STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455831	A. BUILDING _____ B. WING _____	**12/03/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARIS HEALTHCARE CENTER	**610 DESHONG DR PARIS, TX 75460**

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 0161 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide proof that all residents' personal money which is deposited with the nursing home, is secure.** Based on interview and record review, the facility failed to purchase a surety bond to assure the security of residents ' personal funds. The security bond was less than the most current quarterly balance of the trust fund account for the past three months. This failure could place 39 residents with trust funds at risk of lost funds and financial hardship. Findings included: The surety bond indicated coverage from February 4, 2015 to February 4, 2016 with a bond amount of $30,000.00. The Trust Fund Average Daily Balance statements reviewed on 11/30/15 at 4:30 p.m. Indicated the following ending balances: * $37,941.35 on 07/31/15; * $33,144.65 on 08/31/15; and * $34,436.20 on 9/30/15. During an interview on 11/30/15 at 4:33 p.m., the administrator said he was unaware the trust fund balances were that high and the corporate office managed the trust funds and surety bond. He said he did not have access to the balances. During an interview on 11/30/15 at 4:37 p.m., the business office manager said the surety bond was not enough to cover the monthly trust fund balances. There was no policy provided for bond coverage of trust funds. During an interview on 12/3/15 at 4:50 p.m., the administrator said there were 39 residents with trust funds.
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment for 1 of 2 residents reviewed for [MEDICAL TREATMENT] care. (Resident # 9) Nursing staff did not routinely assess Resident #9's [MEDICAL TREATMENT] and document the condition of the site. This failure could place 2 residents receiving [MEDICAL TREATMENT] at risk for complications with their [MEDICAL TREATMENT] access, bleeding, infections, blood clots, and pain. Findings included: Physician orders [REDACTED].#9 was [AGE] years old, admitted [DATE], with [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] indicated Resident #9 sometimes made himself understood and sometimes understood others. He required extensive assistance of two staff for bed mobility, was dependent for transfers, required extensive assistance with locomotion, and was dependent for dressing and personal hygiene. His MDS assessment indicated he received [MEDICAL TREATMENT]. The care plan updated 9/2/15 indicated Resident #9 had end stage [MEDICAL CONDITION] and required [MEDICAL TREATMENT]. Interventions included assessing his skin around vascular access for signs and symptoms of infection (redness, swelling, warmth, exudate and tenderness), to palpate the access site for a distal thrill, auscultate for bruit to his right arm, and assure the shunt is patent. Nursing notes for Resident #9 from 11/11/15 - 12/1/15 provided no documentation of post [MEDICAL TREATMENT] assessments of his venous access site. During an observation and interview on 11/30/15 at 10:05 a.m., Resident #9 was sitting in a Geri-chair. The ADON said he received [MEDICAL TREATMENT] three times a week and he was confused. She was not sure of the location of the resident ' s [MEDICAL TREATMENT] catheter. During an observation on 12/2/15 at 10:10 a.m., Resident #9 had Kerlix gauze dressing to his upper right arm. The treatment nurse said she was unsure what the wrapped area to his right upper arm was. The treatment nurse agreed it could be his venous access for [MEDICAL TREATMENT]. During an interview on 12/2/15 at 12:45 p.m., Resident #9's family said he was sent to the hospital because his [MEDICAL TREATMENT] access port was clotted. During an observation and interview on 12/2/15 at 2:45 p.m., LVN K said when Resident #9 returned to the facility from [MEDICAL TREATMENT], she assessed him for pain and took his vital signs, but she did not check the [MEDICAL TREATMENT] for bruit or bleeding LVN K said she usually checked for bruit (thrill) on the days he did not go to [MEDICAL TREATMENT]. LVN K said Resident #9 had a history of [REDACTED]. LVN K said she did not document in the nursing notes or the [MEDICAL TREATMENT] communication sheet regarding the assessment of his venous access site. LVN K reviewed the nursing notes from 11/11/15- to current date and verified no documentation was noted regarding assessment of Resident #9's [MEDICAL TREATMENT] venous access site. During an interview on 12/2/15 at 2:50 p.m., LVN H said Resident #9's venous access was in his upper right arm. She said she did not assess the resident ' s access site when he returned from [MEDICAL TREATMENT] on 12/1/15 or mess with his dressing. She said she did not usually chart the condition of his venous access for redness, infection, or swelling. LVN H said Resident #9 was recently sent to the hospital because his access site was clotted, (11/30/15). During an interview on 12/2/15 at 3:25 p.m., the DON said the charge nurses should check Resident #9 for a bruit (thrill), do a head to toe assessment after [MEDICAL TREATMENT], and document their findings in the nursing notes. The [MEDICAL TREATMENT] policy updated 5/9/14 indicated .to ensure continuity of care of the resident who required [MEDICAL TREATMENT] between the nursing facility and the [MEDICAL TREATMENT] unit. Monitor the resident for bleeding at the shunt site, bruit and thrill, signs and symptoms of infections and document these items on the treatment sheet every shift. Notify the physician, responsible party and [MEDICAL TREATMENT] unit of any problems . The CMS 672 dated 11/30/15 indicated 2 residents received kidney [MEDICAL TREATMENT].
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Based on observation, interview, and record review, the facility failed to ensure services were provided based on the comprehensive assessment to maintain personal hygiene for 2 of 4 residents reviewed for ADLs. (Resident #s 8 and 2) Staff did not provide routine showers/baths for Residents #s 8 and 2. This failure could place 45 residents, who required assistance with bathing, at risk for decline in dignity, increased chance of odors, infections, and skin breakdown. Findings included: 1. Physician orders [REDACTED].#8 was [AGE] years old, admitted [DATE], with [DIAGNOSES REDACTED]. The most recent MDS dated [DATE] indicated Resident #8 usually made himself understood and had clear comprehension. His MDS indicated he was independent in most of his ADLs, but required extensive assistance by one staff with dressing, personal hygiene, and bathing. The Point of Care History (Kiosk ADL sheet) for Resident #8 indicated from 11/4/15-12/1/15 (28 days) he received a total of 5 showers. During an observation and interview on 11/30/15 at 9:35 a.m., Resident #8 was up in his electric wheelchair. The ADON said he had a communication sheet he used because he did not talk, but could make his needs known. She said he was independent with a lot of his ADLs and received a shower daily. During an interview on 11/30/15 at 10:10 a.m., Resident #8 spelled out on his communication board, he was not getting bathed. Resident #8 ' s friend said it was very important to the resident to be clean. He said he visited the resident in the last couple of months (every week), did his laundry and noticed Resident #8 smelling of body odor. The friend said he told administrative staff about bathing concerns several times and still was unsure how often Resident #8 received a shower. He said a couple weeks ago Resident #8 slipped out of his wheelchair and fell attempting to sponge bath himself at the sink. During an observation and interview on 12/2/15 at 3:00 p.m., CNA L said Resident #8 received daily showers. CNA L said the showers did not get documented on the Kiosk. Resident #8 continued to shake his head when asked about showers and said he did not get a daily shower. 2. The most recent MDS indicated Resident #2 was [AGE] years old and admitted on [DATE] with [DIAGNOSES REDACTED]. His MDS assessment indicated he had clear comprehension and made himself understood. He required extensive to total care with his ADLs and required total assistance from staff with bathing. During an interview on 11/30/15 at 1:30 p.m., Resident #2 said he was supposed to get a bath three times a week, but had not received a bath in over a week. His hair was oily in appearance. The Point of Care History (Kiosk ADL sheet) for Resident #2 indicated from 11/2/15-12/2/15 (31 days) he received a total of 6 showers. During an interview on 12/1/15 at 2:30 p.m., LVN K Resident #2 and # 8 she received their baths, but said it was not documented on the Kiosk ADL sheets. The only record they kept for showers was a list of residents that should receive showers, no documentation was available on showers, refusals or etc. The CMS 672 dated 11/30/15 indicated 45 residents were dependent/required assistance with baths.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received the necessary treatment and services to promote healing and prevent new pressure sores from developing for 7 of 10 residents reviewed for pressure sores. (Residents #s 1, 4, 5, 9,14,15, and16) The facility did not: *accurately assess Resident #9's pressure sore, did not provide off-loading, and did not communicate with the physician about worsening of the pressure sore or of the new pressure sore. Resident #9 developed one unstageable pressure sore and had another that was non-healing. -accurately assess Resident #s 5, 14, and 1's pressure sores, did not provide appopriate treatment for [REDACTED]. -accurately assess Resident #16's pressure sore and did not provide off-loading, -accurately assess Resident #s 4 and 15's pressure sores and did not provide appropriate treatments. These failures contributed to the development of new, avoidable pressure sores and worsening of existing pressures sores for 7 residents with pressure sores, and placed 3 additional residents with pressure sores at risk for increased healing time, infection, and discomfort. Findings included: 1. Physician orders [REDACTED].#9 was [AGE] years old, and admitted [DATE] with [DIAGNOSES REDACTED]. His orders were to monitor for off-loading of heels every shift, to clean a stage 3 pressure sore on his left outer ankle with normal saline, apply [MEDICATION NAME], wrap with gauze (Kerlix), and clean an unstageable wound to his right heel, apply Santyl and cover with a dressing daily. The most recent MDS dated [DATE] indicated Resident #9 sometimes made himself understood and sometimes understood others. He required extensive assistance of two staff for bed mobility, and was dependent for transfers, and required extensive assistance with locomotion, and was dependent for dressing and personal hygiene. His assessment indicated he was at risk for pressure sores and had one stage 3 pressure sore that measured 0.5 cm x 0.5 cm with eschar. Resident #9's care plan updated 11/2/15 indicated he had a pressure ulcer and to float his heels. His Braden scale (for predicting pressures sores) dated 10/31/15 indicated a score of 18. (16-23 = mild risk for pressure sores). Resident #9's weekly skin documentation included the following: (Right heel) * 11/3/15- eschar 0.8 cm x 0.9 cm, no pain. * 11/17/15- eschar 0.5 cm x 0.5 cm, no pain. * 11/24/15- eschar 0.5 cm x 0.5 cm, no pain. (Left ankle) * 11/3/15- 11/24/15 - 0.2 cm by 0.2 cm depth 0.1 cm - exudate yellow, wound bed pink. Treatment normal saline, [MEDICATION NAME] or triple antibiotic ointment, and dressing foam. His wound measurement and treatment did not change for 4 weeks. During an observation on 12/2/15 at 10:10 a.m., Resident #9 was in bed, his feet were against the foot board and not off-loaded. His right heel had an approximate 3 cm x 4 cm of firm black eschar (an unstageable pressure sore), his left outer ankle had an approximate 3 cm x 2 cm area of black eschar and the skin surrounding the eschar was 2-3 cm in width was red and swollen (unstageable pressure sore with possible infection). Resident #9 had facial grimacing and moaned when his foot and ankle were moved. The treatment nurse and LVN F said he had received pain medication that morning. During an observation on 11/30/15 at 10:05 a.m., Resident #9 was sitting in a Gerichair, his feet were not off-loaded. The ADON said he received [MEDICAL TREATMENT] three times a week, was confused, and had lost weight. During an interview on 12/2/15 at 10:20 a.m., the DON said when she saw Resident #9's left ankle the previous week, it was almost healed and had no eschar. His pressure sores worsened in 6 days. During an interview on 12/3/15 at 12:05 p.m., Resident #9's physician said he had not been called by facility staff or notified of any worsening or new skin breakdown. During an interview on 12/3/15 at 12:45 p.m., Resident #9's family said they had not been notified of any new pressure sores. The family member said she was concerned about his eating, as staff had told her he could feed himself, but she said he was often too weak to eat. She said the last time she visited she fed him and he ate well. During an interview on 12/3/15 at 2:15 p.m., the [MEDICAL TREATMENT] nurse said Resident #9 was not sent with any kind of off-loading pillows or boots for his feet. She said he was currently receiving [MEDICAL TREATMENT] and only had socks on his feet. The [MEDICAL TREATMENT] nurse said if Resident #9 was sent with pillows, cushions or foot boots they would be used to position. She was unaware of any pressure sores to his feet or ankle. She said Resident #9 did complain at times of pain to his feet and ankles.

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 2) 2. Consolidated physician orders [REDACTED].#1 was [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The orders indicated a weekly head to toe skin assessment to be completed every Thursday. The most recent MDS dated [DATE] indicated Resident #1 usually understood others and usually made her needs known. Resident #1 required extensive to total assistance from staff with transfers, dressing, toileting, and bathing. Resident #1 had impairments to her lower extremities. The MDS indicated Resident #1 had one stage 2 pressure sore that was not present upon admission. The most recent care plan dated 10/15/15 indicated on 10/29/15 Resident #1 had a stage 2 pressure sore to her right heel measuring 1.2 cm x 1.0 cm x 0.1 cm. The care plan indicated Resident #1 would wear a protective boot to her right foot. An infection report dated 11/18/15 indicated Resident #1 had an infection; the report did not indicate where the infected area was. The report indicated the wound was red, warm, and swollen. The report indicated a culture was obtained on 11/19/15 and on 11/22/15 results were positive [MEDICAL CONDITION] and the physician was notified. The infection report indicated Resident #1 was placed on standard precautions and antibiotic therapy. The most recent Braden score for Resident #1 dated 10/10/15 was 13. (a score of 13-14 represents moderate risk) The weekly skin assessment sheets indicated the following measurements for the pressure sore on Resident #1's right heel: *11/5/15- 1.2 x 1.0 x 0.1 cm; Stage 2 *11/12/15- 1.2 x 1.0 x 0.1 cm; Stage 2 *11/13/15- 5.3 x 11.0 x 0.2 cm; Stage 2 *11/20/15- 5.5 x 10.0 x 0.2 cm; Stage 2 *11/26/15- 5.4 x 10.4 x 0.2cm. Stage 2 During an observation and interview on 11/30/15 at 2:00 p.m., Resident #1 had an open area to her right heel measuring 2.5 x 7.0 cm with a pink and yellow wound bed, and a 1 x 1 cm open area to her right inner ankle area with a yellow wound bed. The treatment nurse said the pressure sore on Resident #1's heel had worsened to a stage 3, and she had not seen the pressure sore on the resident's ankle on her last assessment. During an observation on the following dates and times Resident #1's feet were not off loaded and she was not wearing a protective boot: *11/30/15 at 12:40 p.m.; and *12/1/15 at 8:45 a.m. and 10:00 a.m. During an observation on 12/1/15 at 10:06 a.m. Resident #1 wore a sock on her left foot that had a bloody spot the size of a half dollar to her heel. Resident #1's right heel pressure sore did not have a dressing. During an interview on 12/1/15 at 10:15 a.m., CNA B said she had just given Resident #1 a shower about 15 minutes ago and took her to her room and placed a sock on her right foot and left her in her room. CNA B said she did not tell the nurse she was done with the resident's shower. She said the treatment nurse knew Resident #1 needed a daily dressing change so she did not notify them when she was finished with Resident #1's shower. During an interview on 12/1/15 at 10:16 a.m., the treatment nurse said the nurse aids should notify her when residents are out of the shower and need dressings changed. The treatment nurse said she was unaware Resident #1 needed a dressing replaced to her right foot. The treatment nurse said staff should never place a sock on an open pressure sore to a foot. During an interview on 12/2/15 at 9:30 a.m., the DON said when CNAs finish showering a resident with a pressure sore they should immediately notify the treatment nurse or charge nurse so a dressing can be reapplied. A nurse note dated 11/13/15 at 10:30 a.m. written by the treatment nurse indicated Resident #1 was in the therapy department and PTA C informed her that Resident #1's right foot began bleeding during therapy. The treatment nurse indicated Resident #1's right foot was wrapped in a towel with a blood soaked sock on. The treatment nurse indicated Resident #1 stated the sock was stuck to my heel a little bit ago, but I knocked it loose. When the treatment nurse removed the sock there was tissue stuck to the inner part of the sock. The note indicated Resident #1 said her dressing was removed this morning prior to taking a shower and a sock was placed on her foot without a dressing. Resident #1's right heel stage 2 pressure sore was noted to now be larger and measured 5.6 cm x 11.0 cm x 0.2 cm. A progress note dated 12/2/15 at 4:50 p.m. written by Resident #1's nurse practitioner indicated the wound on the right heel was a stage 2-3 shallow pressure ulcer. An undated skin assessment by RN D provided on 12/3/15 at 8:30 a.m. indicated Resident #1's right heel pressure sore measured 8.2 cm x 4.0 cm. RN D incorrectly documented Resident #1's pressure sore as a stasis ulcer. 3. Physician orders [REDACTED].#5 was [AGE] years old, and admitted [DATE] with [DIAGNOSES REDACTED]. A physician order [REDACTED]. A physician's orders [REDACTED].#5's left foot. The most recent MDS dated [DATE] indicated Resident #5 made herself understood. She had clear comprehension, was totally dependent for bed mobility, transfers, dressing and person hygiene. Her assessment indicated she was at risk for pressure sores but did not have any pressures sores nor did she have pressure sore during her previous MDS assessment. Resident #5's record indicated she was hospitalized from 11/6-11/9/15 for [MEDICAL CONDITION] (high sodium level) and UTI. Resident #5's weekly skin documentation indicated the following: * 11/10/15 (readmission) - No skin issues. * 11/12/15- 1.0 by 1.0 cm, clear fluid filled blister left heel. (Treatment [MEDICATION NAME] of [MEDICATION NAME] every shift.) * 11/19/15 - 1.0 by 1.0 cm, clear fluid filled blister left heel. * 11/27/15 - no measurement clear/pink blister. (intact) During an observation on 11/30/15 at 4:00 p.m., the treatment nurse lifted Resident #5's left foot, and an approximate 5 cm x 3 cm dark, purple/brown boggy (soft) area to her left heel was noted. (This indicated a possible DTI (deep tissue injury, or unstageable pressure sore.) The treatment nurse said the area was not there during her last assessment, (11/27/15) but was clear in color and nearly healed. The treatment nurse applied [MEDICATION NAME] of [MEDICATION NAME] to her left heel. Resident #5's left foot had declined to eschar in 3 days. During an interview on 12/1/15 at 4:40 p.m., the treatment nurse said she had not received any wound care training other than taking care of wounds as a home health nurse. She said she did not stage wounds and would notify the DON or ADON if she found a new skin issue, or if a resident's wound had changed, and she would assess the wound. The treatment nurse said the charge nurses did wound care on the weekends. During an interview on 12/1/15 at 4:50 p.m., the DON said she had not received formal training on pressure sores, but had received a directed inservice on pressure sores. The DON said the weekend RN was becoming wound care certified and she would teach the staff wound care. The DON said she or the ADON observed residents' pressure sores weekly and wounds were discussed in stand up meetings. During an observation and interview on 11/30/15 at 9:45 a.m., the ADON said Resident #5 had an area to her left heel and was receiving treatment for [REDACTED].#2 was sitting in her recliner, with shoes on both feet, and heels not off-loaded. During an observation on 11/30/15 at 11:35 a.m., Resident #5 was sitting in her recliner, asleep, shoes on both feet, heels not off-loaded. During an observation on 11/30/15 at 3:45 p.m., Resident #5 was lying in bed, with heels directly on the mattress, not off-loaded. Following surveyor intervention, a physician order [REDACTED].#5 to the wound care center for wound to the left heel. 4. Current electronic physician orders [REDACTED].#4 was [AGE] years old, admitted [DATE], with [DIAGNOSES REDACTED]. [MEDICAL TREATMENT] was started March 2015. On 10/23/15 these orders indicated to clean with NS, apply [MEDICATION NAME] and dress daily for a pressure sore to his left heel. The heels were to be floated at all times. The MDS dated [DATE] indicated Resident #4 made himself understood and he understood others. He required limited assistance for bed mobility and required limited to extensive assist for ADLs. A care plan created 11/02/15 indicated Resident #4 had a pressure sore to his left heel identified on 10/23/15. The pressure sore measured 3 cm x 2.7 cm x 0.1 cm with a tan and firm wound bed with a small amount of yellow exudate. The care plan did not include intervention to float Resident #4's heels at all times. A daily pressure sore form dated 11/17/15 through 11/30/15 completed by the treatment nurse indicated each day the pressure sore on Resident #4's left heel was a stage 2 with no necrotic tissue. A weekly skin documentation form completed by the treatment nurse recorded the following information regarding the pressure

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 3) sore to Resident #4's left heel: On 11/5/15 (documented as the 1st week of assessment) - Stage 2, left heel, 1.0 cm x 0.8 cm with pink granulating tissue. (This assessment conflicts with the 11/2/15 documentation on the care plan which indicated a 3 cm x 2.7 cm x 0.1 cm pressure sore with a tan and firm wound bed, with a small amount of yellow exudate) On 11/12/15 - Stage 2, left heel, 2.2 cm x 2.2 cm x 0.1 cm with pink granulating tissue, size has increased with slow improvement. On 11/19/15 - Stage 2, left heel, 2.2 cm x 2.2 cm x 0.1 cm with dark, tan, firm wound bed. On 11/26/15 - Stage 2, left heel, 2.2 cm x 2.2 cm x 0.1 cm with a dark firm wound bed During an observation and interview on 12/1/15 at 12 p.m., Resident #4 was sitting in his bed with both heels directly on the floor. Resident #4 had a 2.5 cm x 2.5 cm pressure sore, with firm, dark brown/black tissue covering the wound bed (unstageable pressure sore). The skin surrounding the wound was thick and white. The treatment nurse applied [MEDICATION NAME] and a sponge cushion to the wound and wrapped it with Kerlix. The treatment nurse said the wound was usually beefy red. She said he was supposed to keep his foot propped up, but most of the time he kept it on the floor. Resident #4 said his left heel was painful at times. A nutrition care plan edited on 10/7/15 indicated no new interventions regarding a low [MEDICATION NAME] of 3.1. (Normal [MEDICATION NAME] level is 3.5-6.0 g/dl.) A dietary consult dated 11/21/15 recommended Nephro-Vite 1 can daily. (Nephro-Vite is a dietary supplement for renal patients used to provide vitamins that are not obtained through diet.) After surveyor intervention, the treatment nurse obtained a new physician order [REDACTED]. The new order was to clean daily with normal saline, apply Santyl to wound bed, cover with non-adherent dressing, pad with gauze 4 x 4, and wrap with Kerlix, secure with tape, and re-evaluate in 7 days. During an interview on 12/1/15 at 3:30 p.m., the treatment nurse said the DON or ADON staged all pressure sores. The treatment nurse said Resident #4 was offered a pressure relief boot but refused. During interview on 12/1/15 at 5:00 p.m., the DON said the wound bed was yellow, dark brown, and she assessed it as a stage 2 at the present time. During an observation and interview on 12/1/15 at 5:10 p.m., Resident #4 said he had never been asked to wear a pressure relief boot. Resident #4 was sitting in the wheel chair in his room with both feet directly on the floor. 5. Physician orders [REDACTED].#16 was [AGE] years old, and admitted [DATE] with [DIAGNOSES REDACTED]. His orders included to off-load heels every shift. The most recent MDS dated [DATE] indicated Resident #16 usually made himself understood and usually understood others. He required extensive assistance of two staff for bed mobility, and was dependent for transfers, locomotion, eating and personal hygiene. His assessment indicated he was at risk for pressure sores but did not have any pressures sores nor did he have pressure sore during her previous MDS assessment. Resident #16's weekly skin documentation from 11/2/15-11/30/15 indicated no skin issues. During an observation on 12/2/15 at 11:15 a.m., Resident #16 was lying in bed, the treatment nurse raised his left leg and his heel had an approximate 5 cm x 4 cm pressure sore with black firm eschar on his heel (unstageable pressure sore). LVN F said he had a skin graft to his left heel several years ago, and she thought the discoloration was normal for him. His weekly skin assessments did not indicate normal black discoloration on his left heel. During an observation on 12/2/15 at 10:45 a.m., Resident #16 was sitting in his Gerichair in a reclined position. He was wearing socks and house shoes. There was no pillows or off-loading device in use. 6. A computerized physician order [REDACTED].#15 was [AGE] years old, and admitted [DATE] with [DIAGNOSES REDACTED]. A significant change MDS assessment dated [DATE] indicated Resident #15 had no cognitive impairment. The MDS indicated he was always understood, and always understands others. He is mostly independent and only requires limited staff assistance of one staff person for dressing and hygiene. The MDS indicated Resident #15 had one stage III pressure sore. Section M 1200 B. indicated Resident #15 had a pressure relieving device on his bed. A Wound Surveillance Form dated 11/30/15 indicated Resident #15 had a stage II pressure sore to his right upper buttock that developed in the nursing home on 11/17/15. After surveyor intervention during an observation and interview on 12/2/15 at 1:30 p.m. the treatment nurse identified two new stage 2 pressure sores to resident #15's coccyx. The larger pressure sore measured 1 cm x 0.6 cm x 0.1 cm and the second measured 0.3 cm x 0.1 cm x 0.1 cm. The pressure sore to the right buttock measured 1.0 cm x 0.3 cm x 0.3 cm. Resident #15 was lying on a regular pressure reduction mattress. The treatment nurse said she did not know why he was not on a pressure relieving mattress. A physician order [REDACTED].#15 was to receive wound treatment to his right buttock every 3 days and as needed. Staff was to clean with normal saline, pat dry, and apply a duoderm dressing. A Care Plan updated 9/15/15 indicated Resident # 15 would have a mattress overlay on his bed to reduce pressure when he layed on his back. A Braden scale dated 11/1/15 indicated Resident #15 was a mild risk for pressure sore development. 7. A Consolidated Physician order [REDACTED].#14 was [AGE] years old. Her [DIAGNOSES REDACTED]. An MDS dated [DATE] indicated Resident #14 required extensive one person assistance with Activities of Daily Living and bed mobility. A care plan created on 11/2/15 with a start date of 10/19/15 said to float heels. A physician telephone order dated 10/19/15 ordered pressure sore treatment for [REDACTED]. Float heels at all times. A physician telephone order dated 11/26/15 indicated to discontinue the skin prep and duoderm treatment and to begin lanoderm skin protectant cream to left and right heels every shift for seven days then re-evaluate. During an observation and interview on 12/2/15 at 11:00 a.m., Resident #14's right heel had no dressing and was not off-loaded. The resident's right heel was hard and pale reddish purple in color, and covered with dry, hard, brown, eschar (unstageable pressure sore). Resident #14 said she would wear pressure relieving boots if she had them. She told the DON no one had ever offered her boots. She was not on a pressure relieving mattress. During an interview on 12/2/15 at 11:53 a.m., the DON said she staged Resident #14's current pressure sore as a stage 1. She said she did not feel comfortable staging the wound. During an interview on 12/2/15 at 12:10 p.m., the ADON said Resident #14's pressure sores to her right and left heels were hard and brown. She said she thought they were a stage one. She described eschar as a scab, hard and brown or black. Weekly Skin documentation on 11/30/15 indicated the treatment nurse performed wound care with [MEDICATION NAME] of [MEDICATION NAME], but the treatment administration record showed she applied lanoderm. During an interview on 12/2/15 at 2:45 p.m., the treatment nurse said she applied the lanoderm, not the [MEDICATION NAME] of [MEDICATION NAME] and she did not know why she signed both treatments. The NPUAP web site at << http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/ >> accessed on 12/3/15 indicated the following: Category/Stage II: Partial thicknessPartial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister.Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated [MEDICAL CONDITION], maceration or excoriation.*Bruising indicates deep tissue injury. Category/Stage III: Full thickness skin lossFull thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage IV: Full thickness tissue lossFull thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by

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	455831	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARIS HEALTHCARE CENTER	610 DESHONG DR PARIS, TX 75460

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 0314 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 4) anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteo[DIAGNOSES REDACTED] or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable. Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknownFull thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without [DIAGNOSES REDACTED] or fluctuance) eschar on the heels serves as the body ' s natural (biological) cover and should not be removed. Suspected Deep Tissue Injury - depth unknownPurple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment. The undated Pressure Ulcer Policy, provided by the DON on 12/1/15 at 2:30 p.m., described pressure ulcer definitions, skin treatments and wound care documentation. No interventions or nursing care were listed. The policy indicated the wound documentation must be done daily and weekly. Skin rounds completed 12/3/15 indicated there were 10 residents with 21 pressure sores.
F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** Based on observation, interview and record review, the facility failed to ensure pharmaceutical services were provided to meet the needs of each resident and failed to ensure expired medications were removed from 2 of 2 medication carts (East/South medication cart and West medication cart), and the medication room. The East/South Hall medication cart and the medication room contained expired medications and medications with no open dates. The West Hall medication cart had unlabeled loose pills in the cart and contained undated opened medications. This failure could place the census of 51 residents at risk of not receiving the intended therapeutic benefit of their medication. Finding included: 1. During an observation on 12/2/15 at 10:45 a.m., the medication room contained the following: *One unopened bottle of Goldline Ear Drops, expired August 2007. *Two unopened bottles of Loperamide, expired date November 2015. 2. During an observation on 12/2/2015 at 3:03 p.m., the East/South Medication Cart contained the following: *Pataday 0.2% eye drops with no open date, *Two bottles of Latanoprost 0.005% eye drops with no open date, *Travatan eye drops with no open date, Erythromycin 3.5 gm with no open date, *Tears Eyes Drops expired May 2015, *GenTeal eye drops expired July 2015 and, *A large stock bottle of Sodium Bicarbonate 10gr #1000 expired September 2015. 3. During an observation on 12/2/15 at 2:51p.m., the West Hall medication cart contained the following: *one white capsule labeled Pliva 648 found loose in the cart drawer, *one pink tablet labeled N 343 and 2.5 found loose in the cart drawer, *one white tablet labeled Mylan 216 found loose in the cart drawer, *one yellow tablet labeled 7.5 found loose in the cart drawer, *Artificial Tears with no open date and no resident name, *Durezol 0.05% eye drops with no open date and, *Moxeza 0.5% eye drops with no open date During an interview on 12/3/15 at 9:50 a.m., the regional nurse consultant said there should be no expired medications on the medication carts or the medication room. She said the nurses were responsible for checking expired medications. The CMS 672 dated 11/30/15 indicated the census was 51.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection control program that provided a safe, sanitary, and comfortable environment, to help prohibit the development and transmission of disease and infection in 1 of 6 residents reviewed for infections. (Resident #1) The facility did not track organisms or implement contact isolation procedures to prevent the spread of infection in Resident #1's wound infected with MRSA. This failure could place the census of 51 residents at risk of infection. Finding Included: Consolidated physician orders [REDACTED].#1 was [AGE] years old, admitted on [DATE] with [DIAGNOSES REDACTED]. The orders indicated a weekly head to toe skin assessment to be completed every Thursday. The most recent MDS dated [DATE] indicated Resident #1 usually understood others and usually made her needs known. Resident #1 required extensive to total assistance from staff with transfers, dressing, toileting, and bathing. Resident #1 had impairments to her lower extremities. The MDS indicated Resident #1 had one stage two pressure sore that was not present upon admission. The most recent care plan dated 10/15/15 indicated on 10/29/15 Resident #1 had a stage 2 pressure sore to her right heel. The care plan indicated staff would use good infection control precautions when dealing with Resident #1's pressure sore. An infection report dated 11/18/15 indicated Resident #1 had an infection; the report did not indicate where the infected area was. The report indicated the wound was red, warm, and swollen. The report indicated a culture was obtained on 11/19/15 and on 11/22/15 results were positive for MRSA and the physician was notified. The infection report indicated Resident #1 was placed on standard precautions and antibiotic therapy. A laboratory report dated 11/22/15 indicated Resident #1 had MRSA in her right heel wound. During an interview on 12/2/15 at 1:45 p.m., LVN A said she received the results of Resident #1's wound culture on 11/22/15. LVN A said she did not read the entire report to know that Resident #1 had MRSA to the wound on her right heel. LVN A said she only noticed the report indicated that Resident #1 was resistant to the antibiotic she received so they changed her antibiotic. During an observation and interview on 11/30/15 at 2:00 p.m., Resident #1 had an open area to her right heel with a pink and yellow wound bed and an open area to her right inner ankle area with a yellow wound bed. During an interview on 12/2/15 at 11:00 a.m., the treatment nurse said she was aware on 11/22/15 that Resident #1's wound was MRSA positive. She said she did not implement contact precautions for Resident #1. During an observation on 12/1/15 at 10:06 a.m., Resident #1 wore a sock on her right foot that had a bloody spot the size of a half dollar to her heel. Resident #1's right heel pressure sore did not have a dressing. An order dated 12/2/15 indicated for Resident #1 to have a wound culture to her heel and be placed on contact isolation. During an interview on 12/2/15 at 10:50 a.m., LVN E said he provided care for Resident #1 three of the four days he worked. LVN E said he was never notified that Resident #1's wound was MRSA positive. LVN E said he became aware today, 12/2/15, of the results of the wound culture.

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARIS HEALTHCARE CENTER	**610 DESHONG DR PARIS, TX 75460**

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F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) During an interview on 12/2/15 at 11:05 a.m., LVN F said she was unaware that Resident #1 had MRSA. She said she just found out today, 12/2/15, Resident #1 was MRSA positive. During an observation on 12/2/15 at 11:23 a.m., after surveyor intervention, there was a plastic container in the hall by Resident #1's door that contained gloves, mask, and gowns. During an interview on 12/2/15 at 11:23 a.m., CNA B said she assisted Resident #1 with showers and she was unaware that Resident #1 was MRSA positive. CNA B said she had never received any special instructions on how to care for a resident with MRSA. CNA B said when she gave Resident #1 a shower she removed the dressing herself and after the shower would transport Resident #1 to her room. CNA B said she did not notify the treatment nurse or charge nurse when she was finished care for Resident #1. During an interview on 12/2/15 at 11:40 a.m., the therapy director said Resident #1 had been on therapy services since 10/10/15 and was provided physical therapy four times a week. The therapy director said she and the physical therapy assistants were all unaware that Resident #1 had MRSA. During an interview on 12/2/15 at 11:45 a.m. PTA C said he provided physical therapy services to Resident #1 weekly and was unaware that she had MRSA in the wound on her foot. During an interview on 12/2/15 at 9:00 a.m. the ADON said she was over the infection control program and did not track organisms. The ADON said Resident #1's wound culture to her right heel was MRSA positive and she had been aware since the culture results on 11/22/15. The ADON said Resident #1 was not placed on contact isolation. After surveyor intervention, the ADON said Resident #1 should be in contact precautions. During an interview on 12/2/15 at 9:30 a.m. and 2:00 p.m., the DON said when CNAs finish showering a resident with a pressure sore they should immediately notify the treatment nurse or charge nurse so a dressing can be reapplied. The DON said Resident #1 should have been placed on contact isolation when a positive culture was received. The DON said the ADON was over the infection control program. The DON said when wound cultures were received the ADON or herself should be notified with the results. The DON said she was unaware that Resident #1's wound was MRSA positive. The DON said she did not know what the policy was concerning follow up wound cultures. During an interview on 12/2/15 at 12:00 p.m., Resident #1's physician said Resident #1 should have been placed on contact precautions for MRSA when a positive culture was received. The infection control police dated 5/1/09 indicated the following: *residents known or suspected to have MRSA infection or colonization will be placed on contact precautions. *residents will remain on contact precautions until a clear culture report has been obtained. *in order to be considered free of MRSA, a resident must have a negative screen of all breaks in skin and anterior nares. *at the first indication a resident may be infected, contact precautions must be instituted. *when precautions are implemented, the charge nurse in the section where precautions are instituted shall maintain an adequate array of isolation supplies near the isolation room so that appropriate protective clothing can be easily put on before entering the isolation room. *in addition to standard precautions, contact precautions must be implemented for resident known or suspected to be infected with skin or wound infections or colonization with multidrug-resistant bacteria. The CMS 672 dated 11/30/15 indicated the census was 51.
F 0465 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, interview, and record review, the facility failed to ensure a safe, functional, sanitary, and comfortable environment for the facility. The shower stalls had discolored or broken tiles/grout, 5 shower chairs had pink goo and brown splatters in the shower chair joints and on the seat of the shower chairs. The ice machine in the dining room had pink, blackish goo inside the edges and upper lining of the ice machine. Empty oxygen cylinders were left unsecured. Resident window screens were torn and had holes in them. The glass doors leading from the dining room had a 1/4 inch gap between the doors to the outside. A resident window was broken. This failure could place the census of 51 residents at risk of living in an unclean, unsanitary environment. Findings included: During observations on 11/30/15 the following was noted: * 2:45 p.m. - The East Hall shower room, had a venipuncture bandage on the floor of the shower stall and the drain cover was loose and would slip off when touched. The soap dispenser had a grey grunge down the side of the dispenser, and brown splatters were noted on the commode seat. Two floor tiles had an approximate 0.2 cm splatter of dried blood on the floor, and approximate 30 (2 inch) floor tiles were discolored brown in the shower room. The shower chair had pink goo like material in the joints and beneath the seat of the shower chair. * 3:05 p.m. - in the West Hall shower room; a plastic corner piece that ran from the floor to the top of the shower stall was missing, leaving sharp tile edges. A clump of hair was in the drain of the shower stall, and black splotched mildew was in the caulk encircling the shower stall. Three shower chairs had pink goo in the shower chair joints and beneath the seats of the chairs. A 6 inch by 2 inch strip of paint was missing near the vent in the ceiling. During observations on 12/1/15 of the exterior of the building, the following was noted: * 9:20 a.m. - A resident's outside window had a cracked window pane near the front entrance. * 9:23 a.m. - A clump of cigarette butts were near the front entrance outside a resident window. * 9:25 a.m. - A torn resident window screen near the kitchen. * 9:26 a.m. - A torn resident window screen in the court yard. * 9:30 a.m. - 3 small, empty oxygen bottles were left unsecured in the oxygen storage shed. During an observation and interview on 12/2/15 at 3:00 p.m., the Life Safety Code surveyor provided a paper towel filled with pink/greyish goo. He said the goo had come out of the ice machine in the dining room. During an interview on 12/3/15 at 10:45 a.m., the maintenance supervisor said the empty oxygen bottles were left by residents. He said he was aware of the broken plastic on the corner. He was unaware of the broken window, torn screens and cleaning needed in both shower rooms, but he said he would take care of it. He said the ice machine was cleaned and ice in the machine was disposed of before cleaning. The CMS 672 dated 11/30/15 indicated the census was 51.