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 _____	C 08/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2466138/IL176327	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)2) 300.1210d)5) 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. Section 300.1210 General Requirements for Nursing and Personal Care 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.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 1	S9999		

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:

2) All treatments and procedures shall be administered as ordered by the physician.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to monitor and prevent a wound from worsening, failed to prevent new wounds from developing, failed to implement pressure reducing interventions and failed to complete treatments as ordered for three of three residents (R1, R2, R3) reviewed for pressure ulcers in the sample list of three. This failure resulted in R1 requiring hospitaliztion. for a maggot infestation of R1's wound.

Findings include:

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 _____	C 08/07/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

The facility's Pressure Ulcer Prevention, Identification and Treatment policy with a revised date of 8/31/23 documents, "Purpose: To v guidelines that will assist nursing staff in prevention, identification, and appropriate treatment of pressure ulcers." "The facility will initiate an aggressive treatment program for those resident who have pressure ulcers." "Responsibility: It is the responsibility of the Charge Nurse/Designee to care for pressure areas, and provide treatments as ordered. It is the responsibility of the Charge Nurse/Designee to measure and document on the pressure areas weekly. It is the responsibility of the Charge Nurse/Designee to monitor for healing progress, and ensure appropriate treatment are in use. It is recommended that D.O.N. (Director of Nursing)/Designee make frequent pressure ulcer rounds with the charge nurse. It is the responsibility of the CNA (Certified Nursing Assistant) to report any skin conditions to the charge nurse immediately upon identification. Procedure: 1. All residents will have a Pressure Ulcer Risk Assessment (Braden Assessment) completed weekly for 4 weeks upon admission. Assessments shall continue at least quarterly thereafter and with any significant change of status. 2. Nurses are to complete skin assessments daily on resident deemed 'High Risk' for skin breakdown (Scoring 12 or lower on Braden Scale). Skin assessments shall be done at least weekly on all other residents. 3. Support services shall be utilized in the prevention of wound development, including, but not limited to: Redistributing pressure (repositioning, off-loading, etc. {etcetera}), minimizing exposure to moisture, providing appropriate pressure-redistributing, non-irritating support surfaces and evaluation/maintenance of proper nutrition and

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 _____	C 08/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3	S9999		

hydration. 4. When a pressure ulcer is identified, whether in-house or upon a resident's admission, the area will be assessed using the Skin & Wound assessment, a skin inspection assessment shall be completed, and initial treatment started per physician's orders. Daily skin checks shall be initiated initiated on residents with a pressure wound to provide increased monitoring from nursing staff. Resident may be referred to wound physician for evaluation and treatment (where applicable). The physician is to be notified when A) pressure ulcer develops, B) when there is a noted lack of improvement after a reasonable amount of time, C) and/or upon signs of deterioration."

1.) R1's Order Summary Report Osteomyelitis, Type 2 Diabetes Mellitus with Hyperglycemia, Pressure Ulcer of Right Heel Unstageable, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-dominant Side, Chronic Pain and Acquired Absence of Other Left Toes. This Order Summary documents R1 was readmitted to the facility on 8/4/24. R1's electronic census documents R1 was originally admitted to the facility on 6/16/23.

R1's Care Plan with a revised date of 6/24/24 documents R1 has an actual pressure ulcer on the Right Heel with interventions dated 2/24/24 of daily skin checks, float heels, monitor for signs and symptoms of infection daily - increased warmth of surrounding tissue, redness, swelling, pain, purulent drainage, foul odor, notify physician if identified, assess pressure ulcer weekly by a licensed nurse and provide off loading of ulcer site.

R1's Treatment Administration Record (TAR) dated 7/1/24 through 7/31/24 documents an order

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 _____	C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

to cleanse wound on right heel with wound cleanser, apply collagen to wound bed and cover with an abdominal pad and rolled gauze every day and as needed every evening shift with an order start date of 4/16/24 and discontinue date of 7/17/24. The treatment order was not signed off as completed on 7/15/24. This TAR documents an order with a start date of 7/17/24, "may change clear dressing to right heel as needed. Do not remove anything below clear dressing. Will be done by wound Nurse Practitioner weekly as needed for wound care." This order is not signed off as completed from 7/17/24 through 7/27/24.

V3 Wound Nurse Practitioner's note dated 7/17/24 documents R1's wound on the right heel measured 4.1 cm (centimeters) x (by) 2.5 cm x 0.1 cm with a treatment of a skin graft, apply normal saline moistened gauze, oil emulsion dressing, super absorbent dressing covered with a bordered gauze dressing. Secure with a transparent medical dressing, monitor and change daily every one time a week and as needed.

R1's Nurse's Note dated 7/23/24 at 11:52 AM, V11 Licensed Practical Nurse (LPN) documented V11 called and spoke with V3 Wound Nurse Practitioner in regards to R1's right heel not having the clear under dressing on the heel and gave a one time order to clean with normal saline/wound cleanser apply collagen to wound bed and cover with dry bordered gauze until follow up with V3 tomorrow 7-24-24.

V3's wound note dated 7/24/24 documents R1's right heel wound measured 4 cm x 2.5 cm x 0.1 cm with the same treatment as 7/17/24.

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 _____	C 08/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

R1's Nurse's Notes dated 7/28/24 at 11:23 AM by V11 documents V11 could not find the clear film of R1's dressing and R1's wound dressing was slipping down, V11 reinforced the dressing with foam gauze dressings. There is no documentation that V3 Wound Nurse Practitioner was notified.

R1's Nurse's Notes dated 7/30/24 at 10:08 AM by V11 documents the wound Nurse Practitioner (V3) will do the wound treatment tomorrow.

R1's Nurse's Notes with an effective date of 7/31/24 at 11:00 AM and an entered date of 8/1/24 at 3:55 PM by V2 Director of Nursing documented an SBAR (Situation Background Assessment Recommendation) for a change in condition of a skin wound/ulcer. This note documents R1's wound on the right heel has had increased drainage and odor with recommendations to send to the emergency room.

R1's Nurse's Notes dated 7/31/24 entered at 4:06 PM documents effective at 11:00 AM by V5 Licensed Nurse Practitioner V3 here to see R1 for wound on the right heel. V3 noted wound to have foul smell and had deteriorated. Wound culture was done and V5 requested R1 be sent to the emergency room to be evaluated for Osteomyelitis. POA (Power of Attorney) contacted and was agreeable with plan.

V3's Wound Assessment dated 7/31/24 documents a Right Heel Pressure Injury with declining status measuring 4.4 cm x 3.3 cm x 0.1 cm with a large amount of exudate and odor. This Wound Assessment also documents, "Strong odor and new wound beneath dressing when removed. Increased measurements. Wound

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 _____	C 08/07/2024

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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S9999	Continued From page 6	S9999		

declined with unstable eschar noted within wound bed. Wound culture obtained. Wound nurse and DON (V2 Director of Nursing) present in room and aware of changes." Ordered to send R1 to Emergency Room for evaluation to rule out Osteomyelitis and Sepsis. V3 documents a Wound Assessment of the new wound on the right medial foot as pressure injury, measuring 4.4 cm x 2.4 cm and 100% eschar. V3 documents a strong odor and red streaking observed to periwound measuring 8.5 cm x 8 cm.

R1's Nurse's Notes dated 7/31/24 at 4:07 PM, R1 admitted to the hospital, on IV (Intravenous) antibiotic, wound consult tomorrow.

R1's hospital records dated 7/31/24 documents R1 has had on ongoing wound involving the right heel and was receiving wound care at the nursing facility and reportedly maggots were expressed from the wound along with malodorous material. Plain films do not show any obvious bony destruction. There is some surrounding erythema and a dark eschar overlying the wound along with some other traction types of abrasion around the Calcaneus.

R1's MRI (Magnetic Resonance Imaging) results dated 8/1/24 documents recent debridement after maggots were present on plantar wound. Impression: soft tissue ulcer in the plantar subcutaneous tissues inferior to the posterior calcaneal bone associated with both cellulitis and Osteomyelitis.

R1's hospital physical exam note dated 8/4/24 documents wound cultures from 8/2/24 demonstrate Proteus Mirabilis and R1 will require 6 weeks of Daptomycin and Ceftriaxone (antibiotics) and a PICC (Peripherally Inserted

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 _____	C 08/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 7	S9999		

Central Catheter) line has been placed for IV antibiotic administration.

R1's Nurse's Progress notes dated 8/4/24 at 6:30 PM documents R1 returned to the facility with a diagnoses of Osteomyelitis.

On 8/5/24 at 9:45 AM, R1 stated that the Wound Nurse Practitioner was trying a skin graft on his wound on his foot. R1 stated that the dressing was supposed to stay on for 7 days. R1 stated that the wound was smelling but staff didn't do anything except agree that it smelled. R1 stated when they went to remove the dressing on 7/31/24 there were maggots on the wound. At this time R1 is laying in his bed with his heels laying on the bed. R1 has foam rings around both calves but they are not keep his heels off the bed. There are two different types of heel cushions on R1's wheelchair but are not being used. On 8/5/24 at 11:40 AM, R1's heels are laying directly on the bed. On 8/5/24 at 2:17 PM, R1's heels are laying directly on the bed.

On 8/5/24 at 2:57 PM, V5 Licensed Practical Nurse (LPN) stated on 7/31/24 that V3 Wound Nurse Practitioner and V8 Business Office Manager went in to change R1's dressing and V3 came out and told her that the wound had maggots on it and V3 wanted R1 sent to the hospital for evaluation. V5 stated that she did notice an odor outside of R1's room earlier that morning when she was passing medications but did not address it.

On 8/6/24 at 10:06 AM, V11 LPN stated R1's dressing was coming off and she could not find the transparent dressing so she just reinforced what was already on there. V11 stated that they were told not to touch the wound dressing. V11

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 _____	C 08/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 8	S9999		

stated that she informed V8 since she assists the Wound Nurse Practitioner. V11 stated that on 7/30/24 the shower aide (V9) told V11 that R1's odor was really bad and thought she was going to throw up from the smell. V11 stated she informed V8 regarding the strong odor but did not document anything about it or notify the Wound Nurse Practitioner.

On 8/6/24 at 10:26 AM, V8 stated that V8 is a Licensed Nurse in another stated but not here so she cannot practice as a nurse but goes with the Wound Nurse Practitioner on her rounds to get things for her. V8 stated that on 7/31/24 she was rounding with V3. V8 stated that V3 pulled the top of R1's dressing back and said "Oh my gosh" and put the dressing back in place. V8 stated there was a very strong odor. V8 stated that they went to get more supplies to clean the wound. V8 stated that on 7/30/24 someone told her that there was an odor but V8 stated V3 Wound Nurse Practitioner told them there would be some odor since the graft was a living thing. V8 confirmed that she did not assess the odor or report the odor to V3. V8 confirmed there was a new pressure area under the dressing and confirmed there were maggots present along with the strong odor.

On 8/6/24 at 10:58 AM, V2 Director of Nursing confirmed V2 was present in the room when R1's dressing was being changed on 7/31/24 and confirmed there was a new pressure area and confirmed there were maggots present and there was a strong odor. V2 stated that the nurses should have been going in and visually inspecting the dressing and V2 stated that if the nurses noticed an odor that strong they should have notified the Wound Nurse Practitioner.

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 _____	C 08/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 9	S9999		

On 8/6/24 at 11:09 AM, V9 Certified Nursing Assistant/Shower Aide stated on 7/30/24 that R1's odor was awful and there was drainage soaking through the dressing. V9 stated that there was also drainage on R1's bed sheet. V9 stated that she reported the odor and drainage to V11 and V8. V9 stated that it was the worst smell she had every smelled.

On 8/6/24 at 11:59 AM, V3 Wound Nurse Practitioner stated that R1's wound had previously been treated with collagen and it had stalled out so she discussed trying a skin graft with R1 and he was willing to try it. V3 stated that the skin graft needed to try to stay in place for 7 days at a time. V3 stated she placed the skin graft over the wound and used tape strips to hold it in place then covered with a dressing and then a secondary dressing that the nurses could change if needed. V3 stated that the nurses should have been monitoring the secondary dressing everyday. V3 stated on 7/31/24 there was a strong odor coming from R1's foot and confirmed there were maggots present on his wound when she removed the dressing. V3 stated that the dressing must have had a break in the seal and it would have only taken one fly to get inside the dressing. V3 stated that R1 was mobile in his chair throughout the facility and went outside frequently so it is no surprise that the maggots were present. V3 confirmed that she was not made aware of the strong pungent smell coming from R1's wound and should have been made aware. V3 stated R1 has a history of Osteomyelitis so she wanted him evaluated and had him transferred to the hospital right away on 7/31/24.

On 8/6/24 at 1:12 PM, V12 LPN stated V12 worked night shift 6:00 PM to 6:00 AM on 7/29/24

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 _____	C 08/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 10	S9999		

and confirmed that there was an odor to R1's wound. V12 stated that the day shift nurse V11 was aware of the odor.

On 8/6/24 at 1:17 PM, V13 Certified Nursing Assistant (CNA) confirmed taking care of R1 7/29/24 and 7/3024 and confirmed there was an awful odor coming from R1. V13 stated that she told the nurses and they thought it was coming from the skin graft.

On 8/6/24 at 1:33 PM, V14 CNA stated that there was an odor outside of R1's room on either 7/30/24 or 7/31/24 and stated that she changed R1's bedding after they cleaned up his wound and confirmed there were a couple of maggots on the sheets after the dressing change.

On 8/6/24 at 1:40 PM, V15 CNA stated that she could smell the odor outside of R1's room on 7/30/24 and V15 stated that she reported it to the nurse V11.

On 8/6/24 at 3:27 PM, V16 CNA stated that she worked on 7/29/24 and 7/30/24 and remembers that on 7/29/24 she let the nurse know that the odor was bad and stated that R1 told her that the odor was coming from his foot.

On 8/6/24 at 1:54 PM, V11 completed a dressing change on R1's right foot. There was a large wound on R1's heel that was pink and was clean and there were two other areas in the arch of the foot that were open and red with some scabbed areas on them.

2.) R2's Treatment Administration Record (TAR) dated 7/1/24 through 7/31/24 documents diagnoses including Type 2 Diabetes Mellitus, Severe Morbid Obesity and Extended Spectrum

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 _____	C 08/07/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 11	S9999		

Beta Lactamase (ESBL) Resistance. This TAR documents an order dated 7/18/24 for the Coccyx wound to cleanse with wound cleanser or normal saline, pack with bleach solution soaked gauze, cover with a bordered foam dressing two times a day. This TAR documents this treatment was not signed off as completed on 7/18/24 at 8:00 AM, 7/20/24 at 8:00 PM and 7/24/24 at 8:00 PM.

3.) R3's Treatment Administration Record dated 7/1/24 through 7/31/24 documents diagnoses including Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, Personal History of Traumatic Fracture, Crohn's Disease, Severe Protein Calorie Malnutrition, Pressure Ulcer of Sacral Region Stage 4, Adult Failure to Thrive and Extended Spectrum Beta Lactamase (ESBL) Resistance. This TAR documents a treatment order for the Coccyx with a start date of 7/19/24 to cleanse the area with normal saline, apply skin protectant to the periwound, apply collagen dressing to wound bed and cover with a bordered gauze daily. This treatment is not signed out as completed on 7/19/24, 7/21/24, 7/27/24 and 7/28/24.

R3's TAR dated 8/1/24 through 8/31/24 documents an order dated 7/24/24 for the Right Heel to cleanse with normal saline, pat dry, apply Betadine to the wound bed and leave open to air daily and as needed. This treatment is not signed off as completed on 8/1/24, 8/2/24 and 8/3/24. This TAR documents an order dated 7/30/24 for the Sacrum to cleanse with normal saline, apply skin protectant to the periwound, apply a collagen dressing to the wound bed and cover with a bordered gauze daily. This treatment is not signed off as completed on 8/2/24 and 8/3/24. This TAR documents an order to float R1's heel every shift. On 8/5/23 at 11:43 AM R3 was laying

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 _____	C 08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 12 in bed with his feet directly on the bed. R3 did not have any heel protectors on or any device to float his heels. On 8/6/24 at 9:23 AM, R3 is in bed laying on his right side and he did not have any heel protectors on and did not have any device in place to float his heels. R3's feet were laying directly on the bed. On 8/5/24 at 1:40 PM, V6 Registered Nurse stated that R3 should have heel protectors on his feet and did not know where they were. On 8/6/24 at 10:58 AM, V2 Director of Nursing stated that the nurses are supposed to sign off the treatments on the Treatment Administration Record when they are completed and confirmed there were days that were not signed off as completed for R1, R2 and R3. (A)	S9999		