DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145469	A. BUILDING ______ B. WING ______	C **08/11/2016**

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

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F 000	INITIAL COMMENTS Complaint #1664368/IL87466 - F323 Complaint #1664460/IL87568 - F225, F226	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		

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

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.

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F 225	Continued From page 1 certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to investigate an allegation of sexual abuse and to remove the alleged perpetrator (R6), allowing continued access to other residents R5, R7 and R9 through R32 residing on the south hall of the facility. R5, R6, R7 and R9 through R32 are 27 residents reviewed for abuse in the sample of 32. Findings include: The Physician Order Sheet dated August 2016 for R6 documents the following diagnoses: Dementia without Behavior Disturbances and Diabetes. The Minimum Data Set dated 7/11/16 documents that R6 is a 13 out of 15 on the Brief Interview for Mental Status, indicating that R6 is cognitively intact. On 8/9/16 at 12:30 pm, R6 was self-propelling in a wheelchair from the dining room down the south hall of the facility unsupervised. A Progress Note dated 7/28/16 at 12:21 pm documents that staff informed E3, Social Service that R6 has been making inappropriate sexual acts and/or comments toward another male resident. On 8/9/16 at 1:03 pm, E3 stated that a CNA on	F 225		

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F 225	Continued From page 2 7/28/16 had informed E3 of R6 inappropriately touching R7 on the thigh and had asked if R7 liked that. E3 stated the incident was reported to the Administrator. E3 could not recall who the CNA was that had reported the incident. On 8/9/16 at 1:15 pm, E1, Administrator stated that E3 had informed E1 of the incident between R6 and R7. E1 stated "I don't recall (E3) telling me that (R6) had asked (R7) if (R7) liked it. I did not do an investigation.....I see now....I should have. On 8/9/16 at 3:50 pm E6, Certified Nursing Assistant (CNA), stated on 7/28/16 she observed R6 sitting next to R7 and saw R6 slide R6's hand up R7's thigh and heard R6 ask if R7 liked that. E6 stated that the observation was reported to E8, Licensed Practical Nurse. E6 stated that E8 told E6 to report it to E3, Social Services. E6 stated the incident was reported to E3 immediately and it was "close to noon." On 8/11/16 at 10:45 am, E10 CNA stated that E10 witnessed on 7/28/16, along with E16, Registered Nurse, R6 having R6's hand on R7's thigh and stating how do you like that or if R7 liked what R7 saw? On 8/11/16 at 10:55 am, E16 confirmed that E16 had witnessed on the morning of 7/28/16 R6 having R6's hand on R7's thigh and asking R7 "how do you like that?" E16 stated that the early morning incident was reported to E3. On 8/11/16 at 11:05 am, E3 stated "E16 could have told me....I just don't remember. I do remember now that it was E6 telling me of the incident between R6 and R7 on 7/28/16. I	F 225		

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F 225	Continued From page 3 reported it to (E1, Administrator) right away and made a progress note." The facility Midnight Census dated 8/5/16 documents R5, R6, R7 and R9 through R32 residing on the south hall of the facility.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to operationalize their Abuse Prohibition policy, by failing to investigate, protect and not reporting to the state agency an allegation of sexual abuse. The facility failed to remove the alleged perpetrator (R6), leaving 26 residents (R5, R7 and R9 through R32) accessible to further potential sexual abuse. R5, R6, R7 and R9 through R32 are 27 residents reviewed for abuse in the sample of 32. Findings include: The facility policy titled "Abuse Prevention" dated 8/10/11 directs the facility protocol on abuse as follows: "Should an incident or suspected incident of resident abuse, neglect or injury of unknown source be reported, the administrator, or his/her designee, will appoint a member of management to investigate the alleged incident.....	F 226		

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F 226	Continued From page 4 the individual conducting the investigation will, at a minimum, review the resident's medical record to determine events leading up to the incident; interview the person(s) reporting the incident; interview any witnesses to the incident; interview the resident (as medically appropriate); interview the resident's attending physician to determine the resident's current mental status; interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; interview the resident's roommate, family members, and visitors; interview other residents......The facility shall immediately contact local law enforcement authorities in the following situations: Sexual abuse of a resident by a staff member, another resident or a visitor. Allegations of abuse are reported to the state survey agency within 24 hours. The administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the state survey and certification agency within five days of the reported incident.....During abuse investigations, residents will be protected from harm by the following measures: If the alleged abuse involves another resident, the accused resident's representative and attending physician will be informed of the alleged abuse incident and that the accused resident will not be permitted to make visits to other residents rooms unattended. If necessary, the accused resident's family members may be required to provide assistance in meeting this requirement. The accused resident may be placed on 1 to 1 supervision or every 15 minute monitoring based upon the severity of the allegation." A Progress Note dated 7/28/16 at 12:21 pm entered by E3, Social Services documents staff	F 226		

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F 226	Continued From page 5 informed E3 that R6 "has been making inappropriate sexual acts and/or comments toward another male resident." The Physician Order Sheet dated August 2016 for R6 documents the following diagnoses: Dementia without Behavior Disturbances and Diabetes. The Minimum Data Set dated 7/11/16 documents that R6 is a 13 out of 15 on the Brief Interview for Mental Status, indicating that R6 is cognitively intact. On 8/9/16 at 12:30 pm, R6 was self-propelling in a wheelchair from the dining room down the south hall of the facility unsupervised. On 8/9/16 at 1:03 pm, E3 stated that a CNA on 7/28/16 had informed E3 of R6 inappropriately touching R7 on the thigh and had asked if R7 liked that. E3 stated the incident was reported to the Administrator. E3 could not recall who the CNA was that had reported the incident. On 8/9/16 at 1:15 pm, E1, Administrator stated that E3 had informed E1 of the incident between R6 and R7. E1 stated "I don't recall (E3) telling me that (R6) had asked (R7) if (R7) liked it. I did not do an investigation.....I see now....I should have. On 8/9/16 at 3:50 pm E6, Certified Nursing Assistant (CNA), stated she observed R6 sitting next to R7 and saw R6 slide R6's hand up R7's thigh and heard R6 ask if R7 liked that. E6 stated that the observation was reported to E8, Licensed Practical Nurse. E6 stated that E8 told E6 to report it to E3, Social Services. E6 stated the incident was reported to E3 immediately and it was "close to noon."	F 226		

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F 226	Continued From page 6	F 226		

On 8/11/16 at 10:45 am, E10 CNA stated that E10 witnessed on 7/28/16, along with E16, Registered Nurse, R6 having R6's hand on R7's thigh and stating how do you like that or if R7 liked what R7 saw?

On 8/11/16 at 10:55 am, E16 confirmed that E16 had witnessed on the morning of 7/28/16 R6 having R6's hand on R7's thigh and asking R7 "how do you like that?" E16 stated that the early morning incident was reported to E3.

On 8/11/16 at 11:05 am, E3 stated "E16 could have told me....I just don't remember. I do remember now that it was E6 telling me of the incident between R6 and R7 on 7/28/16. I reported it to (E1, Administrator) right away and made a progress note."

On 8/11/16 at 1:10 pm, E1 acknowledged the sexual abuse allegation incident on 7/28/16 with R6 should have been investigated per facility policy.

The facility Midnight Census dated 8/5/16 documents R5, R6, R7 and R9 through R32 residing on the south hall of the facility.

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

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F 323	Continued From page 7	F 323		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to supervise a resident and ensure a resident's environment was free of a slipping hazard for one (R3) of three residents reviewed for falls in the sample of 32.

Findings include:

The Physician's Order Sheet dated 8/1/16 through 8/31/16 documents that R3 has diagnoses of Dementia and Parkinson's Disease. The Minimum Data Set dated 5/16/16 documents that R3 is severely cognitively impaired and requires extensive assistance with transfers, locomotion and activities of daily living. The Care Plan revised 2/24/16 documents R3 is legally blind.

The Incident/Accident Report dated 7/31/16 documents "another resident (R8) yelled "man down" nurse passing meds (medications) at DR dining room. Nurse ran to N (nurses) station, (R3) found on floor face down.....nose split, cleansed, applied steri strips....."

E14's LPN (Licensed Practical Nurse) written witness statement dated 7/31/16 states "this nurse.....ran from dining room to nurses desk (R3) was on the floor face down with blood on floor staff assisted to turn (R3) to back to evaluate, (R3) nose split.....(R3) able to answer all questions appropriately.....housekeeping had mopped floor. (R3's) clothes wet and states falling out of chair after reaching for table and slipping on wet floor."

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F 323 Continued From page 8 F 323

E13's CNA (Certified Nurses Aide) written witness statement dated 7/31/16 states "I saw (R3) face down on the floor with the wheel chair behind (R3).....(R3) said (R3) was looking for the table. (R3) thought (R3) was in (R3's) room and then (R3) slid out of the chair and fell. Housekeeping had just mopped the area (R3) was (sitting) and (R3's) clothes were wet."

On 8/10/16 at 2:40 pm E13 CNA stated on the morning of 7/31/16 E13 propelled R3 out of the dining room and left R3 at the nurses station so E14 could check R3's vital signs. E13 stated that E13 left R3 at the nurses station and went to check a sounding alarm. E13 stated E15 Housekeeper was on the hall mopping. E13 stated the the nurses station floor area was not wet when E13 left R3. E13 stated while E13 was checking the sounding alarm E15 mopped around R3. E13 stated E13 heard a resident (R8) yell "man down". E13 stated R3 was face down on the floor at the nurses station and the floor and R3's clothes were wet.

On 8/10/16 at 3:00 PM E14 LPN stated that on 7/31/16 R3 was at breakfast and was not feeling well so E13 propelled R3 out of the dining room and left R3 at the Nurses Station. E14 stated, prior to R3's fall, E14 could see a housekeeper (E15) mopping the floor around the nurses station. E14 stated, E14 could not see the side of the nurses station where R3 was sitting in the wheel chair. E14 stated, E14 then heard another resident (R8) and the housekeeper (E15) yelling that R3 was on the floor near the nurses station. E14 stated, E14 found R3 face down on the floor and that R3's clothing was wet from the wet floor. E14 stated, R3 thought R3 was in R3's room and

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F 323	Continued From page 9	F 323		

was reaching for water on the bedside table. E14 stated, R3 stated that R3's feet slipped and R3 slid out of the wheel chair.

On 8/11/16 at 12:10 PM E13 stated E15 has a history of mopping around residents and has been told not to do it. E13 also stated that R3 is blind and that R3 does not self propel in the wheel chair for fear of running into a wall. E13 stated that no nursing or CNA staff were present at the nurses station when E13 left R3. E13 stated E13 thought E14 would be right up to assess R3.

On 8/5/16 at 10:00 am E2 Director of Nurses confirmed that R3 fell (on 7/31/16) when R3 slipped on a wet floor.

On 8/11/16 at 3:00 pm E15 Housekeeper stated E15 does not mop around residents who are up walking. E15 stated "well I don't remember if the floor was wet (on 7/31/15 when R3 fell)".

On 8/11/16 at 11:10 am E17 Housekeeping Supervisor stated to keep residents safe housekeepers should mop half the area and stay around until the area is dry. E17 stated housekeepers should wait until residents are not in an area instead of trying to mop around residents.