STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455544	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at Stevens	204 Walter St Yoakum, TX 77995

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on record review and interview the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect and exploitation for 1 of 4 residents (Resident #1) reviewed for abuse, in that; The facility failed to develop and implement a written abuse policy for reporting abuse within 2 hours to the State Survey Agency (HHSC) which resulted in a failure to report an allegation of abuse made by Resident #1 until surveyor intervention. This failure could place all residents at risk for potential abuse due to unreported allegations of abuse. The findings included: Record review of the facility policy titled Abuse, Neglect, and Exploitation Prevention Policy and Procedure last revised 9/10/2020 revealed: The facility Administrator, or his/her designee, will be designated as the facility's ANE Coordinator and will be responsible for overseeing the ANE Prevention program and directing any such investigation. Investigation of ANE: 13. Administrator, or his/her designee, shall immediately (within 24 hours) notify the State Health department, local law enforcement, and local ombudsman. (This section did not indicate reporting to the State Survey agency/HHSC). Reporting/Response of ANE: 28. The Administrator, Director of Nursing, or his/her designee shall report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required .report all reasonable suspicion of a crime against an individual to local law enforcement within 2 hours if the alleged violation involves serious bodily injury; within 24 hours if the alleged violation does not involve serious bodily injury. (This section did not have reporting guidelines for reporting to the State Survey Agency/HHSC). Record review of Resident #1's face sheet dated 3/26/2024 revealed an admitted [DATE] with diagnoses which included: cerebral infarction, hemiplegia and hemiparesis following cerebral infarction (stroke with resulting paralysis and weakness on one side of the body), major depressive disorder, recurrent mild and generalized anxiety disorder. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated the resident was cognitively intact. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan initialed on 1/08/2024 revealed the resident had a history of inappropriate behaviors which included calling cops/911 and making false allegations. Record review of Resident #1's nurse progress note dated 3/25/2024 documented by LVN A revealed: Nurse was called to room .wanted his phone charger and started accusing nurse that he was missing his box (charger box) .then stated he was missing his shoes, nurse found them in his box behind his recliner .he (Resident #1) then decides to call the [local] police department. He told police that nurse was going to put the back scratcher in his mouth. Nurse told the police that she did not say that. CNA B told DON and the policeman; I did not say that. Resident has made false accusation against staff before. During an interview on 3/26/2024 at 12:29 p.m., Resident #1 stated LVN A refused to bring him items he wanted from his boxes including shoes and clothes and packaged food items he brought from a previous facility. He stated LVN A called him a liar and said he was crazy. Resident #1 stated he did not have any mental health issues, although he thought LVN A was trying to put him on psychiatric medications. He stated LVN A threw a temper tantrum and said she was going to shove his back scratcher down his throat if he kept saying people were taking his things. He stated he told LVN A he was going to call the police and she laughed at him. Resident #1 stated two police officers came and talked to management. Resident #1 stated the DON came and ranted at him for making false allegations. Resident #1 stated the DON then tried to intimidate him by calling his parole officer. Resident #1 stated he told the Administrator what he told this surveyor. He stated the Administrator responded by asking him if he wanted to go somewhere else to which he replied yes. Resident #1 stated his visitor was a witness to this event. He stated he did not want to stay in the facility because he did not like his life threatened or to be falsely accused. Resident #1 stated he also felt like they were putting something in his food, and he thought he was going to die. He stated he knows they are putting something in his food because his stomach gets hard, and he gets constipated. Resident #1 stated he was scared the facility was poisoning him. During an interview on 3/26/2024 at 4:21 p.m., CNA B stated on 3/20/2024 she had just finished changing Resident #1. She stated he had a Reacher (tool used to reach items out of reach) and a back scratcher between his legs. She stated Resident #1's phone charger was on the nightstand. She stated she and LVN A pulled him up in bed. CNA B stated he asked to go up higher but there was no room for him to go higher. He was already at the top. CNA B stated Resident #1 did not get angry. They had a discussion about it and he seemed okay with it. She stated when they were done, she personally put the back scratcher and Reacher on the table. CNA B stated on 3/25/2024 Resident #1 called the local police and made a false allegation that LVN A said something about his back scratcher and allegations about his phone charger. CNA B stated, no one was taking his stuff and LVN A never said anything about a back scratcher. CNA B stated she didn't even know where the allegation came from. She stated Resident #1 made it up and had a known history of false allegations. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2024 at 4:26 p.m., LVN A stated she never threatened Resident #1 with the stick (back scratcher). She stated she never told Resident #1 she was going to shove it down his throat. She stated she would never say or do that. LVN A stated a doctor ordered medication for Resident #1 for his depression, but he won't take it and refused to cooperate with psychiatric therapy. LVN A stated the police department had come to the facility and questioned her and asked for her statement. She stated she wrote a nurses note about the encounter. LVN A stated she did not threaten Resident #1 with a stick and the police did not press charges against her. LVN A stated the stick came up when CNA B removed it (back scratcher) from the bed while they were changing him (date unknown) LVN A stated she did notify his physician and did document the scenario in the nurse's notes (on 3/25/2024 when allegations were made). During an interview on 3/26/2024 at 5:04 p.m., the DON stated Resident #1 had behaviors of accusations. The DON stated Resident #1 gets a two person staff assistance for all visits due to the false allegations. The DON stated they added the target behaviors of false allegations to his care plan. The DON stated he first learned of the allegation on 3/25/2024 at approximately 3:00 pm when police arrived at the facility. The DON stated the police came out (3/25/2024) and interviewed the resident and stated there were no charges pending. The DON stated he notified the Administrator of the allegations on 3/25/2024 at approximately 5:00 pm. The DON stated he interviewed both LVN A and CNA B after the allegations of abuse. He stated they said they were repositioning the resident in his room, and both denied using any threatening words. He stated he did not know if it was reported to the State Survey Agency/HHSC because that was up to the Administrator. During an interview on 3/27/2024 at 10:07 a.m., the Administrator stated Resident #1 called the police on 3/25/2024 and made an allegation about a back scratcher. The Administrator stated false allegations were a target behavior. She stated a target behavior means they are aware of it and it is a documented part of his care. The Administrator stated she was not in the facility when the allegation about the back scratcher was made. She stated she became aware from the DON and the police on 3/25/2024. The Administrator stated she was on speaker phone when the cops were in the facility. The Administrator stated she did not report to HHSC because she was waiting for the final police report. She stated she discussed with Corporate about whether or not they had to report it because there were his targeted behaviors. She stated she had gone back and forth with his history of allegations on whether or not what he said about the back scratcher was abuse due to his history. She stated to her knowledge she had 24 hours to report allegations of abuse to HHSC. During an interview on 3/27/2024 at 12:30 p.m., the Administrator stated after the previous interview she remembered that allegations of abuse should be reported within 2 hours of the allegation, and she looked online to verify the information. She stated she changed her mind about reporting because she called her mentor who is an administrator at another facility who stated that although it was a target behavior it should still be reported (to HHSC) because the allegation involved abuse. The Administrator stated the facility abuse policy was last reviewed on 12/20/2023 by an attorney and corporate staff and last revised in 2020. The Administrator stated she was not a part of the policy review. She stated the current policy did not meet state regulations of reporting to the State Survey Agency immediately or within 2 hours for abuse and/or significant injury. The Administrator stated she was not aware before surveyor intervention that the abuse did policy did not indicate reporting of abuse within 2 hours to HHSC according to regulations.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38511 Based on interview and record review, the facility failed to ensure that all allegations involving abuse, neglect, and misappropriation were reported immediately, but no later than 2 hours after the allegation of abuse to the State Survey Agency for 1 of 4 residents (Resident #1) reviewed for abuse, in that: The facility failed to report to the State Survey Agency (HHSC) allegations of abuse made by Resident #1 immediately or within 2 hours. This failure could place all residents at increased risk for potential abuse due to unreported allegations of abuse. The findings included: Record review of Resident #1's face sheet dated 3/26/2024 revealed an admitted [DATE] with diagnoses which included: cerebral infarction, hemiplegia, and hemiparesis following cerebral infarction (stroke with resulting paralysis and weakness on one side of the body), major depressive disorder, recurrent mild and generalized anxiety disorder. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated the resident was cognitively intact. Record review of Resident #1's Care Plan initialed on 1/08/2024 revealed the resident had a history of inappropriate behaviors which included calling cops/911 and making false allegations. Record review of Resident #1's nurse progress note dated 3/25/2024 documented by LVN A revealed: Nurse was called to room .wanted his phone charger and started accusing nurse that he was missing his box (charger box) .then stated he was missing his shoes, nurse found them in his box behind his recliner .he (Resident #1) then decides to call the [local] police department. He told police that nurse was going to put the back scratcher in his mouth. Nurse told the police that she did not say that. CNA B told DON and the policeman; I did not say that. Resident has made false accusation against staff before. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2024 at 12:29 p.m., Resident #1 stated LVN A refused to bring him items he wanted from his boxes including shoes and clothes and packaged food items he brought from a previous facility. He stated LVN A called him a liar and said he was crazy. Resident #1 stated he did not have any mental health issues, although he thought LVN A was trying to put him on psychiatric medications. He stated LVN threw a temper tantrum and said she was going to show his back scratcher down his throat if he kept saying people were taking his things. He stated he told LVN A he was going to call the police and she laughed at him. Resident #1 stated two police officers came and talked to management. Resident #1 stated the DON came and ranted at him for making false allegations. Resident #1 stated the DON then tried to intimidate him by calling his parole officer. Resident #1 stated he told the Administrator what he told this surveyor. He stated the Administrator responded by asking him if he wanted to go somewhere else to which he replied yes. Resident #1 stated his visitor was a witness to this event. He stated he dd not want to stay in the facility because he did not like his life threatened or to be falsely accused. Resident #1 stated he also felt like they were putting something in his food, and he thought he was going to die. He stated he knows they are putting something in his food because his stomach gets hard, and he gets constipated. Resident #1 stated he was scared the facility was poisoning him. During an interview on 3/26/2024 at 3:04 p.m., Resident #1's parole officer stated Resident #1 had a pattern of facility hopping and going from nursing home to nursing home to nursing home. The parole officer stated she was notified on 3/25/2024 by Resident #1 that he had called the police to report the facility because they stole his shoes. The parole officer stated this was a pattern of his behavior. She stated she last visited him one week ago and he reported that everything was fine, so the current allegations were a big surprise to her. She stated she was unsure why he suddenly moved to another nursing facility. During an interview on 3/26/2024 at 3:09 p.m., Resident #1's visitor stated she visited with Resident #1 frequently. She stated Resident #1 had a history of frequently moving to different nursing home facilities, but she was not sure why and was not privy to that information. She stated Resident #1 frequently refused to take medication but did not understand why and she knew he had been resistant (to care) at the facility. She stated this was a pattern for the resident. She stated she did not know if Resident #1 was paranoid or what was going on but he complained about people thinking he was crazy. The visitor stated she had no knowledge of any abuse to the resident. She stated the facility had always been responsive and addressed any concerns she had shared. During an interview on 3/26/2024 at 3:36 p.m., CNA B stated Resident #1 had extreme behaviors. She stated if someone does not respond immediately to his calls, he made allegations. She stated he had a history of false allegations. She stated the staff had been instructed to go into his room in pairs of 2 to cover themselves from allegations of abuse. She stated they were also instructed to notify the Abuse Coordinator (Administrator) and DON immediately of any allegations. CNA B stated she had never witnessed anyone mistreat or abuse Resident #1. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/26/2024 at 4:21 p.m., CNA B stated on 3/20/2024 she had just finished changing Resident #1. She stated he had a reacher (tool used to reach items out of reach) and a back scratcher between his legs. She stated Resident #1's phone charger was on the nightstand. She stated she and LVN A pulled him up in bed. CNA B stated he asked to go up higher but there was no room for him to go higher. He was already at the top. CNA B stated Resident #1 did not get angry. They had a discussion about it and he seemed okay with it. She stated when they were done, she personally put the back scratcher and reacher on the table. CNA B stated on 3/25/2024 Resident #1 called the local police and made a false allegation that LVN A said something about his back scratcher and allegations about his phone charger. CNA B stated, no one was taking his stuff and LVN A never said anything about a back scratcher. CNA B stated she didn't even know where the allegation came from. She stated Resident #1 made it up. During an interview on 3/26/2024 at 4:26 p.m., LVN A stated she tried to be nice to Resident #1 but he turns it around and makes allegations. LVN A stated she never threatened Resident #1 with the stick (back scratcher). She stated she never told Resident #1 she was going to shove it down his throat. She stated she would never say or do that. LVN A stated a doctor ordered medication for Resident #1 for his depression, but he won't take it and refused to cooperate with psychiatric therapy. LVN A stated the police department had come to the facility and questioned her and asked for her statement. She stated she wrote a nurses note about the encounter. LVN A stated she did not threaten Resident #1 with a stick and the police did not press charges against her. LVN A stated the stick came up when CNA B removed it (back scratcher) from the bed while they were changing him. LVN A stated she did notify his physician and did document the scenario in the nurse's notes. LVN A stated she had completed abuse training multiple times and she knows she was to report abuse immediately to the Administrator. During an interview on 3/26/2024 at 5:04 p.m., the DON stated Resident #1 was a transfer from another nursing facility. He stated on the day of admission he called 911 on the facility. The DON stated he knew immediately he had to get psychiatry involved with Resident #1's care. The DON stated psychiatry came and visited with Resident #1, but ultimately Resident #1 refused care. The DON stated Resident #1 had behaviors of accusations. He stated he gets a two person staff assistance for all visits due to the false allegations. The DON stated they added the target behaviors of false allegations to his care plan. The DON stated he has also notified the Ombudsman of the behaviors and also spoke with Resident #1's parole officer about it. The DON stated he has assessed the resident after the allegation and there was no evidence the allegation took place. The DON stated he has talked to Resident #1 about finding him a place that will better meets his needs as he says he does not know why he is here (at the facility). The DON stated he interview both LVN A and CNA B after the allegations of abuse. He stated they said they were repositioning the resident in his room, and both denied using any threatening words. The DON stated the police came out and interviewed the resident and stated there were no charges pending. The DON stated he notified the Administrator of the allegations on 3/25/2024 at approximately 5:00 pm. He stated he did not know if it was reported to the State Survey Agency/HHSC because that was up to the Administrator. The DON stated he didn't think it was reported because the allegations were a target behavior that were constant, and the facility was aware of. The DON stated he first learned of the allegation on 3/25/2024 at approximately 3:00 pm. The DON stated at the time he reported the allegations to the Administrator we looked to see if it was reportable but did not think so because it was a target behavior and the police did not have any concerns. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/27/2024 at 10:07 a.m., the Administrator stated Resident #1 had behaviors since he came into the facility. The Administrator stated when he first arrived he told them he did not want to come to the facility, although the Social Worker at the previous facility had asked him if he wanted to come and he said yes. The Administrator stated they have assessed Resident #1 several times and asked him if he wanted to transfer to another facility. He will say yes and then later decline. The Administrator stated Resident #1 had a behavior of going from one facility to another. She stated she was not aware of this upon admission because they did not have Resident #1's full clinical record until after admission. The Administrator stated Resident #1 thinks they have a storage facility where they are keeping his stuff, but everything he owns in in his room. The Administrator stated he called the police and made an allegation about a back scratcher. The Administrator stated his false allegations were a target behavior. She stated a target behavior means they are aware of it and it is a documented part of his care. The Administrator stated she was not in the facility when the allegation about the back scratcher was made. She stated she became aware from the DON and the police. The Administrator stated she was on speaker phone when the cops were in the facility. The Administrator stated she did not report to HHSC because she was waiting for the final police report. She stated she discussed with Corporate about whether or not they had to report it because the allegations were his targeted behaviors. She stated she had gone back and forth with his history of allegations on whether or not what he said about the back scratcher was abuse due to his history. She stated to her knowledge she had 24 hours to report allegations of abuse to HHSC. During an interview on 3/27/2024 at 12:30 p.m., the Administrator stated after the previous interview she remembered that allegations of abuse should be reported within 2 hours of the allegation, and she looked online to verify the information. She stated she changed her mind about reporting because she called her mentor who is an administrator at another facility who stated that although it was a target behavior it should still be reported (to HHSC) because the allegation involved abuse. Record review of the facility policy titled Abuse, Neglect, and Exploitation Prevention Policy and Procedure last revised 9/10/2020 revealed: The facility Administrator, or his/her designee, will be designated as the facility's ANE Coordinator and will be responsible for overseeing the ANE Prevention program and directing any such investigation. Investigation of ANE: 13. Administrator, or his/her designee, shall immediately (within 24 hours) notify the State Health department, local law enforcement, and local ombudsman. (This section did not indicate reporting to the State Survey agency/HHSC). Reporting/Response of ANE: 28. The Administrator, Director of Nursing, or his/her designee shall report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required .report all reasonable suspicion of a crime against an individual to local law enforcement within 2 hours if the alleged violation involves serious bodily injury; within 24 hours if the alleged violation does not involve serious bodily injury. (This section did not have reporting guidelines for reporting to the State Survey Agency/HHSC).