Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007090	A. BUILDING: ______ B. WING ______	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARIS HEALTH AND REHAB CENTER	1011 NORTH MAIN STREET PARIS, IL 61944

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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	S9999	Attachment A Statement of Licensure Violations	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These Regulations are not met as evidenced by:

Based on observation, interview, and record review the facility failed to follow resident care plan fall interventions for three (R10, R48, R59)

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residents. The facility also failed to provide safe feeding assistance for one (R23) resident on swallowing precautions while eating and facility failed to securely store a pressurized Oxygen tank for one resident (R6). These failures affect five residents (R6, R10, R23, R48, R59) out of eight residents reviewed for Accidents. These failures resulted in R10 sustaining a Right front of scalp Hematoma and R59 sustaining Right sided 10th, 11th Rib Fractures and a Hematoma.

Findings include:

1.) On 6/13/23 at 2:15 PM R59 observed sitting in a wheelchair next to the nurse's station.

On 6/15/23 at 3:00 PM V22 observed Certified Nurse Aide (CNA) assist R59 in wheelchair from end of hallway to nurse's station.

On 6/15/23 at 11:55 AM V26 Physical Therapy Assistant (PTA) stated "I will remember that day forever. I felt so bad that I caused that fall. (R59) was in a therapy session with me in the therapy gym. The therapy gym was full of people that day. I was assisting (R59) with walking. (R59) was using his walker heading towards the end of the line to meet his goal. I forgot to put (R59's) wheelchair at the end of the line so when we (V26, R59) got down there, I had to reach around to pull his wheelchair so that it was positioned in front of him. When I was getting the wheelchair, (R59's) pants were too loose so he took his hand off of the walker to hold up his pants. That is when (R59) lost balance and fell. (R59) ricocheted off of the padded table onto the floor. (R59) hit his Right torso on the padded table and then landed on his Left side on the floor. That is how (R59) hit his head and got the big goose egg and Hematoma. I caused that poor man to fall. If

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I would have had my eyes on him, if I would have thought ahead to position (R59's) wheelchair ahead of time or if I hadn't taken my hands off of him, he would not have fallen. After (R59) fell, V18 Certified Occupational Therapy Assistant (COTA) got him up with a gait belt. (R59) did complain of a backache. I bet (R59's) back did hurt as hard as he fell. We (V18, V26) were educated afterwards on how to prevent that fall and to always use a total body mechanical lift to reposition someone after a fall."

On 6/16/23 at 11:30 AM V30 Nurse Practitioner stated R59's fall could have been prevented if (V26) PTA would have not let go of (R59) or if (V26) would have got the wheelchair in position prior to having him walk away from it. V30 stated "This facility absolutely caused harm to (R59) by causing the Right 10th and 11th rib fractures. This could affect (R59's) ability to take deep breaths which could cause him to get Pneumonia. (R59's) mobility has also decreased because of the fall due to (R59) is using his wheelchair more now than when he did prior to falling. This facility has a lot of falls and they (facility) need to get a handle on them."

R59's undated Face Sheet documents R59's medical diagnoses as Cerebral Infarction, Aspers Disease, Spinal Stenosis, Abnormality of Gait and Mobility, Left Ear Sensorineural Hearing Loss with restricted hearing on the Right side, Dizziness, Dementia and Cognitive Communication Deficit.

R59's Minimum Data Set (MDS) dated 4/21/23 documents R59 as severely cognitively impaired. This same MDS documents R59 requires extensive assistance of two people for transfers and extensive assistance of one person for walking in room and corridor, locomotion on and

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S9999	Continued From page 4 off unit. R59's Fall Risk Assessment dated 4/13/23 documents R59 as a high fall risk. R59's Nurse Progress Note dated 4/19/23 at 11:15 AM documents "Went to therapy and seen (R59) laying on left side of body. (V26) Physical Therapy Assistant (PTA) said "(R59) was walking with walker and (V26) was locking wheelchair brakes and (R59) took hand off walker to fix his shorts and lost balance backwards and hit left side of head. Small Hematoma noted to left side of forehead. No other bruising noted at this time. (R59) did complain of headache." R59's Physician Order Sheet (POS) dated June 1-30, 2023, documents a physician order dated 4/20/23 of "Immediate (STAT) unilateral Right Hip with pelvis X-Ray due to signs and symptoms of pain, and swelling after recent fall portable due to limited mobility" R59's X- Ray of Right Chest report dated 4/19/23 documents "Fractures of the anterior Right 10th and 11th ribs are noted." 2.) On 6/14/23 at 2:15 PM R10 observed sitting in wheelchair with traditional socks on. (R10) was observed without non-skid socks in place. On 6/15/23 at 1:45 PM V1 Administrator stated "We (facility) did not report (R10's) fall on 5/26/23 which resulted in a major injury to the state agency." V1 Administrator confirmed R10 was supposed to be wearing non-skid socks per previous care plan intervention and was not wearing non-skid socks at time of fall. V1 Administrator stated R10 may not have fallen if R10 was wearing the non-skid socks.	S9999		

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On 6/16/23 at 11:30 AM V30 Nurse Practitioner stated "(R10's) fall could have been prevented if staff would have put on her nonskid socks. The facility caused a major injury of a Hematoma to (R10) by not following basic fall interventions. This facility has a lot of falls and they (facility) need to get a handle on them."

R10's undated Face Sheet documents medical diagnoses of Dementia, Legal Blindness and Dysphagia following Cerebral Infarction.

R10's Minimum Data Set (MDS) dated 4/14/23 documents R10 as severely cognitively impaired. This same MDS documents R10 as requiring extensive assistance of two people for transfers, bed mobility and toileting.

R10's Fall Risk Assessment dated 4/25/23 documents R10 as a high fall risk.

R10's Fall investigation dated 5/26/23 documents R10 had an unwitnessed fall on 5/26/23 at 7:33 AM. This same report documents R10 has decreased safety awareness, impaired memory and gait imbalance. This same report documents "(R10) was found face forward on the floor in front of (R10's) wheelchair. Injury type: Right hand bruise, face bruise, top of scalp laceration, Right Knee bruise and top of scalp Hematoma."

R10's Hospital Record dated 5/26/23 documents diagnoses as "Closed Injury of Head and Accident due to Fall."

R10's Computerized Tomography (CT) of Head and Cervical Spine without Contrast dated 5/26/23 documents "Acute pathology is a large Right Frontal Scalp Hematoma".

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R10's Nurse Progress Note dated 6/13/23 at 3:08 PM documents "(R10) had un-witnessed fall this AM at the nurse's station. (R10) was face forward on the floor in front of her wheelchair. Large Hematoma noted to center of (R10's) forehead with small laceration. (R10) complained of pain in her head. (R10) sent to emergency room."

R10's Nurse Progress Notes dated 5/26/23 at 11:18 AM documents "(R10) returned from Emergency Room (ER). Computerized Tomography (CT) scan results state large right frontal scalp Hematoma. (R10) has 1 cm laceration on Hematoma."

R10's Fall Care Plan Intervention dated 3/10/23 instructs staff to apply nonskid socks while in the wheelchair. This same care plan documents a fall intervention for staff to anticipate needs.

3.) On 06/13/23 between 12:05 PM - 12:45 PM, during continuous observation, R23 sat in a high back wheelchair, in the Dementia Unit full dining room. R23 was eating a pureed meal without assistance or verbal cues. V9, Certified Nursing Assistant (CNA) and V23, CNAs were feeding other residents (unidentified) at back table. R23's sat with R23's back towards V9, CNA and V23, CNA. R23's table was approximately 25 feet away from where V9, CNA and V23 CNA were seated. V9, CNA and V23 did not provide R23 physical or verbal assistance with dining.

On 6/15/23 at 11:55 AM, R23 sat in a high back wheelchair, in the dementia unit full dining room. R23 was eating a pureed meal without assistance or verbal cues. V9, CNA and V22, CNA were feeding residents (unidentified) at the back table, approximately 25 feet away from R23's table.

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On 6/15/23 at 12:17 PM, R23 continued to attempt to eat on R23's own, without physical or verbal assistance. R23 consumed a half portion of pureed broccoli that set on the plate closest to the resident. R23 had not eaten the pureed chicken fried steak, or mashed potatoes on the far side of R23's plate. R23 had not eaten the pureed pie, in a bowl on the opposite side of resident plate. V9, CNA and V22, CNA did not offer physical or verbal assistance with dining.

On 6/15/23 at 12:25, V22, CNA removed R23's food tray from R23's table to place on the food cart. V22, CNA confirmed R23 had not eaten anything but R23's pureed broccoli. V22, CNA stated "We never help (R23). (R23) eats on his own. (R23) didn't eat much today, sometimes (R23) doesn't. I don't know what it says on his care plan, I did not know we needed to help him."

On 6/15/23 at 12:40 PM, V21, Speech Therapist reviewed R23's Speech Therapy notes. V21, Speech Therapist stated "(R23) has Dysphagia (swallow disorder). In March 2023, I (V21, Speech Therapist) clarified his (R23's) order (physician order) and completed a bed-side swallow (evaluation). The swallow study documents, sips, lidded cup and to alternate food. I think staff need to provide (R23) assistance. (R23) requires rate modification, which indicates feeding assistance which should be slow, in bolus, which means small amounts, and alternate liquids and solids."

R23's "Speech Therapy SLP Evaluation and Plan of Treatment" dated 3/24/23 - 4/06/23 confirms V21, Speech Therapist interview and also documents the following: "Supervision, how often does patient require supervision/assistance at

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mealtime d/t (due to) swallow safety? = (equals) 91-100% (percent) of the time."

R23's Physician "Order Summary" Sheet (POS), dated 6/15/23 documents the following: Unspecified Dementia with Unspecified Severity, Parkinson's Disease and Dysphagia Oropharyngeal Phase and Unspecified Protein Calorie Malnutrition. The same POS documents the following diet order: Regular diet Pureed, Thin/Regular.

R23's Minimum Data Set (MDS) dated 4/10/23 documents the following: R23's Brief Interview of Mental Status score of four, out of a possible 15, indicates severe cognitive impairment. The same MDS documents R23 requires extensive physical staff assistance with eating. The same MDS document: Swallowing Disorder: C. Coughing or choking during meals or when swallowing medications is checked marked, yes.

4. On 6/13/23 at 10:05 AM, there was an unsecured/unrestrained/ free-standing E-type (680 liter, 24.96 cubic feet, capacity of compressed oxygen) metal oxygen cylinder in the corner of R6's room in the direct path of the bathroom door swing area.

On 6/13/23 at 10:06 AM, V8, Licensed Practical Nurse, stated, "Our oxygen tanks are supposed to be stored in our enclosed room." V8 then stated, "Oh you have got to be kidding me right now, those tanks are not supposed to be sitting around standing on the floor."

On 6/13/23 at 11:40 AM, V3, Regional Clinical Nurse, provided the facility's oxygen policy and stated, "I had to contact the oxygen supplier company to make sure you have the most current

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up to date policy."

The facility's policy "Storage" (undated) documents, "The following oxygen cylinder storage requirements are relative to the National Fire Protection Association Standards 99 Health Care Facilities. The Joint Commission has adopted these requirements and will measure for them during surveys." "Cylinders must be secured in racks or by chains." This statement is repeated twice in this policy, once for oxygen storage in any room or alcove, and again for larger quantities of oxygen stored in special designated rooms.

5. On 6/14/23 at 3:39 PM, R48 was seated in a recliner in R48's own room. There was not a reacher/ grabber instrument in R48's room to assist R48 with hard-to-reach items. There was not a sign in R48's room to remind R48 to call for assistance with toileting. There was not a card on R48's walker seat to remind R48 to lock the walker wheels.

On 6/14/23 at 3:44 PM, V16, Licensed Practical Nurse, searched throughout R48's room, drawers, and closet, then stated, "I am not seeing a grabber and I don't think I have ever seen (R48) use one. There is no reminder sign on the wall, and there is no sign on (R48's) walker except one under the seat with (R48's) name and room number but no reminder."

R48's Care Plan focus area "At risk for falls and injuries r/t (related to) Medications: Narcotics, Medical Factors: dementia," dated 9/4/22 documents nursing interventions including, "11/22/22-resident will be given grabber to assist with hard to reach items, 3/6/23-Place sign in room to remind resident to call for assistance with

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S9999	Continued From page 10 toileting, and 5/2/23-Card placed on walker seat to remind resident to lock his walker wheels." R48's Nursing Notes document R48 had experienced 8 falls, one each on 11/21/22, 12/26/22, 12/28/22, 3/6/23, 5/2/23, 5/23/23, 6/2/23, and 6/12/23. These same nurses' notes document on 11/21/22 R48 slid off the bed while picking something up from the floor. On 12/26/22 R48 fell while standing up from a seated walker with the walker brake unlocked. On 12/28/22 R48 unwitnessed fall and was found on the floor in R48's own room. On 3/6/23 R48 fell by slipping in R48's own urine in R48's own room. On 5/2/23 R48 was found on the floor of R48's own room in front of the walker while the walker brake was unlocked. On 5/23/23 R48 fell in front of staff while ambulating back from a supervised smoking period. On 6/2/23 R48 fell outside the facility while exiting an activity door. On 6/12/23 R48 unwitnessed fall in R48's own room. (B)	S9999		