STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445224	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henry County Health and Rehabilitation	239 Hospital Circle Paris, TN 38242

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and interview the facility failed to revise a care plan for 1 of 20 (Resident #90) sampled residents reviewed. The findings include: 1. Review of the facility's undated policy titled, Providing End of Life Care, revealed The facility is committed to providing the needed care and services to those residents at or approaching end of life in accordance with the resident's preferences, goals, and professional standards in order to promote their highest practicable physical, mental, and psychosocial well-being.The facility and resident/family will coordinate a plan of care, and will implement interventions in accordance with the comprehensive assessment, and the resident's needs, goals, and preferences.The plan of care will identify the care and services that each discipline will provide.Factors influencing the choice of treatments may include.The resident's preferences expressed either directly or in an advance directive.The care plan of care will be revised to reflect and/or address changes. 2. Review of the medical record revealed Resident #90 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure, Dementia, Chronic Kidney Disease, and Hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated Resident #90 was severely cognitively impaired. Resident #90 received hospice care. Review of the care plan dated [DATE], revealed .Full code .initiate cpr [cardiopulmonary resuscitation] .limited measures, hospice care .Notify hospice if no heart rate and no respirations. Do not activate EMS [Emergency Medical Services] services if no heart rate and no respirations .notify next of kin .RESIDENT IS FULL CODE .K [Kardex- a patient summary worksheet that provides key information for direct care]. The care plan was not revised to reflect Resident #90's change in code status. Review of the Tennessee Physician Orders for Scope of Treatment, form dated [DATE], revealed .Do Not Attempt Resuscitation .Comfort Measures . Review of the progress notes dated [DATE], revealed .Care conference held with resident's wife and IDT [Interdisciplinary Team]. Reviewed medications and code status. Code status updated to DNR [Do Not Resuscitate] comfort measures . Review of the Physician's Orders dated [DATE], revealed .DNR comfort measures. Review of the Kardex dated [DATE], revealed .RESIDENT IS FULL CODE. During an interview on [DATE] at 2:03 PM, the MDS Coordinator was asked when a care plan should be revised if a resident changes their code status. The MDS Coordinator responded as soon as possible.

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.

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