3. A significant change in the physical, mental or psychosocial status of the resident. assessment of the skin area is documented in the clinical software.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that residents are fully informed and understand their health status, care and treatments. Based on observation, interview, and record review the facility failed to keep residents informed, in advance, of the care to be furnished and the type of care giver or professional that would furnish the care for 14 of 18 residents reviewed for laboratory services. (Anonymous Residents #1, AR#2, AR #4, AR#5, AR#7, AR#8, AR#9, AR#10, AR#11, AR#12, AR#14, AR#15, AR#16, and AR#17) 1.The facility failed to protect and promote the rights of Anonymous Residents #1, AR#2, AR #4, AR#5, AR#7, AR#8, AR#9, AR#10, AR#11, AR#12, AR#14, AR#15, AR#16, and AR#17 by failing to keep them informed of medical procedures and results. This failure could place residents at risk of decreased psychosocial wellbeing, decreased privacy and decreased quality of life.The findings included:During a record review on 02/03/2026 at 9:45 a.m. of the forms titled 'Resident Council Minutes', dated September 2025 through December 2025 revealed no documented concerns from the residents about being informed of medical procedures or staff entering their rooms without permission.During a record review on 02/03/2026 at 10:00 a.m. of the facility grievance log dated February 2025 through February 2026 showed no grievances related to informing residents of medical procedures or staff entering their rooms without permission.During a record review on 02/03/2026 at 10:15 a.m. of the facility in-service binder, no in-services were noted related to informing residents of medical procedures such as labs and x-rays, informing residents of medical procedure results, or not entering resident's rooms until they have been given permission to enter by the resident.During a confidential interview at an undisclosed date and time, AR#1 stated they had been to the DON and Administrator with concerns that he and the other residents were not kept informed of medical procedures, such as labs and x-rays prior to them being performed. AR #1 stated it startled them each time someone came in in the middle of the night to take their blood. AR #1 stated the facility was not informing the residents of the results of their medical procedures. AR #1 stated he spoke with the DON on 01/22/2026 regarding the concerns and the Administrator on 01/29/2026 when he had no response for the DON. AR#1, AR#2, AR#4, AR#5, AR#7, AR#8, AR#9, AR#10, AR#11, AR#12, AR#14, AR#15, AR#16, and AR#17, stated they are not being informed of lab draws, x-rays or doppler studies done within the facility prior to the outside individual showing up to perform the procedures and it made them feel scared and uneasy.During an interview on 02/04/2026 at 10:15 a.m., the DON stated she was not informed of the residents having a concern about not being aware of the days the lab technician drew blood. She stated she was also not aware of the resident concern about x ray and dopplers being performed without their prior knowledge. She stated had she been made aware of this concern, she would have filled out a grievance form and followed up with the complaint of the resident or family member. The DON stated the resident's responsible party was informed of all new orders including labs and x-rays. She stated routine labs are done without notification of the residents or family because they were notified when the new order came in. The DON stated she could understand it may be frightening to the residents to see an unfamiliar face when the lab or x-ray technician showed up in the middle of the night.During an interview on 02/04/2026 at 11:00 a.m., LPN F stated she did not inform the residents only the responsible party of new orders for labs and x-rays. She stated she did not go down a list and inform the residents that they were due for labs that day or that they would be getting labs drawn. LPN F stated she was not certain how the residents being uninformed of when their labs would be drawn could negatively impact them. During an interview on 02/04/2026 at 11:30 a.m., the Administrator stated he was informed that one resident had concerns about what labs were being drawn. He stated when he interviewed the resident, the resident explained he was frightened by a stranger entering his room in the middle of the night because no one explained the way the lab worked in a long-term care facility. The Administrator stated he explained the process, and he felt the issue had been resolved. He stated the resident spoke with him around 01/29/2026. He stated his expectation was for nursing staff to explain procedures to residents that would understand and keep them informed on their health status.Review of a facility policy titled (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dignity dated 2021 indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. When assisting with care, residents are supported in exercising their rights.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interviews, and record review, the facility failed to follow the menu to ensure the meals served met the nutritional needs of residents for 1 of 1 meal (the lunch meal), as evidenced by: The facility failed to ensure the Dietary Manager followed the menu for the lunch meal on 02/02/2026. This failure could place residents at risk of weight loss, not having their nutritional needs met, and a decreased quality of life. Findings included: During record review of a facility menu dated 02/02/2026 indicated the meal menu for the day was roast breast of turkey and gravy, savory bread stuffing, green bean casserole, and buttered dinner roll served with margarine, chocolate pudding cake. (Cycle: Texas 6 Week 4 Regular) During an observation of the lunch meal on 02/02/2026 at 12:15 p.m., the residents were served turkey and gravy, bread stuffing, green bean casserole, chocolate pudding cake. The residents were not served a dinner roll. During an interview on 02/02/2026 at 12:25 p.m., the Dietary Manager said there were no rolls to serve any residents in the facility with the lunch meal. The Dietary Manager said there should have been a substitution made such as a slice of bread to ensure the caloric content was the same value as the menu indicated to prevent nutritional weight loss. During an interview on 02/04/2026 at 2:50 PM., the DON said there were no rolls to be served to the residents because the delivery truck was unable to get into the parking lot due to the ice and snow the previous week. The DON said it was important to follow the menus to prevent weight loss. During an interview on 02/04/2026 at 3:00 PM, the ADM stated he expected dietary staff to follow the menu and the recipes for the facility's meals. The ADM stated he expected the Dietary Manager to ensure menus were printed for each meal. The ADM stated the importance of following the meal plans was to ensure residents had the appropriate nutrients. Record review of the Menus Changes and Substitutions policy, last revised on 08/02/2017 indicated, Any variation from the planned menu will be properly documented by the Dietary Services Manager and reviewed and signed by the Dietitian. Fundamental Information: Substitutions are generally necessary when an item needed to prepare the planned menu item is not available.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and interview, the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 7 of 18 anonymous residents reviewed for resident rights (Anonymous Resident (AR) AR#7, AR#8, AR#10, AR#12, AR#13, AR#16, AR#18). The facility failed to protect and promote the rights of Anonymous Residents #7, AR #8, AR #10, AR#12, AR#13, AR#16, and AR#18 by failing to wait for permission to enter the resident's room after knocking. These failures could place residents at risk for decreased self-esteem, decreased privacy and decreased quality of life. The findings included: During a confidential interview at an undisclosed date and time, AR #7 stated they have in the past requested the staff wait for permission to enter their room after knocking. She stated the day before she was sitting on the toilet and the staff member (LVN C) knocked and came into the room with the lunch tray. She stated she was embarrassed, but she was getting used to the staff just coming in no matter what. During a confidential interview at an undisclosed date and time, AR# 13 stated staff knocked and came into the room in the middle of her getting dressed this morning to open her blinds (ADON D) and bring in daylight. AR#13 stated they were completely capable of opening their own blinds and letting their own sunshine into the room when they were ready for it. During an observation and confidential interview at an undisclosed date and time, AR #8 was being interviewed behind a closed door by this state surveyor. ADON D knocked on the door and opened it without waiting for permission. She advanced into the room and opened the blinds and told AR#8 to have a good day and exited the room leaving the door open. AR#8 stated I am so sorry she did that, it was very disrespectful. All the staff just burst into the room without waiting for me to say come in. I bet they would be really upset if someone did that to them in their bedroom. AR#8 stated staff not waiting for permission to come in happens multiple times daily, especially when they are passing meal trays out. During an observation on 02/02/2026 at 11:40 a.m., LVN C entered 4 rooms (AR#7, #10, #12, and #18) without waiting for the resident's permission while passing lunch trays. During an interview on 02/02/2026 at 12:00 p.m., LVN C stated she knocked on the door and announced she had their lunch tray prior to entering the room. She stated she does not always wait for the residents to respond because sometimes they are asleep, and she needed to wake them to eat lunch while it was hot. She stated it is the resident's choice to eat when they want, and she would not like it if someone delivering food knocked and came on in her house. She stated she would feel disrespected and frightened. During an interview on 02/03/2026 at 2:20 p.m., ADON D stated she had not realized she was walking into the room without permission. She stated she knocks and greets the residents and opens their blinds to bring in light to start their day. She stated she would not like it if someone walked into her bedroom without permission or in the middle of a conversation with someone else. During an interview on 02/04/2026 at 10:15 a.m., the DON stated she was unaware the staff was walking into the residents' rooms without waiting for permission to enter. She stated it was a violation of their dignity to be barged in on. She stated it was her expectation that all staff wait to be welcomed in by any resident capable of welcoming them. The DON stated the resident could feel embarrassed or angry for the intrusion. During an interview on 02/04/2026 at 11:15 a.m., the Administrator stated it was his expectation for all residents to be treated with dignity and respect and for the staff to treat the facility as the resident's home. He stated he expected all doors to be knocked on and no one to enter the rooms of the residents without permission. He stated many staff members would be highly offended if someone just walked into their home with permission. Review of a facility policy titled Dignity dated 2021 indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. When assisting with care, residents are supported in exercising their rights.		

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 02/04/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 (Resident #7, Resident #29, and Resident #67) of 18 residents reviewed for care plans. Resident #7 had no care plan developed for her bilateral lower extremity limited range of motion. The care plan for Resident #29 had interventions for a fall mat at bedside that was not implemented. Resident #67 had no care plan developed for his left lower extremity contracture. These failures could place residents at risk of not having their individualized needs met, falls, decreased range of motion and a decline in their quality of care and life. Findings included: 1. Record review of an undated face sheet revealed Resident #7 was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of Wernicke's Encephalopathy (an acute, life-threatening neurological emergency caused by a severe deficiency of thiamine (vitamin B1) commonly associated with alcohol use disorder or malnutrition), diabetes type II (a chronic metabolic disorder occurring when the body becomes resistant to insulin or fails to produce enough, leading to high blood sugar), and chronic pain (persistent discomfort lasting longer than three to six months, often continuing beyond the expected healing time of an initial injury). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #7 had a BIMS of 99 which indicated the inability of the resident to participate in the assessment and severe cognitive impairment. Resident #7 was dependent for ADLs such as toileting, transfer, and bathing. Resident #7 had limited range of motion to her bilateral (right and left) lower extremities. Record review of a care plan dated 01/06/2026 revealed no care plan for Resident #7's limited range of motion to her bilateral lower extremities. During an observation and interview on 02/03/2026 at 8:45 a.m. Resident #7 was lying in bed and stated she had trouble moving her legs. She stated she could wiggle her toes, but she could not move her ankles or knees well. She stated no one exercised her legs anymore since she was no longer in therapy. She stated her legs were only painful if she sat up in the wheelchair too long. 2. Record review of an undated face sheet revealed Resident #29 was a [AGE] year-old female admitted on [DATE] with the diagnoses bipolar disorder (a chronic mental illness characterized by extreme mood swings, ranging from high-energy mania/hypomania to low-energy depression, which impair daily functioning), major depression (a serious, common mood disorder characterized by persistent, severe sadness, loss of interest, and physical symptoms like fatigue, lasting at least two weeks), and anxiety (intense, excessive, and persistent worry that interferes with daily life, causing symptoms like restlessness, rapid heartbeat, sweating, trouble sleeping, and difficulty concentrating). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #29 had a BIMS of 99 which indicated severe cognitive impairment. Resident #29 required dependent assistance for ADLs such as toileting, transfer, and bathing. Resident #29 had two or more falls in the last 90 days with no injury. Record review of a care plan dated 08/13/2025 titled '?High Fall Risk' revealed Resident #29 had an intervention from previous falls to have a fall mat beside bed. Record review of the consolidated physician orders dated 02/03/2026 revealed Resident #29 had an order for a fall mat beside bed when in bed started on 09/05/2025. Record review of an incident report dated 09/05/2025 revealed Resident #29 rolled out of bed and was observed lying beside the bed on the floor. Record review of an incident report dated 11/04/2025 revealed Resident #29 rolled out of bed and was observed lying on the fall mat beside the bed. Record review of an incident report dated 11/05/2025 revealed Resident #29 rolled out of bed and was observed lying on the fall mat beside the bed. During an observation and interview on 02/03/2026 at 9:00 a.m., Resident (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#29's fall mat was noted to be propped against the wall across the room. Resident #29 stated the staff sometimes forget to put the mat back down after they mop. Resident #29 explained she had the fall mat because she had fallen out of bed a few times in the past. During an observation on 02/03/2026 at 11:15 a.m., Resident #29's fall mat remained propped against the wall across the room from the resident. During an observation on 02/03/2026 at 2:40 p.m., Resident #29's fall mat remained propped against the wall across the room from the resident. 3. Record review of an undated face sheet revealed Resident #67 was a [AGE] year-old male admitted on [DATE] with the diagnoses CVA (Cerebrovascular Accident (CVA), commonly known as a stroke, occurs when blood flow to the brain is interrupted, causing brain cells to die), atrial fibrillation (the most common heart arrhythmia, causing the heart's upper chambers to quiver chaotically instead of beating effectively), and dementia (a general term for a progressive decline in memory, thinking, and behavior, severe enough to interfere with daily life, usually caused by neurodegenerative diseases like Alzheimer's). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #67 had a BIMS of 13 which indicated no cognitive impairment. Resident #67 required substantial assistance (helper does more than half of work) for ADLs such as toileting, transfer, and bathing. Record review of Resident #67's consolidated physician orders dated January 2026, revealed the following order dated 05/02/2025: Apply knee brace to left leg daily. Remove only during bathing or patient care. Re apply after treatment to prevent progression of joint contracture due to flexor spasticity (a type of increased muscle stiffness where muscles, often in the arms or legs, involuntarily contract and stay in a bent or flexed position, making it hard to straighten the limb) from old CVA. Record review of the care plan dated 01/20/2026 revealed no care plan for Resident #67's left knee contracture or brace usage. During an interview on 02/03/2026 at 10:15 a.m., Resident #67 stated the staff used to put the brace on everyday but had not done so in the last couple of months. He stated before Christmas was the last time he recalled a nurse putting it on him. He stated he was unsure if the knee contracture had gotten worse because he did not feel much in that knee and never tried to walk on it anymore. During an interview on 02/03/2026 at 3:40 p.m., MDS Coordinator B stated care plans were to include all things that were coded on the MDS. She stated they should be reviewed by the nursing staff to know the individual care instructions for each resident. She stated not care planning an important item like a contracture with the interventions could result in the staff not knowing what is needed for the management of the contracture to prevent it from becoming worse. She stated she felt like leaving the contracture and knee brace off of the care plan was an oversight. She stated Resident #7's limited ROM not being care planned could lead to the staff being unaware she needs passive ROM performed during ADL care. During an interview on 02/04/2026 at 11:00 a.m., the DON stated it was the floor nurse and the administrative nurses' responsibility to ensure that staff was educated about interventions for all aspects of the resident's care. She stated without interventions for contracture management, Resident #67's contracture could worsen causing pain and decreased quality of life. During an interview on 02/04/2026 at 2:00 p.m., the ADM stated he expected the staff to follow the interventions decided on by the MDS coordinator and interdisciplinary team. He stated the interventions were in place to keep everyone safe and prevent accidents. He stated not following the interventions could decrease the resident's quality of life. Record review of a facility policy undated titled ?Comprehensive Care Planning revealed The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The facility will establish, document, and implement the care and services to be provided for each resident to assist in attaining or maintaining his or her highest practical quality of life.		

Department of Health & Human Services
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an accurate MDS assessment was completed for 1 of 18 residents reviewed for MDS accuracy. (Resident #17) The facility failed to accurately code Resident #17's use of high-risk drug class medications (drug classes, including antipsychotics, anticoagulants, benzodiazepines, hypnotics, opioids, antiplatelets, hypoglycemics (including insulin), diuretics, and, newly added, anticonvulsants). This failure could place residents at risk of not receiving needed care and services. Findings included: Record review of an undated face sheet revealed Resident #17 was a 72- year-old- female, admitted on [DATE] with the diagnoses CHF (congestive heart failure- is a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), anxiety (intense, excessive, and persistent worry that interferes with daily life, causing symptoms like restlessness, rapid heartbeat, sweating, trouble sleeping, and difficulty concentrating), and dementia (a general term for a progressive decline in memory, thinking, and behavior, severe enough to interfere with daily life, usually caused by neurodegenerative diseases like Alzheimer's). Record review of a quarterly MDS assessment dated [DATE] for Resident #17 revealed a BIMS of 09, which indicated moderate cognitive impairment. The MDS also revealed Resident #17 required dependent level assistance with bed mobility, transfer, and toileting. The MDS revealed Resident #17 had not taken any high-risk drug class medications. Record review of Resident #17's consolidated physician orders dated 11/01/2025 revealed the following orders: Sertraline (antidepressant) 100mg once daily, start date 08/13/2025 Torsemide (diuretic) 20mg once daily, start date 08/13/2025 Seroquel (antipsychotic) 25 mg twice daily, start date 10/24/2025 Record review of the MAR dated November 2025 revealed Resident #17 received the following medications each day: Sertraline (antidepressant) 100mg once daily Torsemide (diuretic) 20mg once daily Seroquel (antipsychotic) 25 mg twice daily. Record review of care plan dated 08/13/2025 revealed Resident #17 used psychotropic medications: antidepressants and antipsychotics daily. A care plan also dated 08/13/2025 revealed Resident #17 used diuretic medications daily for congestive heart failure. During an interview on 02/03/2026 at 3:15 p.m., MDS Coordinator B revealed that Resident #17 received sertraline, torsemide and Seroquel each day during the month of November 2025. She stated those medications should have been coded on the MDS to capture the items for a complete representation of the resident's care. She stated not coding them could lead to not including them on the care plan which is the blueprint for individualized resident care. She stated the miscoding was an oversight. During an interview on 02/04/2026 at 11:00 a.m., the Administrator stated it was the responsibility of the MDS Nurse to produce accurate MDSs and care plans. The Administrator stated accuracy is important for revenue as well as to ensure the facility was reporting the correct information to CMS on the quality measures. During a record review of the facility's undated Minimum Data Set Policy for MDS assessment Data Accuracy, revealed the purpose of the MDS policy was to ensure each resident received an accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being. The assessment should accurately reflect the resident's status.		

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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** 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 grooming and personal hygiene for 1 of 5 residents reviewed for ADLs (Resident #2). The facility failed to provide assistance for Resident #2 with the removal of facial hair on 02/02/2026. These failures could place residents at risk of not receiving services/care and decreased quality of life. Findings Include: 1. Record review of a face sheet dated 01/08/2026 indicated Resident # 2 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Parkinson disease (progressive neurodegenerative disorder impacts central nervous system), congestive heart failure (heart cannot pump blood well enough to supply your body), stiff-man syndrome (autoimmune disease - severe muscle stiffness), hypertension (high blood pressure). Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #2 usually understand and usually understood others. The MDS assessment indicated Resident #2 had a BIMS score of 11 which indicated moderate cognitive impairment. The MDS assessment indicated Resident #2 was dependent for all ADLs. Record review of the care plan with target date 02/17/2026 indicated Resident #2 had an activity of daily living (ADL) self-care performance deficit related to Parkinson disease with dyskinesia (involuntary, erratic, and uncontrollable muscle movements). The care plan indicated interventions included Resident #2 was dependent with bathing and required a shower, shave, oral care, hair care, and nail care provided per schedule and when needed. Record review of Resident #2's electronic medical record reflected CNA G gave Resident #2 a shower on Monday, 02/02/2026. Record review of the facility's schedules for resident shower indicated Resident #2 received showers on Monday, Wednesday and Fridays on the 6AM to 6PM shift. During an interview and observation on 02/02/2026 at 08:30 AM, Resident #2 said he was waiting for the aide because it was his shower day. Resident #2 had approximately one half inch facial hair growth and stated, he sure would like to be shaved and showered. A musty odor was noted upon entering Resident #2's room. Resident #2's top linen sheet had several dark brown circular stains. During an interview and observation on 02/03/2026 at 08:40 AM, Resident #2 had a clean-shaven-face, and he smiled when asked about it. Resident #2 stated he had been shaven on the morning of 02/03/2024. Resident #2 said the aide was going to come and get him for his shower in a little while. A musty odor was noted upon entering the room. Resident #2's top linen sheet continued to have the same noted dark brown circular stains. Resident #2 said his sheets had not been changed on 02/02/2026 or 02/03/2026. During an interview on 02/04/2026 at 09:15 AM, Resident #2 said he did not get a shower or his linens changed on yesterday's date. Resident #2 said the aide never came back to get him yesterday. A musty odor was noted upon entering the room. Resident #2's top linen sheet continued to have the same noted dark brown circular stains. During an interview on 02/4/2026 at 09:30 AM, CNA H said she was the shower aide unless the aides were shorthanded on the floor. CNA H said she was responsible for giving the residents showers. CNA H said there was a shower schedule posted at the nurse's station to let the CNAs know who needed a shower on what day. CNA H said it was important for residents to receive their showers so staff could observe their skin and to maintain the residents' cleanliness. CNA H said Resident #2 should have received a bath on Monday, Wednesday and Fridays. CNA H said she worked the halls on Monday therefore Resident #2 would have had a shower by CNA G. CNA H said CNA G had asked her to finish shaving Resident #2 on 02/03/2026, Tuesday morning, but she was not asked to shower Resident #2. CNA H said she was not aware if Resident #2 received a shower on 02/02/2026 or 02/03/2026. During an interview on 02/04/2026 at 02:15 PM, CNA G said she had not given a bath or changed the linens for Resident #2 on Monday or Tuesday. CNA G said she got busy and forgot with surveyors in the building. CNA G said she had documented on Monday that she gave Resident #2 a bath by mistake. CNA G said that she was assigned to Resident #2 but had failed to complete the shower as scheduled. CNA G said it was (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	important to give regular scheduled showers and baths to the residents for their dignity and cleanliness. During an interview on 02/02/2026at 2:50 PM, the DON said it was the CNAs responsibility to give the residents their showers and provide personal hygiene. The DON said there was a shower list that identified what resident received a shower on which day. The DON said the CNAs performed showers on the residents, but any of the nursing staff could and should perform showers when needed. The DON said she expected the CNAs to communicate with the charge nurses daily to ensure resident's needs were being met. The DON said if a resident refused, she expected staff to try again a couple times or send a different staff member to ask the resident. The DON said if a resident continued to refuse, she expected staff to report the refusal to the family and document the refusal. The DON said she was responsible to ensure the oversight of resident ?s being bathed and showered appropriately according to the resident's Plan of Care. The DON said the importance of the residents receiving their scheduled showers was to maintain dignity, hygiene, skin integrity, skin inspections and prevent skin infections. The DON said ultimately it was her responsibility to ensure the showers and personal hygiene were performed for the residents by the staff. During an interview on 02/04/2026 at 03:50 PM, the Administrator said he expected baths/showers as scheduled or as requested by the resident. The Administrator said clinical staff were responsible for making sure the baths/showers were provided for the residents. The Administrator said if the residents refused ADL care, the staff should educate the residents. The Administrator said if a resident refused, he expected staff to try again a couple times or send a different staff member to ask the resident. The DON said if a resident continued to refuse, he expected staff to report the refusal to the family and document the refusal. The Administrator said it was important for the residents to receive baths/showers for hygiene according to the resident's plan of care to make the residents feel good, infection control and dignity. Record review of undated facility policy and procedure titled, Activities of Daily Living Care Guidelines, reflected a resident who is 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 2 of 5 residents with limited range of motion (Resident #7 and Resident #67) Resident #7 had limited range of motion to bilateral lower extremities with no services to prevent further decrease in range of motion. Resident #67 had an order for a knee brace to prevent further contracture that was not carried out. These failures could place residents at risk of not having their individualized needs met, decreased range of motion and a decline in their quality of care and life. The findings included: 1. Record review of an undated face sheet revealed Resident #7 was a [AGE] year-old female admitted to the facility on [DATE] with the diagnoses of Wernicke's Encephalopathy (an acute, life-threatening neurological emergency caused by a severe deficiency of thiamine (vitamin B1) commonly associated with alcohol use disorder or malnutrition), diabetes type II (a chronic metabolic disorder occurring when the body becomes resistant to insulin or fails to produce enough, leading to high blood sugar), and chronic pain (persistent discomfort lasting longer than three to six months, often continuing beyond the expected healing time of an initial injury). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #7 had a BIMS of 99 which indicated the inability of the resident to participate in the assessment and severe cognitive impairment. Resident #7 was dependent for ADLs such as toileting, transfer, and bathing. Resident #7 had limited range of motion to her bilateral (right and left) lower extremities. Record review of a care plan dated 01/06/2026 revealed no care plan for Resident #7's limited range of motion to her bilateral lower extremities. Record review of the ADL sheet dated January 2026 for Resident #7 showed no range of motion exercises being performed. Record review of the ADL sheet dated February 2026 for Resident #7 showed no range of motion exercises being performed. During an observation and interview on 02/03/2026 at 8:45 a.m. Resident #7 was lying in bed and stated she had trouble moving her legs. She stated she could wiggle her toes, but she could not move her ankles or knees well. Resident #7 stated therapy used to exercise her legs, and it would help, but they had to stop. She stated no one had exercised her legs since she stopped therapy. She could not recall how long-ago therapy stopped. 2. Record review of an undated face sheet revealed Resident #67 was a [AGE] year-old male admitted on [DATE] with the diagnoses CVA (Cerebrovascular Accident (CVA), commonly known as a stroke, occurs when blood flow to the brain is interrupted, causing brain cells to die), atrial fibrillation (the most common heart arrhythmia, causing the heart's upper chambers to quiver chaotically instead of beating effectively), and dementia (a general term for a progressive decline in memory, thinking, and behavior, severe enough to interfere with daily life, usually caused by neurodegenerative diseases like Alzheimer's). Record review of a quarterly MDS assessment dated [DATE] revealed Resident #67 had a BIMS of 13 which indicated no cognitive impairment. Resident #67 required substantial assistance (helper does more than half of work) for ADLs such as toileting, transfer, and bathing. Record review of Resident #67's consolidated physician orders dated January 2026, revealed the following order dated 05/02/2025: Apply knee brace to left leg daily. Remove only during bathing or patient care. Re apply after treatment to prevent progression of joint contracture due to flexor spasticity (a type of increased muscle stiffness where muscles, often in the arms or legs, involuntarily contract and stay in a bent or flexed position, making it hard to straighten the limb) from old CVA. Record review of the administration records for Resident #67 revealed no order or documentation for the application or removal of the ordered brace. Record review of the care plan dated 01/20/2026 revealed no care plan for Resident #67's left knee contracture or brace usage. During an observation and interview on 02/02/2026 at 8:40 a.m., Resident #67 stated the staff was supposed to put the leg brace on him everyday because he had a bad knee on his left side that had started to draw up since his stroke. He (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the brace was over in the chair next to his bed. A long-hinged knee brace was noted under towels and a jacket in the chair next to Resident #67's bed. During an observation on 02/02/2026 at 11:30 a.m., Resident #67's knee brace remained in the chair beside his bed under a jacket and towels. During an observation on 02/02/2026 at 2:30 p.m., Resident #67's knee brace remained in the chair beside his bed under a jacket and towels. During an observation on 02/03/2026 at 8:30 a.m., Resident #67's knee brace remained in the chair beside his bed under a jacket and towels. During an interview on 02/03/2026 at 10:15 a.m., Resident #67 stated the staff used to put the brace on everyday but had not done so in the last couple of months. He stated before Christmas was the last time he recalled a nurse putting it on him. He stated he was unsure if the knee contracture had gotten worse because he did not feel much in that knee and never tried to walk on it anymore. During an interview on 02/04/2026 at 11:00 a.m., the DON stated it was the floor nurse and the administrative nurses' responsibility to ensure that staff was educated about interventions for all aspects of the resident's care. She stated without interventions for contracture management, Resident #67's contracture could worsen causing pain and decreased quality of life. She stated he recently started hospice services, and she was unsure if the brace would continue. The DON stated Resident #67 had limited ROM to her lower extremities because she did not like to get out of bed. She stated the facility did not have an official restorative nursing program, but she felt confident her staff did ROM exercises with the residents during ADL care. During an interview on 02/03/2026 at 3:40 p.m., MDS Coordinator B stated she was aware Resident #7 had limited range of motion to her bilateral lower extremities. She stated she was not sure who was doing range of motion exercises with her because the facility did not have a restorative nursing program and unless the resident was on therapy services the resident probably was not getting any range of motion exercises. She stated Resident #67 should have been getting the leg brace applied daily by nursing as ordered by the doctor. She stated she was unsure why he had not been wearing it. She stated no refusals were reported to her. During an interview on 02/04/2026 at 2:00 p.m., the ADM stated he expected the staff to follow the physician and nursing recommendations and perform ROM exercises to decrease the risk for contractures and contracture worsening on anyone with limited ROM. Facility policy requested for limited range of motion on 02/04/2026 at 2:30 p.m. None was provided prior to exit.		

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 02/04/2026
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 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** Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 out of 5 residents (Resident #35) reviewed for respiratory care. The facility failed to have Resident #35's oxygen sign outside the door on 02/02/2026 and 02/03/2026. This failure could place residents who receive oxygen for respiratory care at risk of safety accidents, including fire hazards and potential harm. Findings included: Record review of Resident #35's face sheet, dated 02/04/2026 indicated he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included, myopathies (a group of disorders causing primary dysfunction of skeletal muscle fibers causing progressive weakness), dementia (decline in cognitive abilities related to memory, language, and reasoning), dysphagia (difficulty swallowing), heart disease. Record review of Resident #35's comprehensive care plan, dated 02/04/2026, did not indicate, Resident #35 had oxygen usage. Record review of Resident #35's quarterly MDS assessment, dated 01/13/2026, indicated Resident #35 usually understood and was usually understood by others. Resident #35's BIMS score was 12, which indicated his cognition was moderately impaired. The MDS indicated Resident #35 required assistance with toileting, bed mobility, dressing, personal hygiene, transfers, and eating. The MDS indicated during the 7-day look-back period, he was not receiving oxygen. Record review of Resident #35's Physician order dated 02/01/2026 indicated oxygen at 2-4 liters via nasal cannula as needed for shortness of breath. During an observation on 02/02/2026 at 08:26 a.m., Resident #35 had oxygen on at 2 liters per nasal cannula. No oxygen sign was noted outside his door. During an observation on 02/02/2026 at 4:00 p.m., Resident #35 had oxygen on at 2 liters per nasal cannula. No oxygen sign was noted outside his door. During an observation on 02/03/2026 at 4:00 p.m., Resident #35 did not have on oxygen. The oxygen concentrator was observed at Resident #35's bedside. No oxygen sign was noted outside his door. During an observation and interview on 02/03/2026 at 04:10 p.m., CNA G said she was aware that the resident wore oxygen by the oxygen sign outside the door. She said the charge nurse usually put up the oxygen sign outside the door of the residents that had oxygen. CNA G said she could not recall if Resident #35 wore oxygen as he is a new resident and she just came onto shift. During an interview on 02/04/26 at 1:08 p.m., the ADON said all residents that require oxygen should have an oxygen sign on the door to prevent accidents and for the safety of the residents and staff. The ADON said she was not aware of Resident #35 did not have an oxygen notification sign on his door. She said Resident #35 had declined quickly and that had gone unnoticed. During an interview on 02/05/2026 at 02:50 p.m., the DON said any resident with oxygen use should have a sign on the door to notify the staff and visitors that oxygen was in use to prevent any safety hazards such as flames or fires. During an interview on 02/05/2026 at 03:00 p.m., the Administrator said all residents who require oxygen should have an oxygen sign on the door for the safety of residents and staff. Record review of the facility's policy titled Oxygen Administration, review date of 01/05/2020, indicated, Fundamental Information: During a respiratory emergency it is appropriate for nursing to administer oxygen immediately then notify. Oxygen signs remain on room doorway the entire time the oxygen source is in the patient room.		

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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** Based on 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 1 of 5 residents (Resident #9) reviewed for trauma-informed care. The facility did not ensure Resident #9 had an accurate trauma screen that identified possible triggers when Resident #9 had a history of trauma. This failure 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 02/04/2026 indicated Resident #9 was a [AGE] year-old female originally admitted to the facility on [DATE] with diagnoses which included Alzheimer's (progressive irreversible brain disorder), chronic obstructive pulmonary disease (difficulty breathing), Type 2 diabetes (high sugar in the bloodstream), 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), post-traumatic stress disorder (a mental health condition triggered by experiencing or witnessing terrifying, life threatening or violent content - lasting over a month). Record review of the Quarterly MDS dated [DATE] indicated Resident#9 understood others and was able to make herself understood. The MDS assessment indicated Resident #9 was independent for eating, toileting, personal hygiene, and required supervision/touching assistance with showering/bathing. The MDS assessment indicated Resident #9 used the wheelchair for mobility. The MDS assessment indicated Resident #9 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #9 had anxiety, depression and post traumatic Disorder. Record review of Resident #9's care plan revised 12/02/2025 indicated she had alteration in mood related to disease process, diagnosis of depression and anxiety. Resident #9's 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 physician any 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 sexual trauma. Record review of Resident #9's Comprehensive Trauma Screening with effective date 09/30/2022 completed by the previous social worker did not indicate Resident #9 had a history of trauma on Section C Question B. During an interview on 02/03/2026 at 10:00 AM, Resident #9 said she had a history of trauma, and she preferred not to discuss it with the surveyor because she had already told the facility about those incidents of her past and sometimes it still affects her sleep. During an interview on 02/03/2026 at 11:00 AM, the Social Worker said that she was not aware of Resident #9 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 #9's trauma assessment because she was new at the facility (started in April 2025). The Social Worker said addressing trauma informed care was important because it could affect the resident's well-being and quality of life, and how they interacted with staff and each other and it could affect their sleep. The Social Worker said the trauma assessment for Resident #9 should have been marked yes in Section C Question B based upon the answers reflected in Section 2 according to the assessment instructions. Section 2, question f of the Comprehensive Trauma assessment dated [DATE] was marked yes for have you ever been sexually assaulted. The Social worker said the care plan was (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updated by several different staff such as herself, MDS Nurse, DON or the ADONS. The Social Worker stated the care plan did not adequately reflect the trauma assessment but that she could update the care plans with the triggers associated with Resident #9's traumas. During an interview on 02/03/2026 at 11:15 AM, the MDS Nurse said the informed trauma assessment was inaccurately filled out, and the care plans should reflect the triggers associated with Resident #9's trauma. The MDS Nurse said it was important for history of trauma and triggers to be identified so that the staff would not trigger Resident #9's anxiety or go in her room and say something that was going to upset her because Resident #9 did have a lot of anxiety. During an interview on 02/04/2026 at 2:50 PM, the DON said she was not aware of Resident #9 having any sexual trauma. The DON said if Resident #9 had sexual 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. The DON said the trauma assessments are completed upon admission, and she feels it is impossible to back track before her employment started with the facility to ensure accuracy. During an interview on 02/04/2026 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. Record review of the facility's policy Trauma Informed Care dated 10/24/2022 Reflected, 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 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to store all drugs and biologicals in locked compartments for 1 of 21 residents reviewed. (Resident #50)The facility failed to securely store wound care treatment chemicals (Povidone-Iodine 10% Solution and .9% Sodium Chloride Irrigation Solution) for Resident #50.This failure could place residents at risk for adverse reactions.Findings included:Record review of Resident #50's face sheet dated 12/15/25 indicated Resident #50 was [AGE] years old and was admitted on [DATE] with diagnoses including Aphasia (a language disorder caused by brain damage), Hypertension (high blood pressure), Amputation of the right foot.Record review of the MDS dated [DATE]indicated Resident #50 could understand and was understood by others. The MDS indicated a BIMS score of 09 indicating Resident #50 had moderately impaired cognition.Record review of a care plan revised on 12/30/25 indicated Resident #50 has impaired cognition and was at risk of a further decline in cognitive and functional abilities related to: Dementia.During an observation on 2/2/26 at 8:51 a.m. Resident #50's room was observed with Povidone-Iodine 10% Solution and .9% Sodium Chloride Irrigation Solution in his room unsecured. Chemicals were in plain view and readily accessible to any individual in the building. Resident was not in room for interview. During an observation on 2/3/26 at 9:15 a.m. Resident #50's room was observed with Povidone-Iodine 10% Solution and .9% Sodium Chloride Irrigation Solution in his room unsecured. Chemicals were in plain view and readily accessible to any individual in the building. Resident was not in room for interview. During an interview on 2/3/26 at 9:20 a.m. LVN A said that residents are not allowed to keep medications inside their room. She said that there is a risk that a resident could get ahold of the medication or chemical and misuse it. She said the main risk is if a resident drank the Povidone-Iodine 10% Solution or .9% Sodium Chloride Irrigation Solution. She said all these items should be kept on either a medication cart or the treatment cart and not left in a resident's room. She said that the treatment medications, Povidone-Iodine 10% Solution or .9% Sodium Chloride Irrigation Solution, should have been kept on the medication cart. She stated that she would remove the chemicals from resident's rooms.During an interview on 2/4/26 at 10:45 a.m. the Director of Nurses said that chemicals used for wound care or treatments should be kept in the treatment cart. She said that there was a risk that any resident could get the medication and harm themselves if they misused the chemicals. It is the responsibility of all staff to ensure that residents do not have access to potentially harmful chemicals.During an interview on 2/4/26 at 10:50 a.m. the Administrator said that wound care treatment chemicals should not be left in plain sight in residents' rooms. He said that there was a risk that a resident could get ahold of the chemicals and improperly use them. Record review of a facility policy dated 01/20/2021 titled Medication Storage revealed that the purpose of this policy was to, It is the policy of this facility to ensure all medications housed on our premises will be stored, dated, and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security All drugs and biologicals will be stored in locked compartments under proper temperature controls.		