

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2025
NAME OF PROVIDER OR SUPPLIER Patriot Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Volunteer Drive 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation and interview, the facility failed to ensure the resident's right to be treated with dignity was maintained for 1 of 16 (Resident #7) residents sampled for dignity.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility policy titled, Resident Rights, dated 3/7/2023, revealed .The resident has the right to a dignified existence .The resident has a right to be treated with respect and dignity . 2. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE], with diagnoses including Heart Failure, Depression, Obesity, Anxiety and Diabetes. <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #7 was cognitively intact.</p> <p>Review of the Care Plan revised on 12/26/2024, revealed, .resident has an ADL [activities of daily living] self-care performance deficit .BATHING/SHOWERING .resident requires ext [extensive] assist by 1-2 staff with showering .requires extensive assist by 1 staff to a standing position .</p> <p>Review of the medical record dated 1/1/2025, revealed Resident #7 weighed 294 pounds.</p> <p>Observation and interview in Resident #7's room on 1/16/2025 at 9:04 AM, revealed the resident was dressed and lying in bed. Resident #7 stated, .had a shower yesterday .stuck me in a smaller shower chair .I couldn't get up, the chair stuck to me, think they [staff assisting] were laughing at me, it made me feel bad, big fat man stuck in the shower chair . Resident #7's eyes watered up and a tear ran down his face while talking about this.</p> <p>Observation and interview in Resident #7's room on 1/16/2025 at 1:29 PM, revealed the resident was dressed and lying in bed, Resident #7 stated, .the Administrator and Social Worker came and asked me where I wanted it [referring to the 3 CNAs (Certified Nursing Assistants) laughing in the shower room] to end . they were supportive and said they shouldn't have laughed .I didn't know what their [referring to the 3 CNA's] motive was .it made me feel bad . Resident #7 confirmed that was his first time being put in the smaller shower chair and stated, .I didn't know what was going on .nobody was talking .</p> <p>(continued on next page)</p>

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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview in Resident #7's room on 1/17/2025 at 2:21 AM, revealed staff assisted the resident from his large wheelchair to his bed and Resident #7 stated, .they have ordered 2 more large shower chairs .</p> <p>During an interview on 1/16/2025 at 10:09 AM, CNA K, confirmed when she went in the shower room, Resident #7 was in the smaller shower chair. CNA K stated, .we do have one that is bigger .when I came in the other 2 CNA's were already assisting him .they were both on each side of him and he suggested we used baby oil .he had a shirt on and shorts pulled up above his knee .put baby oil on the right side .I'm behind the shower chair .and when they went to transfer .he leaned to one side to make it easier to get him up .and I pulled the chair out .pulled his pants .and that's when I slid .and that's when we started laughing . and he was at the bar/rail in the shower room .holding on .I was behind him . CNA K confirmed Resident #7 couldn't see her or the other 2 CNAs and they were all 3 laughing. CNA K stated, .we didn't verbalize what happened about me almost fallen . CNA K was asked can you understand why he would think you all were laughing at him. CNA K stated, Absolutely.</p> <p>During an interview on 1/16/2025 at 10:35 AM, CNA J confirmed Resident #7 was a 2 persons assist to get up and one person assist to walk. CNA J was asked why she had used the smaller wheelchair on Resident #7 for his shower. CNA J stated, I have used it before on him .It [referring to the larger shower chair] wasn't in the shower room at the time .I didn't go to the 300 [referring to the shower room] to get it .CNA H helped me get him from the wheelchair to the shower chair . CNA J confirmed she wouldn't use the smaller chair anymore and stated, .stood him up and the shower chair was stuck to him .put baby oil on both his sides .he was laughing and joking about it as well .and I told her [referring to CNA H] to go get another CNA .when she [referring to CNA K] came in she slipped .he [referring to Resident #7] is still in the chair .his back is to her . we giggled .the floor stays wet and then with the baby oil .she catches herself from slipping and she comes over .she holds the back of the chair .and we go under each arm and he came on up .he had on a shirt . shorts about to his knees .I pulled his pants up and rolled the wheelchair under him . CNA J confirmed the resident couldn't see [Named CNA K] slip, he didn't know why they were laughing and it wasn't appropriate for them to laugh and stated, I totally get it .</p> <p>During an interview on 1/16/2025 at 11:11 AM, CNA H stated, .[named CNA J] had asked me to help stand him [referring to Resident #7] up so she could dry his bottom and put him back in the wheelchair .we tried to stand him up and we couldn't get him up . CNA H confirmed the shower chair was stuck on his right side and stated, I left .went to see if anyone was available and [named CNA K] was the first person I saw . CNA H confirmed that she and CNA K walked in the shower room at the same time and stated, .[named CNA J] put baby oil on his right side .I get back on the right side .and [Named CNA J] is on the left .we are facing the door and his back is towards the door .[named CNA K] was at the back of the wheelchair .we counted 1, 2, 3 and we go to stand him up while we are pulling him up .[named CNA K] is working on his hip .we get him up [named CNA K] slipped and that's why we were laughing .we are together all the time .we are goofy .it was a wrong situation at the wrong time . now he thinks we are laughing at him .we should have handled the situation better .</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/16/2025 at 3:56 PM, the Administrator stated, .me and the Social Worker went down and talked to him [referring to Resident #7] .CNA assigned to him asked if he was ready for shower . didn't have the larger shower chair .used the smaller one .and that Resident #7 said, My butt is too big isn't this funny .this big fat man is stuck in a chair .I think we need to get another person .and suggested that we get baby oil to get me out of chair .the girl behind me or to the right .started laughing .I thought were they laughing at me or the situation .when I got back into my room .I got into my head and thought it was personal .he teared up with me as well and I asked would he like to talk to someone .he said he was seeing someone and he was already taking medication for his anxiety .going to set him up with a visit with our .psych NP .he was grateful for that .we did talk to the 3 CNAs .him being vulnerable .they just didn't think about it .</p> <p>During an interview on 1/21/2025 at 2:57 PM, Assistant Director of Nursing (ADON) A was asked about the incident with Resident #7's shower chair. ADON A stated, .we have a larger chair .apparently the shower chair was occupied and that's why he was stuck in it .they should have waited for the appropriate size chair .</p> <p>During a interview on 1/22/2025 at 9:47 AM, the Director of Nursing (DON) stated, .we do have wider shower chair .in hind site .should have found another shower chair and started again .when [Named Administrator] went to talk to him .it made him feel afterwards .like it was about him . The DON confirmed moving forward the staff will use the larger shower chair for Resident #7.</p> <p>During a telephone interview on 1/22/2025 at 5:05 PM, the Medical Director was asked should residents be treated with dignity. The Administrator stated, Everybody should.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, and interview the facility failed to develop a person-centered care plan for 1 of 19 (Resident # 11) residents reviewed for pressure ulcers.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, Comprehensive Care Plan, dated 12/1/2024, revealed .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental psychosocial needs that are identified in the resident's comprehensive assessment .The comprehensive care plan will describe .The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .</p> <p>2. Review of the medical record revealed that Resident #2 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Dementia, Anxiety, and Depression.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status score of 3, which indicated Resident #2 was severely cognitively impaired, and had two Stage 3 pressure ulcers that were not present on admission.</p> <p>Review of the Weekly Wound assessment dated [DATE], revealed Resident #2 had a Stage 3 pressure ulcer to the left buttock with the initial date of treatment on 12/30/2023.</p> <p>The facility failed to care plan for pressure ulcer care and management.</p> <p>During an interview on 1/21/2025 at 11:53 AM, the MDS Coordinator confirmed that residents assessed for pressure ulcers should have a care plan for pressure ulcers.</p> <p>During an interview on 1/22/2025 at 9:20 AM, the Director of Nursing confirmed that a resident assessed for pressure ulcers should have interventions and goals on the resident's care plan to address the pressure ulcers.</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, record review, and interview the facility failed to ensure residents received the necessary treatment and services consistent with professional standards of practice to promote healing for 9 of 9 (Residents #1, #2, #5, #11, #14, #15, #16, #18, and #19) reviewed for pressure ulcers. The facility's failure to perform wound care treatments and weekly wound assessments in accordance with facility policy contributed to the deterioration of pressure ulcers/injury for Resident #14 and #18, resulting in Harm.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Pressure Injury Prevention and Management, dated 2/14/2023, revealed . provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries .Licensed nurses will conduct a full body assessment on all residents upon admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Assessments of pressure injuries will be performed by a licensed nurse and documented. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS [Minimum Data Set] . The RN [Registered Nurse] Unit Manager . will review all relevant documentation regarding skin assessments, pressure injury risks, program towards healing, and compliance at least weekly, and document a summary of findings in the medical record .</p> <p>Review of the undated facility policy titled, Documentation of Wound Treatments, revealed The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition and changes in treatment .Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. The following elements are documented as part of a complete wound assessment: Type of wound (pressure injury, surgical .) and anatomical location. Stage of the wound, if pressure injury (stage 1, 2, 3, 4, deep tissue injury, unstageable pressure injury) or the degree of skin loss if non-pressure (partial or full thickness) Measurements: height, width, depth, undermining, tunneling .Description of wound characteristics: Color of the wound bed, type of tissue in the wound bed (granulation, slough, eschar, epithelium), Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated), Presence, amount, and characteristic of wound drainage/exudate, Presence of odor, Presence of pain .Wound treatments are documented at the time of each treatment .</p> <p>Review of facility policy titled, Consulting Physician/Practitioner Orders, dated 12/1/2024, revealed Consulting physician/practitioner orders are those orders provided to the facility by a physician/practitioner other than the resident's attending physician .For consulting physician/practitioner orders received .the nurse will .Follow facility procedures for verbal or telephone orders .</p> <p>2. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including, Chronic Obstructive Pulmonary Disease, Schizophrenia, Anxiety, and Diabetes.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a Brief Interview for BIMS score of 3 which indicated Resident #14 was severely cognitively impaired and was at risk for developing pressure ulcers.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Physician Order dated 12/6/2024, for wound care to the right and left buttock included, .cleanse . with normal saline .cover with honey alginate and cover with a foam dressing .one time a day .</p> <p>Review of the TAR dated 12/2024, revealed the wound care was not documented as being provided as ordered for the left and right buttock on 12/7/2024,12/8/2024 and 12/9/2024.</p> <p>Review of Physician Order dated 12/30/2024 for wound care to the left and right buttock included .Cleanse . with wound cleanser or normal saline .cover with calcium alginate . with super absorbent dressing .one time a day .</p> <p>Review of the Resident #14's Wound Assessment Report dated 12/30/2024, revealed resident had an unstageable right buttock pressure ulcer that measured 8.0 cm long x 5.5 cm wide x 0.1 cm deep with 50% slough and large serosanguineous (a thin, pink drainage that comes from an open wound) drainage.</p> <p>Review of the Resident #14's Wound Assessment Report dated 12/30/2024, revealed resident had a stage 3 left buttock pressure ulcer that measured 2.0 cm long x 2.0 cm wide x 0.1 cm deep and had large serosanguineous) drainage.</p> <p>There was no documentation the weekly wound assessment was performed the weeks of 1/6/2025 and 1/13/2025.</p> <p>Review of the TAR dated 1/2025, revealed the wound care was not documented as being provided to the left and right buttock as ordered on 1/9/2025, 1/11/2025, 1/13/2025, 1/14/2025, 1/15/2025 and 1/16/2025.</p> <p>Review of Resident #14's Wound Assessment Report dated 1/21/2025, revealed resident had an unstageable right buttock pressure ulcer that measured 8.0 cm long x 5.0 cm wide x 2.0 cm depth with 15% slough [dead tissue] 75% eschar [dead, dry black tissue] and 2 centimeters of undermining and moderate serosanguineous drainage.</p> <p>During observation and interview on 1/21/2025 at 11:18 AM, LPN D performed wound assessment with measurement and staging and reported foul odor noted, necrotic tissue noted to the right buttock (coccyx) wound bed. LPN D reported slough 25%, 50% necrotic, 25% granulation LPN reported measurements as 8.0 cm long x 5.0 cm wide x 2.0 cm deep with 2.5 cm undermining.</p> <p>LPN D reports wound was staged as Unstageable due to slough. LPN D confirmed Resident #14 currently has 1 visual wound and was unsure when the wound to left buttock closed.</p> <p>The right buttock wound deteriorated from 1/13/2025 to 1/21/2025 with an increase in depth, developed eschar and undermining with an odor. The facility's failure to perform weekly wound assessments and provide wound treatments as ordered resulted in a decline in the wound, resulting in a harm for Resident #14.</p> <p>3. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE], with diagnoses including, Parkinson's Disease, Malnutrition, Heart Failure, Schizophrenia, and Depression.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Physician Order dated 12/4/2024 revealed, .Cleanse open area to sacrum with normal saline, pack with calcium alginate, apply super absorbent dressing and cover with foam .one time a day .</p> <p>Review of the Physician Order dated 12/30/2024 revealed, .Cleanse sacral area with wound cleaner or normal saline .apply calcium alginate .cover with super absorbent foam dressing .one time a day .</p> <p>Review of the TAR dated 12/2024, revealed the wound care was not documented as being provided on the sacrum as ordered on 12/7/2024 and 12/8/2024.</p> <p>Review of the Resident #18's Wound Assessment Report dated 12/30/2024, revealed resident had a stage 4 pressure ulcer on her sacrum that measured 7.0 cm long x 8.0 cm wide x 1.5 cm deep. The wound had undermining and large serosanguineous drainage.</p> <p>Review of the Physician Order dated 12/30/2024 revealed, .Cleanse sacral area with wound cleaner or normal saline .apply calcium alginate .cover with super absorbent foam dressing .one time a day .</p> <p>Review of the TAR dated 1/2025, revealed the wound care was not documented as being provided on the sacrum as ordered on 1/5/2025, 1/8/2025, 1/9/2025, 1/10/2025, 1/11/2025, 1/12/2025, 1/13/2025, 1/14/2025, 1/15/2025, 1/16/2025 and 1/18/2025.</p> <p>There was no documentation the weekly wound assessment was completed for the week of 1/6/2025 and 1/13/2025.</p> <p>Review of Resident #18's Wound Assessment Report dated 1/21/2025, revealed resident had a stage 4 pressure ulcer on her sacrum that measured 7.0 cm long x 10.0 cm wide x 1.0 cm deep with 75 % granulation tissue, 5% slough, 20% eschar and 1 cm] undermining and had moderate serosanguineous drainage.</p> <p>There was no documentation the Weekly Wound Assessment Report was completed the week of 1/6/2024 and 1/13/2024. The wound deteriorated from 1/13/2024 to 1/21/2025 with an increase in width, now has slough and eschar. The facility's failure to perform weekly wound assessments and provide wound treatments as ordered resulted in a decline in the wound, resulting in a harm for Resident #18.</p> <p>4. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Atrial Fibrillation, Coronary Artery Disease, Hypertension, Pneumonia, Diabetes, and Malnutrition.</p> <p>Review of the initial Wound Assessment Report dated 8/9/2024, revealed there were no wound measurements documented in accordance with the facility's policy for the following wounds:</p> <ul style="list-style-type: none"> a. Stage 2 pressure injury to middle lower back b. Deep Tissue Injury to left heel c. Deep Tissue Injury to right heel d. Deep Tissue Injury to right foot 1st digit <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission MDS assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #1 was cognitively intact. Resident required maximum assistance of staff to perform Activities of Daily Living (ADLs). Resident was assessed for the following pressure injuries: one stage 2, one stage 3, and three deep tissue injuries (damage to the soft tissue beneath the skin caused by pressure or shear forces).</p> <p>5. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Dementia, Anxiety, and Depression.</p> <p>Review of the significant change MDS assessment dated [DATE], revealed a BIMS score of 3, which indicated Resident #2 was severely cognitively impaired. Two Stage 3 pressure ulcers were documented that were not present on admission.</p> <p>Review of Physician's Order dated 12/4/2024 revealed, .Cleanse area to left buttock with wound cleanser, apply oil emulsion to wound bed, apply calcium alginate, and cover with foam dressing one time a day every other day for pressure injury AND as needed .</p> <p>Review of Physician's Order dated 12/4/2024, revealed .Cleanse area to right buttock with wound cleanser, apply oil emulsion to wound bed, apply calcium alginate, and cover with foam dressing. one time a day every other day for pressure injury</p> <p>Review of the Treatment Administration Report (TAR) dated 12/2024, revealed the wound care was not documented as being provided as ordered on 12/7/2024 and 12/15/2024.</p> <p>Review of the Weekly Wound Assessments dated 12/23/2024 and 12/30/2024, revealed Resident #2's Left buttock wound stage was changed from a Stage 4 on 12/23/2024 to a Stage 3 on 12/30/2024 with the same following measurements:</p> <p>a. 12/23/2024 - 6.0 cm long (centimeters) x 3.0 cm wide x 0.1cm deep Stage 4</p> <p>b. 12/30/2024 - 6.0 cm long x 3.0 cm wide x 0.1cm deep Stage 3</p> <p>Review of Resident #2's Weekly Wound Assessments revealed wound assessments were not conducted on 12/23/2024 on the right buttock wound, and 1/7/2025 on the right and left buttock wounds, in accordance with the facility policy.</p> <p>Observation on 1/16/2025 at 1:31 PM in Resident #2's room, Licensed Practical Nurse (LPN) C and Certified Nursing Assistant (CNA) E entered the resident's room to perform wound care. LPN C removed the soiled bandage and reported left upper buttock wound was a Stage 2 with minimal greenish drainage and reported right buttock wound was a Stage 2 with blood-tinged greenish drainage. LPN C cleansed right buttock with Normal Saline moistened gauze, cleansed left buttock with Normal Saline moistened gauze, patted dry with gauze, and applied oil emulsion to right buttock. LPN C obtained scissors from her scrub pocket, cut and applied the calcium alginate to the right buttock . LPN C removed gloves and donned gloves without performing hand hygiene, applied oil emulsion, calcium alginate to left buttock, and covered wounds with bordered foam dressing.</p> <p>LPN C failed to follow physician's order for cleansing the wounds with wound cleanser.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/21/2025 at 8:45 AM, the Assistant Director of Nursing (ADON) B was asked regarding Resident #2's wound staging documentation. The ADON B confirmed the 12/23/2024 wound assessment for resident's left buttock documented a Stage 4 and on 12/30/2024 documented a Stage 3. The ADON B confirmed the wound care nurse should not change the staging from Stage 4 to Stage 3. ADON B was asked regarding the blanks on the resident's TAR for wound care. The ADON B confirmed that there should not be blanks on the TAR and cannot confirm if the wound care was provided. The ADON B confirmed that weekly wound assessments should be performed of all wounds with measurements included.</p> <p>6. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including, Adult Failure to Thrive, Dysphagia, Depression, and Polyneuropathy.</p> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated resident was cognitively intact. Resident #5 admitted to the facility with 3 unstageable pressure wounds.</p> <p>Review of the Physician's Order dated 12/6/2024 revealed, .Cleanse coccyx [base of spine/tailbone] area . left hip area .[and] right hip with normal saline .apply honey alginate .cover with border gauze .one time a day .</p> <p>Review of the TAR dated 12/2024, revealed the wound care was not documented as being provided to the right hip, coccyx and left hip as ordered on 12/11/2024 and 12/22/2024.</p> <p>Review of the Physician Order dated 12/25/2024 for wound care to the coccyx, and the left and right hip included, .Cleanse .with wound cleanser or normal saline .apply honey alginate .cover with bordered gauze . one time a day .</p> <p>Review of Resident #5's Wound Assessment Report dated 12/30/2024, revealed an unstageable pressure ulcer on the left iliac crest (curved, bony ridge at the top of the hip bone) that measured 2.5 cm long x 1.5 cm wide x 0.1 cm deep with 25% granulation (new) tissue . 75% of eschar (dead tissue/debris) .and had moderate serosanguineous (pinkish/red) drainage.</p> <p>Review of the Resident #5's Wound Assessment Report dated 12/30/2024 revealed an unstageable pressure ulcer on the coccyx that measured 7.5 cm long x 6.0 cm wide x 0.1 cm deep with 25% granulation tissue . 75% of eschar and . moderate serosanguineous drainage.</p> <p>Review of the Resident #5's Wound Assessment Report dated 12/30/2024, revealed resident had an unstageable pressure ulcer on the right iliac crest that measured 2.5 cm long x 5.0 cm wide x 0.1cm deep with 25% granulation tissue, 75% slough and .moderate serosanguineous drainage.</p> <p>Review of the Weekly Wound Assessment report revealed there was no documentation the wound assessments were completed the weeks of 1/6/2025 and 1/13/2025.</p> <p>Review of the TAR dated 1/2025, revealed the wound care was not documented as being provided to the right hip, coccyx, left hip and right hip as ordered on 1/3/2025, 1/5/2025, 1/8/2025, 1/9/2025, 1/11/2025, 1/12/2025, 1/13/2025, 1/16/2025, and 1/17/2025.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2025
NAME OF PROVIDER OR SUPPLIER Patriot Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Volunteer Drive Paris, TN 38242	
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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #5's Wound Assessment Report dated 1/21/2025, revealed an unstageable pressure ulcer on the coccyx that measured 8.0 cm long x 11.5 cm wide x 1.0 cm deep, 10% granulation tissue, 50% of slough and 40% of eschar and 0.5 cm undermining (a pocket or cavity forming underneath the skin) with large amount of serosanguinous drainage.</p> <p>Review of Resident #5's Wound Assessment Report dated 1/21/2025, revealed an unstageable pressure ulcer on the left hip measured 2.0 cm long x 1.5 wide x 0.4 cm deep with 25% granulation tissue, 50% of slough and 25% of eschar with moderate serosanguineous drainage.</p> <p>Review of Resident #5's Wound Assessment Report dated 1/21/2025, revealed an unstageable pressure ulcer on the right hip that measured 3.0 cm long x 6.0 cm wide x 3.0 cm deep with 25% granulation tissue, 50% of slough (build up of dead cells/tissue) and 25% of eschar and 3 cm undermining with large serosanguineous drainage.</p> <p>Review of Resident #5's Wound Assessment Report dated 1/21/2025, revealed an unstageable pressure ulcer on the left buttock that measured 5.0 cm long x 5.4 cm wide x 0.3 cm deep with 25% granulation tissue, 50% of slough and 25% of eschar and 0.5 cm undermining with large serosanguineous drainage.</p> <p>The facility failed to conduct weekly assessments and provide treatments as ordered.</p> <p>7. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Anemia, Hypertension, and Depression.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS was not assessed due to Resident #11 was severely cognitively impaired. Resident required maximum assistance of staff to perform ADLs. A Stage 2 pressure injury was documented in the assessment that was not present on admission.</p> <p>Review of Physician's Order dated 12/4/2024, revealed Cleanse area to right buttock with normal saline, pat dry, apply honey alginate [used to promote wound healing] to wound bed, and cover with foam dressing one time a day for pressure injury AND as needed .</p> <p>Review of Physician's Order dated 1/21/2025, revealed Cleanse open area to coccyx with NS [Normal Saline, used to cleanse wounds] /wound cleanser; pat dry; apply collagen [used to promote wound healing] and zinc [used to protect the skin as a barrier] to wound bed; cover with dry dressing daily and prn [as needed] one time a day for open area AND as needed for soiled or damaged</p> <p>Review of the TAR dated 12/2024, revealed the wound care was not documented as being provided to the right buttock as ordered on 12/8/2024.</p> <p>Review of Resident #11's Weekly Wound Assessments revealed there was no documentation a wound assessment was conducted the week of 1/7/2025.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 1/21/2025 at 9:48 AM, in Resident #11's room revealed LPN D and CNA G entered the resident's room to perform wound care. LPN D performed ordered wound care with moderate serous drainage reported. Resident did not have a dressing covering wound. LPN D reported wound as a Stage 3. LPN D measured the wound and initially stated the depth was 0.1 cm. LPN D was asked to re-measure the wound bed to the right buttock, as the depth of the wound appeared to be deeper than the first measurement. LPN D reported the measurements as 2.5 cm long x 2.0 cm wide x 0.2 cm deep with the depth measured at the center of the wound bed on the second attempt. LPN D reported wound bed tissue as 75% granulation and 25% slough.</p> <p>8. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE], with diagnoses including, Anxiety, Benign Prostatic Hyperplasia, Hypertension, and Retention of Urine.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #15 had a BIMS score of 14, which indicated resident was cognitively intact and had 1 stage 3 pressure ulcer on admission.</p> <p>Review of the Resident #15's Wound Assessment Report dated 12/30/2024, revealed the resident had a stage 3 pressure ulcer on his pubis (one of the bones that make up the pelvis) that measured 2.0 cm long x 1 cm wide x 0.1 deep and had moderate serosanguineous drainage.</p> <p>There was no documentation the weekly wound assessment was completed for the weeks of 1/6/2025 and 1/13/2025.</p> <p>Review of the Physician's Order dated 12/31/2024 revealed, .Cleanse area on pubis with wound cleanser or normal saline .cover with calcium alginate silver and cover with a super absorbent dressing .one time a day .</p> <p>Review of the Resident #15's Wound Assessment Report dated 1/21/2025, revealed resident had a stage 3 pressure ulcer on his pubis that measured 1.0 cm long x 4.0 cm wide x 0.5 cm deep with moderate serosanguineous drainage.</p> <p>Review of the TAR dated 1/2025, revealed the wound care was not documented as being provided on the pubis as ordered on 1/5/2025, 1/8/2025, 1/9/2025, 1/10/2025, and 1/16/2025.</p> <p>9. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE], with diagnoses including Dementia, Dysphagia, Hypertension, and Psychotic Disturbance.</p> <p>Review of the Physician's Orders dated 12/4/2024 revealed, .apply xeroform gauze and cover with band-aid . to right foot plantar [facility acquired] . one time a day .</p> <p>Review of the Physician's Orders dated 12/13/2024 revealed, .Cleanse area on left buttock [facility acquired] with normal saline and apply hydrogel, apply honey alginate and cover with foam dressing .one time a day .</p> <p>Review of the TAR dated 12/2024, revealed the wound care was not documented as being provided on the left buttock as ordered on 12/22/2024 or on the right foot planter on 12/5/2024, 12/7/2024 and 12/22/2025.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Physician's Orders dated 12/25/2024 revealed, .Cleanse area on left buttock with wound cleanser or normal saline .apply hydrogel, apply calcium alginate .cover with foam dressing .one time a day . Cleanse area on left hip [facility acquired] with wound cleanser or normal saline .apply calcium alginate and cover with bordered gauze daily .Cleanse outside area on right foot with wound cleanser or normal saline . apply betadine .one time a day .Cleanse wound on inside plantar area on right foot with wound cleanser or normal saline .apply betadine .one time a day .</p> <p>Review of the Weekly Wound Assessment dated 12/30/2024 revealed resident had a facility acquired stage 2 pressure ulcer on right foot inside that measured 1.0 cm long x 0.75 cm wide x 0.1 cm deep with 100% granulation tissue.</p> <p>Review of the Weekly Wound Assessment dated 12/30/2024 revealed resident had a facility acquired unstageable right foot lateral that measured 1.0 cm long x 1.0 cm wide and 0.1 cm depth, with 100% eschar and scant serosanguineous drainage.</p> <p>Review of the Resident #16's Wound Assessment Report dated 12/30/2024, revealed resident had a facility acquired stage 3 pressure ulcer on the left iliac crest that measured 3.0 cm long x 2.0 cm wide x 0.1 cm deep with 100% of eschar and scant serous drainage.</p> <p>Review of Resident #16's Wound Assessment Report dated 12/30/2024, revealed a facility acquired stage 4 pressure ulcer on the left buttock that measured 2.0 cm long x 2.0 cm wide x 2.25 cm deep, with 100% granulation tissue and had serosanguineous drainage.</p> <p>There was no documentation the weekly wound assessments were completed for the weeks of 1/6/2025 and 1/13/2025.</p> <p>Review of the TAR dated 1/2025, revealed the wound care was not documented as being provided on the left buttock, left hip, outside lateral right foot and inside planter right foot as ordered on 1/5/2025, 1/8/2025, 1/9/2025, 1/10/2025, 1/11/2025, 1/15/2025, and 1/16/2025.</p> <p>10. Review of the medical record revealed Resident #19 was admitted on [DATE], with diagnoses including Stroke, Heart Failure, Neurogenic Bladder, Diabetes, and Dementia.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed the facility was unable to perform a BIMS due to Resident #19 was severely cognitively impaired. Resident required max assistance of staff to perform ADLs and had one Deep Tissue Injury that was not present on admission.</p> <p>Review of Physician's Order dated 12/4/2024, revealed Cleanse left heel [facility acquired] with normal saline, apply oil emulsion [a secondary dressing to manage drainage] to wound bed, cover with ABD [Abdominal] pad, and wrap with rolled gauze. one time a day for pressure injury AND as needed for pressure injury.</p> <p>Review of Physician's Order dated 12/13/2024, revealed Cleanse area on left heel with normal saline then apply oil emulsion and calcium alginate [absorbent dressing used to treat moderate to heavily draining wounds] and cover with abd pad and rolled gauze one time a day AND as needed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Physician's Order dated 12/31/2024, revealed Cleanse wound on left heel with wound cleanser or normal saline, pat dry, cover eschar [dead tissue in a wound] with xeroform [used as a non-adherent primary dressing] then apply calcium alginate and abd pad and cover with rolled gauze and secure with cohesive bandage daily. one time a day AND as needed.</p> <p>Review of the TAR dated 12/2024 and 1/2025, revealed the wound care was not documented as being provided on 12/7/2024, 12/8/2024, 12/22/2024, 1/2/2025, 1/17/2025.</p> <p>Review of Resident #19's Weekly Wound Assessments revealed a wound assessment was not conducted the week of 1/8/2025.</p> <p>11. During an interview on 1/22/2025 at 9:47 AM, the Director of Nursing (DON) was asked should there be blanks on the TAR for wound care treatments. The DON stated, .it means they didn't do their job . and I can't prove that they did or not .because they did not document .as you can tell I haven't been able to monitor .if I had the meetings like I normally do for my weekly wound meeting .there is definitely some new structure coming in to place for this . The DON confirmed physician orders should be followed, and weekly wound assessments should be done. The DON confirmed the ADON should have picked up the weekly wound assessments. The DON stated, That's the way it was designed .there is failure in the system .we were working on the floor and not doing our job .</p> <p>During a telephone interview on 1/22/2025 at 5:49 PM, the Medical Director confirmed wound care should be provided as ordered by the physician and weekly wound assessments should be done. The Medical Director stated, .does that have anything to do with staffing issue, we have had several to quit . I work here in the hospital and see wounds everyday .and hope we are going to get back up to par from where we were .didn't seem to have as many problems . The Medical Director was asked if not providing treatment to the pressure wounds could contribute to wound decline. The Medical Director stated, Definitely, it's up to us to make sure we are doing everything so the wound will heal .</p> <p>During an interview on 1/22/2025 at 5:49 PM, the Administrator confirmed wound care should be provided as ordered by the physician, that the treatment nurse is responsible for completing wound assessments weekly and accurately, and the ADON is ultimately responsible for ensuring that weekly wound assessments are completed.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, review of staff competency documentation, medical record review, observation and interview the facility failed to ensure licensed nurses had the skills and knowledge to detect changes in a resident's condition related to pressure ulcers for 9 of 9 (Residents #1, #2, #5, #11, #14, #15, #16, #18, #19) sampled residents.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Pressure Injury Prevention and Management, dated 2/14/2023, revealed .to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries .Licensed nurses will conduct a full body assessment on all residents upon admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Assessments of pressure injuries will be performed by a licensed nurse and documented. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS [Minimum Data Set] .Training in the completion of the pressure injury risk assessment, full body assessment, and pressure injury assessment will be provided as needed .After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. The RN [Registered Nurse] Unit Manager . will review all relevant documentation regarding skin assessments, pressure injury risks, program towards healing, and compliance at least weekly, and document a summary of findings in the medical record. The attending physician will be notified of presence of new pressure injury upon identification, the progression towards healing or lack of healing of any pressure injuries weekly, any complications .Any changes in the facility's pressure injury prevention and management processes will be communicated to relevant staff in a timely manner .</p> <p>Review of the undated facility policy titled, Documentation of Wound Treatments, revealed The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition and changes in treatment .Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. The following elements are documented as part of a complete wound assessment: Type of wound (pressure injury, surgical .) and anatomical location. Stage of the wound, if pressure injury (stage 1, 2, 3, 4, deep tissue injury, unstageable pressure injury) or the degree of skin loss if non-pressure (partial or full thickness) Measurements: height, width, depth, undermining, tunneling .Description of wound characteristics: Color of the wound bed, type of tissue in the wound bed (granulation, slough, eschar, epithelium), Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated), Presence, amount, and characteristic of wound drainage/exudate, Presence of odor, Presence of pain .Wound treatments are documented at the time of each treatment .</p> <p>2. The facility was unable to provide documentation of certification or training regarding assessment, staging, treatment, or evaluation of wounds for the Assistant Director of Nursing (ADON) who was responsible for the wound care and treatments in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility competency documentation for LPN D performing wound care, revealed no documentation of education or training related to wound assessment, staging, and treatment of pressure wounds prior to 1/21/2025.</p> <p>Review of the facility form AHC Dressing Change Competency, for LPN C dated 6/20/2024, failed to address wound assessment, staging, and treatment of pressure wounds.</p> <p>Review of the Wound Staging Competency and Wound Care Validation Checklist dated 1/21/2025, revealed LPN D signed and dated the checklist form for completion by third party company.</p> <p>3. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Atrial Fibrillation, Coronary Artery Disease, Hypertension, Pneumonia, Diabetes, and Malnutrition.</p> <p>Facility nursing staff failed to assess and measure the following wounds on 8/9/2024: Stage 2 pressure injury to middle lower back, Deep Tissue Injury to left heel, Deep Tissue Injury to right heel, Deep Tissue Injury to right foot 1st digit.</p> <p>4. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Dementia, Anxiety, and Depression.</p> <p>Review of the Weekly Wound Assessments dated 12/23/2024 and 12/30/2024, revealed Resident #2's Left buttock wound changed from a Stage 4 to a Stage 3 with the following measurements:</p> <p>a. 12/23/2024 - 6.0 cm (centimeters) x 3.0 cm x 0.1cm Stage 4</p> <p>b. 12/30/2024 - 6.0 cm x 3.0 cm x 0.1cm Stage 3</p> <p>During an interview on 1/21/2025 at 8:45 AM, Assistant Director of Nursing (ADON) B was asked regarding Resident #2's wound staging documentation. ADON B confirmed that on the 12/23/2024 wound assessment Resident #2's left buttock was documented as a Stage 4 and on 12/30/2024 it was documented as a Stage 3. ADON B confirmed that the wound care nurse should not change the staging of the wound once it was a Stage</p> <p>5. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses including Adult Failure to Thrive, Dysphagia, Depression, and Polyneuropathy.</p> <p>Review of the Physician's Order dated 12/6/2024 revealed wound care to the coccyx [base of spine/tailbone], left and right hip one time a day.</p> <p>Review of the Treatment Administration Record (TAR) dated 12/2024, revealed no documentation to show wound care was provided to the coccyx, left hip and right hip as ordered on 12/11/2024 and 12/22/2024.</p> <p>Review of the (TAR) dated 1/2025, revealed no documentation to show wound care was provided to the coccyx, left hip and right hip as ordered on 1/3/2025, 1/5/2025, 1/8/2025, 1/9/2025, 1/11/2025, 1/12/2025, 1/13/2025, 1/16/2025, and 1/17/2025.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Patriot Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Volunteer Drive Paris, TN 38242	

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #5's unstageable pressure ulcers to the right hip, left hip, and coccyx (base of spine/tailbone) deteriorated.</p> <p>6. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Anemia, Hypertension, and Depression.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a Stage 2 pressure injury that was not present on admission.</p> <p>Review of Resident #11's Weekly Wound Assessments revealed there was no documentation to show a wound assessment was conducted the week of 1/7/2025.</p> <p>Observation and interview on 1/21/2025 at 9:48 AM, in Resident #11's room, LPN D reported wound as a Stage 3.</p> <p>7. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including, Chronic Obstructive Pulmonary Disease, Schizophrenia, Anxiety, and Diabetes.</p> <p>Review of Physician Order dated 12/6/2024, revealed wound care to the right and left buttock one time a day.</p> <p>??</p> <p>Review of the TAR dated 12/2024, revealed no documentation to show wound care was provided as ordered for the left and right buttock on 12/7/2024,12/8/2024 and 12/9/2024.</p> <p>Review of Physician Order dated 12/30/2024 revealed wound care to the left and right buttock one time a day.</p> <p>There was no documentation the weekly wound assessments were performed the weeks of 1/6/2025 and 1/13/2025.</p> <p>?</p> <p>Review of the TAR dated 1/2025, revealed no documentation to show wound care was provided as ordered to the left and right buttock on 1/9/2025, 1/11/2025, 1/13/2025, 1/14/2025, 1/15/2025 and 1/16/2025.</p> <p>Resident #14's wound deteriorated.</p> <p>8. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including, Anxiety, Benign Prostatic Hyperplasia, Hypertension, and Retention of Urine.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #15 had 1 stage 3 pressure ulcer on admission.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Resident #15's Wound Assessment Report dated 12/30/2024, revealed a stage 3 pressure ulcer on the pubis (one of the bones that make up the pelvis) that measured 2.0 cm long x 1 cm wide x 0.1 deep and had moderate serosanguineous drainage.</p> <p>Review of the Physician's Order dated 12/31/2024 revealed wound care to the pubis one time a day.</p> <p>There was no documentation the weekly wound assessments were completed for the weeks of 1/6/2025 and 1/13/2025.</p> <p>Review of the TAR dated 1/2025, revealed no documentation to show wound care was provided on the pubis as ordered on 1/5/2025, 1/8/2025, 1/9/2025, 1/10/2025, and 1/16/2025.</p> <p>Review of Resident #15's Wound Assessment Report dated 1/21/2025, revealed resident had a stage 3 pressure ulcer on his pubis that measured 1.0 cm long x 4.0 cm wide x 0.5 cm deep with moderate serosanguineous drainage.</p> <p>Resident #15's wound deteriorated.</p> <p>9. Review of the medical record revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including Dementia, Dysphagia, Hypertension, and Psychotic Disturbance.</p> <p>The facility failed to ensure Resident #16's weekly wound assessments were completed on 1/6/2025 and 1/13/2025.</p> <p>Review of the TAR dated 1/2025, revealed no documentation to show wound care was provided as ordered on 1/5/2025, 1/8/2025, 1/9/2025, 1/10/2025, 1/11/2025, 1/15/2025, and 1/16/2025 to the left buttock stage 4, the right outside lateral foot unstageable, right inside planter (sole) foot stage 2 and left iliac crest (curved part at top of hip) unstageable.</p> <p>10. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Malnutrition, Heart Failure, Schizophrenia, and Depression.</p> <p>There was no documentation the weekly wound assessment was completed for the week of 1/6/2025 and 1/13/2025</p> <p>Facility staff failed to properly assess and identify the wound stage due to insufficient training.</p> <p>Review of the TAR dated 1/2025, revealed no documentation wound care was provided as ordered on the sacrum on 1/5/2025, 1/8/2025, 1/9/2025, 1/10/2025, 1/11/2025, 1/12/2025, 1/13/2025, 1/14/2025, 1/15/2025, 1/16/2025 and 1/18/2025.</p> <p>Resident #18's Stage 4 wound deteriorated.</p> <p>11. Review of the medical record revealed Resident #19 was admitted on [DATE], with diagnoses including Stroke, Heart Failure, Neurogenic Bladder, Diabetes, and Dementia.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2025
NAME OF PROVIDER OR SUPPLIER Patriot Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Volunteer Drive Paris, TN 38242	
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the TAR dated 12/2024 and 1/2025, revealed no documentation wound care was provided as ordered on 12/7/2024, 12/8/2024, 12/22/2024, 1/2/2025, 1/17/2025.</p> <p>Review of Resident #19's Weekly Wound Assessments revealed a wound assessment was not conducted the week of 1/8/2025.</p> <p>Resident #19 developed a Deep Tissue Wound Injury that progressed to an unstageable pressure injury as a result of the facility's failure to perform weekly wound assessments and wound care as ordered.</p> <p>During an interview on 1/22/2024 at 9:20 AM, the Director of Nursing (DON) was asked regarding the deterioration of Resident #11's wound from a stage 2 to a stage 3 on 12/30/2024. The DON stated that the wound was staged incorrectly in the beginning. The DON confirmed that the treatment nurse is responsible for completing wound assessments weekly and accurately, and the ADON is ultimately responsible for ensuring that weekly wound assessments are completed.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to serve palatable food at a safe and appetizing temperature for 3 of 6 (Resident #7, #8, and #12) sampled residents reviewed for appetizing and palatable meals.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, Food Safety Requirements. dated 12/1/2024 revealed, .It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state .Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety .</p> <p>2. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE], with diagnoses including Heart Failure, Depression, Obesity, Anxiety and Diabetes.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #7 was cognitively intact.</p> <p>Observation and interview in Resident #7's room on 1/16/2025 at 9:04 AM, Resident #7 was asked how breakfast was on this morning. Resident #7 stated, .like it [breakfast] always is .eggs cold .</p> <p>Observation and interview in Resident #7's room on 1/17/2025 at 2:21 PM, Resident #7 stated, .eggs still cold .have to get adjusted to eating cold eggs .</p> <p>3. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Diabetes, Atherosclerotic Heart Disease, and Fracture of Left Lower Leg.</p> <p>Review of the admission MDS assessment dated [DATE], revealed resident had a BIMS score of 15, which indicated Resident #8 was cognitively intact.</p> <p>Observation and interview in Resident #8's room on 1/16/2025 at 1:00 PM, Resident #8 was asked how her meals were. Resident #8 stated, .the food is not really great here .if I don't have someone to bring me something, I try to eat it .the eggs are always cold .</p> <p>4. Review of the medical records revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Diabetes, Anxiety, Hypothyroidism, and Hypertension.</p> <p>Review of the admission MDS assessment dated [DATE], revealed resident a BIMS score of 13, which indicated Resident #12 was cognitively intact.</p> <p>Observation and interview in Resident #12's room on 1/16/2025 at 1:26, Resident #12 was asked how her breakfast was this morning. Resident #12 stated, .I ate the cereal .always cold eggs .sausage .</p> <p>5. Observation in the Kitchen on 1/16/2025 at 7:30 AM, revealed the breakfast tray line began with a menu of scrambled eggs, sausage links, oatmeal, pureed pork, pureed eggs, mechanical sausage, and gravy.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 1/16/2025 at 8:26 AM, revealed the last breakfast tray was served on the 200 Hall.</p> <p>Observation and interview in the Dining Room, on 1/16/2025 at 8:30 AM, with the Dietary Manager present, revealed the Test tray had scrambled eggs were 39.9 degrees in temperature, some of the eggs were brown in color and unpalatable and unappetizing, sausage links were 40.3 degrees in temperature and unpalatable and unappetizing, and the gravy was 31.1 degrees in temperature and unpalatable and unappetizing. The Dietary Manager took a bite of the sausage link, spit it out, and stated, .you can tell we have changed brands . The Dietary Manager was asked if she had any complaints about the food being cold. The Dietary Manager stated, .that's our number one complaint .</p> <p>During an interview on 1/17/2025 at 11:38 AM, Assistant Director of Nursing (ADON) A confirmed most of the complaints are about the breakfast being cold, and stated, . the residents are used to the [food] quality with [Named the previous company] .and now they aren't happy with a lot of those changes .</p> <p>During a telephone interview on 1/17/2025 at 2:47 PM, Licensed Practical Nurse (LPN) L was asked if she had any complaints related to resident's meals being cold. LPN L stated, Many times .</p> <p>During an interview on 1/22/2025 at 9:47 AM, the Director of Nursing (DON) confirmed she had complaints related to residents' food being cold, that meals are important, and residents should enjoy their food.</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, observation and interview the facility failed to provide its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to maintain adequate supplies for staff or services necessary to provide for the needs of residents.</p> <p>The findings include:</p> <p>1. Review of the medical record revealed that Resident #3 was admitted to the facility on [DATE], with diagnoses including Hemiplegia, Hypertension, Diabetes, and Asthma.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated that Resident #3 was cognitively intact.</p> <p>During an interview on 9/15/2025 at 9:57 AM, Resident #3 was asked about the facility running out of supplies. Resident #3 stated the facility ran out of toilet paper and briefs 2 weeks ago and staff had to go to [named retail store]to purchase some.</p> <p>2. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses including Coronary Artery Disease, Diabetes, Debility, and Renal Insufficiency.</p> <p>Review of the quarterly MDS dated [DATE], revealed a BIMS score of 15, which indicated Resident #4 was cognitively intact.</p> <p>Observation and interview in the Resident's room on 1/15/2025 at 3:47 PM, when asked about the facility running out of supplies Resident #4 stated that the size briefs that he normally wears are larger than the pink briefs that the facility has recently been providing him. The Resident picked up a pink brief and stated that it is too tight.</p> <p>3. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses including Neurogenic Bladder, Traumatic Brain Injury, Anxiety, Bipolar Disorder, and Schizophrenia.</p> <p>Review of the quarterly MDS dated [DATE], revealed a BIMS score of 15, which indicated Resident was cognitively intact.</p> <p>During an interview on 1/15/2025 at 2:42 PM, Resident #6 stated that the facility ran out of wipes, briefs, and pads. Resident #6 confirmed that her family had to purchase items and bring to the facility for her. The Resident stated that the facility has been out of tea for several weeks.</p> <p>4. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including Heart Failure, Depression, Obesity, Anxiety and Diabetes.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #7 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/15/2025 at 1:09 PM, Resident #7 was asked how his meals were at the facility. Resident #7 stated, .breakfast is crappy, they got a new owner, it's gotten bad, eggs burnt .I asked for ketchup, but I haven't seen it .went 2 days didn't have coffee or tea .no explanation given just said we didn't have any .</p> <p>5. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including, Diabetes, Atherosclerotic Heart Disease, and Fracture of Left Lower Leg.</p> <p>Review of the admission MDS assessment dated [DATE], revealed the resident had a BIMS score of 15, which indicated Resident #8 was cognitively intact.</p> <p>Observation and interview in Resident #8's room on 1/16/2025 at 1:00 PM, revealed the resident was dressed and sitting in her wheelchair. Resident #8 was asked how her meals were. Resident #8 stated, .this week I got coffee, a couple of days last week I didn't get it [coffee] .I like tea and last week got Kool-Aid .said they didn't have it [tea] . Resident #8 stated, .I have been buying all my wet wipes .said they didn't have any . they don't have briefs the right size .buying my own briefs . I had to wear those diapers, were cutting into me . was uncomfortable .it's just different from when I was here before .</p> <p>6. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Diabetes, Anxiety, Hypothyroidism, and Hypertension.</p> <p>Review of the admission MDS assessment dated [DATE] revealed the resident had a BIMS score of 13, which indicated Resident #12 was cognitively intact.</p> <p>During an observation and interview in Resident #12's room on 1/16/2025 at 8:55 AM, revealed the resident was neatly dressed and sitting in her wheelchair. Resident #12 was asked how her breakfast was. Resident #12 stated, .sometimes don't get coffee for 3 or 4 mornings .said they didn't have it [coffee] .</p> <p>During an interview on 1/15/2025 at 8:48 AM, the Kitchen Supervisor confirmed the food truck comes to the facility one time a week. The Kitchen Supervisor stated, .transition has been rocky .budget downsized . usually would spend 6,000 to 6,500 a week .they [referring to the new company] wanted it cut back .we aren't able to get the same options as before [change of ownership] .they have sent different option guide . residents not used to it .</p> <p>During an interview on 1/15/2025 at 9:10 AM, the Dietary Manager was asked if the food budget had been cut. The Dietary Manager stated .we got new guidelines .we had a budget of 4,000 when we first transitioned .not enough at all .one day last week they updated the budget to 6,000 .when we were [Named the previous company] we ran 6,000 a week, but they [new ownership company] didn't know .</p> <p>During an interview on 1/15/2025 at 9:25 AM, Dietary Staff M confirmed that last week they ran out of syrup for French toast, Dietary Staff M stated, .just happened with the new company .with the transition, everything was out .tea .coffee .we would go to the store .</p> <p>During an interview on 1/15/2025 at 10:00 AM, Licensed Practical Nurse (LPN) C was asked if the facility had been running out of food. LPN C stated, .coffee, tea .making Kool-Aide .wrote on the cart [referring to meal cart] don't have syrup for waffles yesterday .</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/15/2025 at 11:08 AM, Certified Nursing Assistant (CNA) H, who manages the facility's central supplies, confirmed that the facility ran out of briefs and pull ups. CNA H stated that she entered an order for some to be overnighted. CNA H confirmed that she went to [two named retail stores] to purchase various different sizes of briefs and pull ups.</p> <p>During a telephone interview on 1/15/2025 at 2:51 PM, LPN O stated, .I didn't have supplies I needed to treat the wounds .I'm not going to work somewhere that doesn't supply the needs of the patients .when the new company took over .allotted budget \$2,000 for a week including the wound care supplies, the briefs .wipes .the lady that did the ordering prior to that was \$2300 every week not including the wound care .it was just brief, wipes .everything for the patient that insurance didn't cover .she said she didn't know what to do, her hands were tied .I went to the DON [Director of Nursing] .I told her I was running out of everything to treat these wounds .she [DON] said just do the best you can .beginning of December when I started running out [of wound supplies] she [DON] told me to make a list of everything I needed .gave me a credit card .had the DON's name on it .told me to go to [named retail store] .I went and got koban that I needed .there were many days didn't have wipes and wash clothes . LPN O stated, .before this company took over people would scarf the food down .I guess they cut the food budget .I would talk to the patients [residents] and one morning only had oatmeal, dried toast and eggs .didn't have any meat with their breakfast .</p> <p>During an interview on 1/15/2025 at 3:41 PM, Nurse Practitioner (NP) was asked if wound supplies were available. NP stated, Sometimes no .if I couldn't find it .I could change the order [referring to the wound care order] . NP confirmed the facility has had to buy briefs for residents.</p> <p>During a telephone interview on 1/15/2025 at 4:26 PM, Random Staff P stated, .been out of briefs .wipes . soap and I have had to clean a patient [resident] with a pillow case .yesterday I couldn't find wipes .I talked to the Staffing Coordinator .would say we were out of wipes .she said the truck hadn't come; they need those things .and we just don't have it .</p> <p>During an interview on 1/16/2025 at 10:35 AM, CNA J confirmed the facility had been out of coffee and stated, I have a lot of people that drink coffee . CNA J confirmed sometimes the facility runs out of the correct size briefs for the residents and staff will use the smaller briefs for the residents.</p> <p>During a telephone interview on 1/16/2025 at 3:04 PM, Random Staff Q stated, .it's definitely a lot different since the beginning of December .since the new company .lot more complaints .of food .don't have briefs . out of coffee and tea .said somebody from corporate had changed the order around and not given what we had ordered .</p> <p>During an interview on 1/16/2025 at 1:52 PM, CNA I confirmed that the facility had run out briefs, wet wipes, and soap (for bathing) CNA I stated that she had purchased a couple bottles of soap so that her residents could get baths during her shift. CNA I confirmed that the facility has been out of tea and coffee for the last 2 weeks and had an out of syrup sign on the food cart earlier in the week. CNA I stated there has been a shortage of wash cloths in laundry that she was only 3 wash cloths when going to laundry at 9:00 AM.</p> <p>During an interview on 1/16/2025 at 2:41 PM. The DON confirmed that the facility had run out wound care supplies and had been purchased at the [named retail store].</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/16/2025 at 3:56 PM, the Administrator was asked about the facility running out of supplies. The Administrator stated, .with the change over we had a change in vendors .getting our contracts moved to [Named the new company] .we were placing orders had to go through corporate .and the rep [For the new company] didn't realize our shipments comes through Nashville .they [the new food company] comes through Memphis and Memphis does not delivery through [NAME] .that put us behind .the snow put us behind .in one of our shipments .for paper towels, toilet paper .soap .I actually had to place the order and send it to corporate . The Administrator confirmed the food budget had been lowered and stated, .we did buy some toilet paper .we are just now barely 6 weeks in and just now getting a good grasp on what day to order and what day it's going to come in .we have purchased things and get reimburse .there was some confusing . it does make it harder if you delivery dates is 2 days later than it used to be .</p> <p>During an interview on 1/17/2025 at 8:14 AM, Housekeeping Supervisor confirmed that the facility had ran out of washcloths and stated, .we went and bought some washcloths about a week and half ago .ordered some washcloths in December don't know what happened to the order we didn't get them .</p> <p>During an interview on 1/17/2025 at 11:38 AM, Assistant Director of Nursing (ADON) A confirmed that residents didn't have coffee, briefs and the facility had gone and bought briefs for the residents. ADON A confirmed residents had complained about the breakfast being cold and stated, . the residents are used to the quality with [Named the previous company] .and now they aren't happy with a lot of those changes .</p> <p>During a telephone interview on 1/17/2025 at 3:57 PM, LPN L confirmed the facility had ran out of wipes, briefs, body wash, coffee and stated, I went and bought body wash and shampoo (beginning of last week) . LPN L was asked if staff was having to use the wrong size brief on residents. LPN L stated .I have seen it [referring to resident's briefs] .too small .</p> <p>During a telephone interview on 1/21/2025 at 6:50 PM, Random Staff R stated, .we didn't have coffee for a few days for about a week before you guys got here .2 residents .their waffles didn't have any syrup .family brings in briefs . Random Staff R confirmed the facility had been out of soap and stated, .problems started with transition .</p> <p>During a telephone interview on 1/22/2025 at 10:41 AM, Dietary Staff N confirmed the new company had cut their food budget in the beginning and the facility had run out of coffee, tea and syrup for waffles. Dietary Staff N confirmed the previous owners food budget was higher than the new owners and stated, .cut us back a lot .and the resident was coming back at us .I understand they pay so much money to be there .</p> <p>During a telephone interview on 1/22/2025 at 5:05 PM, the Medical Director stated, I think it's been quite a transition .changed ownership .heard had trouble of getting supplies .switched vendors . The Medical Director was asked is the new company cutting the facility back on supplies. The Medical Director stated, I just heard that this week .at the minimal should have syrup with waffles . The Medical Director confirmed the facility should provide what the residents need.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to provide a safe and sanitary environment to help prevent the transmission of infections when 1 of 2 Licensed Practical Nurses (LPN C) failed to perform hand hygiene during wound care and 5 of 5 (LPN C, LPN D, Certified Nursing Assistant (CNA) E, CNA F, and CNA G) staff failed to wear appropriate Personal Protective Equipment (PPE) for Enhanced Barrier Precautions (EBP) during wound care.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Enhanced Barrier Precautions, dated 12/1/2024, revealed .to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. An order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds .and/or indwelling medical devices .Implementation of Enhanced Barrier Precautions: PPE for enhanced barrier precautions is only necessary when performing high-contact care activities .High-contact activities include . Wound care: any skin opening requiring a dressing .Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the resolution of the wound or discontinuation of the indwelling medical device .</p> <p>Review of the facility policy titled, Hand Hygiene, dated 12/1/2024, revealed All staff will perform proper hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors .If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves .</p> <p>2. Review of the medical record revealed that Resident #2 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Dementia, Anxiety, and Depression.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated Resident #2 was severely cognitively impaired, and had two Stage 3 pressure ulcers that were not present on admission.</p> <p>Observation on 1/16/2025 at 1:31 PM, revealed LPN C and CNA E entered Resident #2's room without PPE or gown. LPN C performed wound care and CNA E positioned the resident without proper PPE. LPN C removed soiled dressing, removed gloves, performed hand hygiene, donned gloves, cleansed right buttock with Normal Saline moistened gauze, cleansed left buttock with Normal Saline moistened gauze, pat dry with gauze, applied oil emulsion to right buttock. LPN C obtained scissors from her scrub pocket and cut and applied the calcium alginate to the right buttock. LPN C removed the soiled gloves and donned gloves without performing hand hygiene, applied oil emulsion to left buttock, applied calcium alginate to left buttock and covered wounds with foam dressing.</p> <p>LPN C and CNA E failed to don PPE for enhanced barrier precautions. LPN C failed to perform hand hygiene that resulted in potential cross-contamination (the transfer of harmful bacteria from one object to another) during wound care to the left buttock.</p> <p>3. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Anemia, Hypertension, and Depression.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2025
NAME OF PROVIDER OR SUPPLIER Patriot Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Volunteer Drive 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score was not assessed due to Resident #11 was severely cognitively impaired and had a Stage 2 pressure injury that was not present on admission.</p> <p>Review of a Physician's Order dated 1/21/2025, revealed Cleanse open area to coccyx [base of spine/tailbone] with NS [Normal Saline, used to cleanse wounds] /wound cleanser; pat dry; apply collagen [used to promote wound healing] and zinc [used to protect the skin as a barrier] to wound bed; cover with dry dressing daily and prn [as needed] one time a day for open area AND as needed for soiled or damaged</p> <p>Observation on 1/21/2025 at 9:48 AM, LPN D and CNA G entered Resident #11's room to perform wound care without PPE/gown for enhanced barrier precautions.</p> <p>4. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including, Chronic Obstructive Pulmonary Disease, Schizophrenia, Anxiety, and Diabetes.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 3, which indicated Resident #14 was severely cognitively impaired and was at risk for developing pressure ulcers.</p> <p>Observation and interview on 1/21/2025 at 11:18 AM, prior to entering Resident #14's room, LPN D confirmed the Treatment Administration Record (TAR) showed 2 pressure wounds, 1 on the right buttocks and one on the left buttocks. LPN D and CNA E entered Resident's room to perform wound care without PPE or gown for enhanced barrier precautions.</p> <p>5. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Malnutrition, Heart Failure, Schizophrenia, and Depression.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 3, which indicated Resident #18 was cognitively impaired, and had 1 Stage 4 pressure ulcer that was present on admission.</p> <p>Observation on 1/21/2025 at 12:06 PM, LPN D and CNA F entered Resident #18's room without PPE or gown for Enhanced Barrier Precautions to perform wound care. LPN D performed ordered wound care and CNA F assisted with positioning the resident without proper PPE.</p> <p>During an interview on 1/21/2025 at 3:24 PM, the Assistant Director of Nursing (ADON) A confirmed that staff should wear gown and gloves as PPE while performing wound care with residents in Enhanced Barrier Precautions.</p> <p>During an interview on 1/22/2025 at 9:20 AM, the Director of Nursing (DON) confirmed that hand hygiene should be performed before donning gloves, immediately after removing gloves and during wound care. The DON confirmed that a gown should be worn as a part of PPE for EBP during wound care.</p>		