STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455831	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paris Healthcare Center	610 Deshong Dr Paris, TX 75460

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observation, interview, and record review, the facility failed to ensure residents who had a urinary catheter, received appropriate treatment and services to prevent urinary tract infections to the extent possible for 1 of 4 residents reviewed for catheter care. (Resident #81). The facility failed to provide physician ordered catheter care for Resident #81 by not emptying the Resident #81's foley catheter once a shift while on an antibiotic for a urinary tract infection. This failure could place residents at risk for urinary tract infections, pain, confusion, and sepsis (infections that spread to the blood). Findings included: Record review of an undated face sheet revealed Resident #81 was a [AGE] year-old-male admitted to the facility on [DATE] with the diagnoses of obstructive uropathy (is blockage of urinary flow, which can affect one or both kidneys depending on the level of obstruction), traumatic brain injury (an injury to the brain caused by an external force), and paraplegia (paralysis of legs and lower body). Record review of an MDS dated [DATE] revealed Resident #81 had a BIMS of 15 which indicated no cognitive impairment. Resident #81 required extensive assistance with transfer and toileting. The MDS indicated Resident #81 had an indwelling foley catheter. Record review of Resident #81's progress note written by LVN C on 09/16/2024, revealed Resident #81 was vomiting in his room .manual heart rate was 174. He complained of severe abdominal pain to his upper quadrants. Abdominal distension was noted. Foley catheter was draining well. The MD was called and ordered Resident #81 was to be sent to the emergency room . Resident #81 was diagnosed with a urinary tract infection. Record review of Resident #81's progress note written by LVN C on 09/25/2024 at 10:00 a.m., Resident #81 was readmitted to the facility following being hospitalized for a urinary tract infection. The resident readmitted with an order for Augmentin 875/125 mg twice daily for 5 days. Record review of September 2024 consolidated MD orders revealed an order to empty foley catheter twice daily and record output dated 2/20/2023. (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #81's TAR for September 2024 indicated the following: *700 cc's of urine emptied on the night shift on 09/29/2024. *2700 cc's of urine emptied on the morning shift on 09/30/2024. During an observation and interview on 09/30/2024 at 7:00 a.m., Resident #81's foley catheter bag contained over 2000 cc of urine. Resident #81 stated his abdomen was hurting and asked if his foley catheter was full. He stated the nurses often forget to empty his catheter bag. During an interview on 09/30/2024 at 10:30 a.m., LVN C stated Resident #81 had 2300 ccs of urine in his catheter bag when she emptied it at around 7:30 a.m. She stated that was not good for the resident. She stated the foley catheter was an anti-reflux (will not back flow urine into the bladder) catheter, but that his bladder had nowhere to empty when the bag was that full. That allowed stagnant urine to stay in his bladder and could cause a further urinary tract infection. During an interview on 10/02/2024 at 10:00 a.m., the DON stated catheter care including emptying the foley catheter should be done twice daily. She stated Resident #81 may need to have his catheter emptied three times a day. She stated not having the catheter emptied and allowing it to be so full that his bladder could not empty promoted bacteria growth that could lead to urinary tract infections. During an interview on 10/02/2024 at 11:00 a.m., the ADM stated it was her expectation that the nurses followed the MD orders and empty catheters at least twice a shift and if they see it needs to be done more often, they do it using their nursing judgement. She stated it was never acceptable to allow a resident with a catheter to have over 2000 ccs of urine in their drainage bag. Review of the facility policy dated April 2018, indicated the staff and physicians will monitor the individual for complications of an indwelling catheter such as a symptomatic urinary tract infection, urosepsis, or urethral erosion or pain, and complications related to foley catheter usage.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on interviews and record reviews, the facility failed to ensure a gradual dose reduction was attempted for 1 of 4 residents (Resident #15) reviewed for unnecessary medications/ gradual dose reduction. The facility failed to do a gradual dose reduction or document contraindication for a gradual dose reduction for Resident #15's ordered Risperdal 2mg orally twice daily ordered 08/14/2023 and Risperdal Consta suspension extended release 25mg/ml (2ml) intramuscular every 14 days ordered 02/22/2024. These failures could place residents at risk for possible psychotropic medication side effects, adverse consequences, decreased quality of life and dependence on unnecessary medications. Findings included: Review of the resident face sheet revealed, Resident #15 was a [AGE] year-old male that admitted on [DATE] with the diagnoses of schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania), seizure disorder, and cerebral infarction (stroke). Review of Resident #15'squarterly MDS dated [DATE] indicated Resident #15 had a BIMS (brief interview of mental status) of 00, which indicated a severe cognitive impairment. The MDS revealed Resident #15 had short- and long-term memory impairment. The MDS revealed Resident #15 required limited assistance with ADLs. No hallucinations, delusions, behavior, rejection of care or wandering was noted on the MDS. Resident #15 received antipsychotic medication 7 days out of 7 days. Review of Resident #15's physician consolidated orders dated 09/01/2024 to 09/30/2024 revealed the following: * Risperdal 2 mg orally twice daily originally ordered on 08/14/2023. *Risperdal Consta suspension extended release 25mg/2ml. Give 2ml intramuscularly every 14 days original order date 02/22/2024. Review of Resident #15's MAR (medication reconciliation record) for September 2024 revealed the following refusals: Risperdal 2mg twice daily 09/02/2024-a.m. dose 09/03/2024-a.m. dose (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/04/2024-a.m. dose 09/06/2024-a.m. dose 09/07/2024-a.m. dose 09/08/2024-a.m. dose 09/11/2024- a.m. dose 09/12/2024- a.m. dose 09/16/2024- a.m. dose 09/17/2024- a.m. dose Risperdal Consta 2ml intramuscular injection 09/19/24 Further review revealed Risperdal Consta 2ml intramuscular injection was administered on 09/05/2024. Record review of the consultant pharmacist recommendations for January through September 2024 and August to December 2023 revealed there was not a GDR for Resident #15's Risperdal 2mg oral twice daily medication nor a GDR for the Risperdal Consta 2ml intramuscular injection. During an interview on 10/02/2024 at 1:15p.m., RPH D stated she made recommendations for the decrease of Resident #15's Risperdal 2mg orally twice daily to be decreased to 1mg in the morning and 2 mg at bedtime. She stated she sent the recommendation to the facility on [DATE] after the DON informed her the GDR for Resident #15 were late. She stated she understood the GDR was supposed to be done every 6 months for the 1st year and annually thereafter for antipsychotic medications. She stated the facility had a lot of GDRs that were out of compliance when she took the building over and she was trying to gradually get everyone on a schedule. She stated it was important to do GDRs so the resident will be on the lowest effective dose of psychotropic medications. During an interview on 10/02/2024 at 2:00 p.m., the DON stated she could not find the GDR for Resident #15 due in February and August 2024 for his Risperdal 2mg orally twice daily. She stated she could not find the GDR for Resident #15's Risperdal Consta 2 ml intramuscularly every 14 days that was due in August. She stated she called the pharmacist after the surveyor asked about the GDR for Resident #15. She stated it was important for GDR to be done so residents did not suffer ill effects of psychotropic medications. She stated she would have to make a system to check behind the pharmacist and ensure the GDRs are done on all residents timely. Review of a facility policy titled 'Psychoactive Medications' dated 07/2024 indicated . Residents who use psychotropic medications shall be evaluated for gradual dose reduction unless clinically contraindicated, in a effort to discontinue these drugs.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46062 Based on interview and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 16 residents reviewed for medications. (Resident #26) The facility failed to ensure Resident #26 received his full eight-week course of Mavyret (antiviral medication used to treat Hepatitis C, which is a disease of the liver caused by a virus that causes damage to the liver) ordered by the Infectious Disease physician and started on 11/15/23. This failure could cause prolonged illness and increased recovery time for residents. Findings included: Record review of Resident #26's face sheet dated 9/30/24 indicated he was [AGE] years old and admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses including Chronic Hepatitis C, encephalopathy (any brain disease that alters brain function or structure). Record review of Resident #26's significant change MDS assessment dated [DATE] indicated he had a BIMS of 4, which indicated he had severe cognitive impairment and required moderate staff assistance to supervision for most ADLs. The MDS indicated Resident #26 had cirrhosis (chronic liver damage from a variety of causes leading to scarring and liver failure). Record review of Resident #26's undated care plan indicated he had a diagnosis of Hepatitis C with an intervention to administer medications per MD orders with a start date of 11/17/23. Record review of Resident #26's Progress Notes dated 11/01/23 indicated RN B received a call from the Specialty Pharmacy to notify the facility of new orders for Mavyret 100/40 mg 3 tabs daily for sixty days from the Infectious Disease doctor. RN B documented the Specialty Pharmacy would send a 30-day supply pending approval. Record review of Resident #26's Progress Notes dated 11/15/23 written by * indicated LVN A documented the new medication for treatment of Resident #26's Hepatitis C was received from the Specialty Pharmacy and the Infectious Disease doctor was notified of the initial dose. LVN A documented she notified Resident #26's primary care physician for order clarification of discontinuing the resident's atorvastatin and pantoprazole until the completion of Mavyret eight-week treatment for chronic Hepatitis C. LVN A documented the medication was to be given daily with food and MUST AVOID ANY MISSED DOSES FOR successful treatment of chronic Hepatitis C and MARs updated. Record review of Resident #26's order history from 11/01/23 revealed an order for Mavyret 100-40 mg three tablets once daily with food with a start date of 11/15/23 and an end date of 12/12/23 entered by LVN A. Record review of Resident #26's MAR dated 11/01/23-11/30/23 indicated Mavyret 100-40 mg 3 tablets once daily with food for Chronic viral Hepatitis C with a start date of 11/15/23 and an end date of 12/12/23. The MAR indicated Resident #26 received the medication 11/16/23 through 11/19/23 and 11/28/23 through 11/30/23. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #26's progress notes dated 11/19/23-11/27/23 indicated he was admitted to the hospital on 11/19/23 and returned to the facility on [DATE] with diagnoses of respiratory failure and metabolic encephalopathy (brain dysfunction caused by a chemical imbalance in the blood that affects the brain). Record review of Resident #26's hospital Infectious Disease Progress Note dated 11/20/23 documented his assessment and plan included Resident #26 had cirrhosis with Hepatitis C and he was on a direct antiviral therapy, Mavyret, and the hospital was going to call his nursing facility and would continue the medication. On 11/23/23, the Infectious Disease Progress Note indicated his assessment and plan included Resident #26 had an underlying cirrhosis and Hepatitis C and he was receiving treatment and he had his medication from the nursing facility, and they would continue the medication. Record review of Resident #26's MAR dated 12/01/23-12/31/23 indicated Mavyret 100-40 mg 3 tablets once daily with food for Chronic viral Hepatitis C with a start date of 11/15/23 and an end date of 12/12/23. The MAR indicated Resident #26 received the medication 12/01/23 through 12/12/23. Record review of Resident #26's Infectious Disease physician's progress note dated 5/28/24 indicated Resident #26 failed his first treatment of Mavyret for his Hepatitis C because he only received four weeks of an eight-week treatment. During an interview on 10/01/24 at 10:07 AM, the Specialty Pharmacy stated they delivered a 28-day supply of Resident #26's Mavyret on 11/15/23. The Specialty Pharmacy said the physician had ordered a 28-day supply with one refill of the medication and it was not refilled. During an interview on 10/01/24 at 12:24 PM, LVN A said she had worked at the facility for 3-4 years until February 2024. LVN A said she was the infection control nurse and worked from home and would come to facility 1-2 days a week. LVN A said she vaguely remembered the order for Resident #26 starting on Mavyret. LVN A said Mavyret was an antiviral medication for his Hepatitis C. LVN A said it seemed like they had some trouble getting the medication, but she did not really remember. LVN A said, maybe Resident #26 had a reaction to the medication or maybe he only received 4 weeks of the Mavyret because he was supposed to go back to the Infectious Disease doctor to see if he was going to continue the medication. LVN A said it seemed like maybe Resident #26 went into the hospital and thought the hospital stopped the medication. LVN A said if Resident #26 was supposed to get 8 weeks of the medication and he did not complete it, it could have kept his Hepatitis C from being controlled. LVN A said she remembered they were in constant communication with the Infectious Disease doctor's nurse during that time. LVN A said she was the infectious disease nurse at that time, and she was on top of it, but it had been almost a year and she just could not remember the specifics. Attempted to call RN B on 10/01/24 at 1:50 PM and 4:35 PM, there was no answer and was unable to leave a message. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/01/24 at 2:35 PM, LVN C said she did not remember much about Resident #26 taking Mavyret for his Hepatitis C. LVN C said she did not remember much about the medication, but she did remember they took the medication to the hospital when he admitted to the hospital shortly after starting the Mavyret. LVN C said she did not remember exactly how long Resident #26 was supposed to have taken the Mavyret, but she thought it was ordered for a couple of months. LVN C said if the Mavyret was ordered for eight weeks and he only received four weeks of the medication, then it could have affected his Hepatitis C and lab results, and the medication would not have effectively treated Resident #26's Hepatitis C as it was meant to. During an interview on 10/01/24 at 4:58 PM, the Regional Nurse said she did not work at the facility in November of 2023, but in reviewing Resident #26's chart, it appeared the nurse made a transcription error and only put the Mavyret in for 28 days when it appeared to have been ordered for 8 weeks. The Regional Nurse said she was still trying to get the original order from the Infectious Disease Physician. During an interview on 10/02/24 at 10:25 AM, LVN AA, the Infectious Disease doctor's nurse, said she had called the facility and spoke to LVN A on 1/08/24 to see what day Resident #26 was scheduled to complete his Mavyret to determine when labs would need to be drawn. LVN AA said LVN A told her Resident #26 had completed the medication on 12/12/23. LVN AA said she told LVN A that Resident #26 should not have completed the medication until 1/10/24 by her calculations. LVN AA said LVN A said she would check on it and call her back. LVN AA said LVN A called her back and said it looked like he had gone into the hospital and then it was not restarted when he returned to the facility. LVN AA said Resident #26 was ordered Mavyret for a total of 8 weeks to treat his Hepatitis C. LVN AA said after learning Resident #26 did not complete the course of treatment, LVN AA informed the Infectious Disease doctor, and he ordered labs. LVN AA said they checked his viral load (the amount of virus in an infected person's blood) that week and none was detected and then they repeated the lab at 3 months (standard procedure) and his viral load was high, which indicated the 4 weeks of Mavyret did not cure his Hepatitis C. LVN AA said Resident #26 had to receive another 12-week course of treatment for his Hepatitis C. LVN AA said by Resident #26 not receiving the correct duration of the medication, it resulted in failed treatment of his Hepatitis C and he had to receive another course of treatment. LVN AA said the Specialty Pharmacy will only fill a month at a time for the medication due to the cost of the medication and that was why it was called into the Pharmacy as a 28 day with one refill. LVN AA said she had spoken with RN B and LVN A prior to Resident #26 starting Mavyret and explained the duration of the medication was for eight weeks and the importance of not missing any doses. During an interview on 10/02/24 at 12:50 PM, the DON said she started work at the facility in February of 2024. The DON said she was not working at the facility in November of 2023, but since then, Resident #26's Infectious Disease doctor had ordered another treatment for Resident #26's Hepatitis C. The DON said Resident #26 completed the new treatment and his Hepatitis C was in remission. The DON said Resident #26's end result of not completing the ordered eight-week course of Mavyret resulted in Resident #26 having a failed treatment for his Hepatitis C. The DON said at the time of when Resident #26's Mavyret was ordered in November 2023, there was no oversight, lack of documentation, and everything that could have gone wrong did and it resulted in Resident #26 not receiving the full course of the medication. The DON said they now have systems in place to prevent these types of things from happening in the future. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/02/24 at 1:17 PM, the ADM said she came to the facility in January 2024 and did not have any firsthand knowledge of Resident #26's missed medication issue, but it appeared the nurse that entered the medication order into the software, made a transcription error in the order. The ADM said it could have delayed Resident #26's treatment of his Hepatitis C by not completing the prescribed course of the medication. The ADM said she would expect staff to transcribe medication orders correctly and follow the physician's orders. Record review of the facility's policy titled Specific Medication Administration Procedures dated 6/01/22, indicated . the purpose was to administer oral medications in a safe, accurate, and effective manner . review and confirm medication orders for each individual resident on the Medication Administration Record prior to administering medications to each resident .