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	05/25/2024

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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39251 Based on interview and record review, the facility failed to provide and document sufficient preparation and orientation to ensure safe and orderly transfer or discharge from the facility for 1 of 6 (Resident #1) residents reviewed for transfer or discharge. The facility failed to ensure sufficient resident education was provided to Resident #1, who had a recent AKA, osteomyelitis (serious infection of the bone), midline (venous access device inserted in a deep vein of the arm) and an order for IV antibiotics/wound care, and his RP when discharged home from the facility on 5/13/24. 1. Facility did not arrange home health services for Resident #1's wound care, ordered 5/10/24, and IV medication administration, ordered 5/11/24, when the resident was discharged on [DATE]. 2. Facility staff did not provide Resident #1's RP with proper education related to IV antibiotic administration. 3. Facility staff did not provide Resident #1's RP with proper education related to midline catheter care. 4. Facility staff did not provide Resident #1's RP with proper education related to wound care to surgical incision s/p left AKA. 5. Facility staff did not provide supplies for RP related to midline catheter and wound care. This failure placed Resident #1 at risk for medical complications after discharge. Findings included: Record review of Resident #1's Admission Record, dated 5/232/4, revealed the resident was admitted to the facility on [DATE], with diagnoses which included: the following: Osteomyelitis (serious infection of the bone), Autistic Disorder (developmental disorder that impairs the ability to communicate and interact), Type 2 diabetes (condition in which the body has trouble controlling blood sugar and using it for energy), and Left AKA. (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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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Comprehensive MDS assessment, dated 5/13/24, revealed Resident #1's BIMS score was blank. Further review revealed Resident #1's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). Resident #1's MDS assessment further revealed he had a surgical wound, received IV antibiotics while at the facility, and IV access (type not specified). Record review of Resident #1's Care Plan, dated 5/16/24 revealed: .IV THERAPY: [Resident #1] requires IV therapy AEB IV ABT orders for Osteomyelitis . Record review of Resident #1's Care Plan, dated 5/17/24 revealed: . [Resident #1] is on IV antibiotic and is at risk for adverse reactions . Record review of Resident #1's Care Plan revealed it did not address wound care. Record review of Resident #1's Clinical Physician Orders, dated 5/23/24, revealed the following orders: Midline site observation: Monitor midline site each shift, dated 5/10/24. Midline flush: Flush each midline lumen with 10 mL NS flush every shift and PRN to maintain patency, dated 5/10/24. Vancomycin IV solution reconstituted 750 mg, start 5/11/24. Change dressing daily with 4x4s, kerlix, ACE (elastic bandage) to keep skin around incision dry, dated 5/10/24 . May discharge to home, revised 5/13/24. May Discharge to home to keep midline and continue IV antibiotics at home through home health of their choice, mother via private duty, revised 5/14/24. May discharge to home on mother's request to keep midline for and continue IV antibiotics at home, mother will arrange PDN to give antibiotics ., revised 5/14/24. Record review of physician's Progress Note, dated 5/13/24, revealed: .Mother wants to take .home. Will have Nurse Friend continue IV antibiotic, midline for IV access, will send home . Record review of facility's 24-hour report, dated 5/13/24, revealed Resident #1 had a midline and was receiving IV Vancomycin. Record review of Resident #1's Transfer/Discharge Report, dated 5/23/24, revealed the resident was discharged home with no home health services on 5/13/24. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's hand-written Discharge Summary and Instructions, dated 5/13/24 and signed by LVN C, revealed: the resident had skin conditions requiring treatment orders (left AKA), no education at discharge choices we selected (medications .wound care), additional education provided included IV medication follow up and instructions, medications were sent with resident, Mother has private Nurses (friends) whom she will ask to assist giving his IV Vancomycin. Further review of this record revealed: Facility on downtime, [MD] gave orders to discharge him & to bring with him IV vancomycin meds to continue @ home, mother said she will take care of it thru some Nurse friends to administer Antibiotics; also, to keep midline for IV use. Mother was given instructions to follow up .x-ray of stump .likewise some few instructions on how IV medication be administered . Further review of this record revealed it included in unsigned hand-written progress note, dated 5/13/24 , which read: Meds sent home [with] resident: 1) IV Vanc 750mg/250mL - 10 2) 3M curos port protect cap - 14 3) Maxplus needless connector - 1 4) [NAME] primary tubing - 4 . Record review of Resident#1's Progress Note, dated 5/13/24 and authored by LVN C, revealed: .LATE ENTRY .Received orders from [MD] to go ahead and DC resident home with medications. This nurse documented on paper all meds sent home with resident. Resident mother took resident home with all belongings and medications . During an interview on 5/24/24 at 8:43 am, the surgeon's nurse said she was working with the MD on 5/13/24 when Resident #1 was discharged from the facility and sent paperwork to the facility for home health services to ensure the resident received proper care for wound care and medications after discharge. She further stated if Resident #1 did not receive proper care it could have led to severe consequences and could be life threatening. The surgeon's nurse said she followed up with the MD on 5/14/24 and was told Resident #1 needed home health services. During an interview on 5/24/24 at 9:07 am, the HCM said Resident #1's RP told the HCM the resident was home from the facility with medications and extra tubing and told the RP what to do but was not given any flushes to take home. She further stated the RP said she tried to infuse a dose of the antibiotic and it wasn't going and Resident #1 was flapping his arms and the RP was told by a nurse-line nurse to remove the midline. The HCM said she called the facility DON to verify the RP's statements and was told by the DON the MD sent Resident #1 home with the medications and did not set up home health or infusion services. The HCM said she was told by Resident #1's RP a Dial-a-flow (medical device that is used when regulating the?flow?of a liquid or fluid through an IV) was attached to the resident's IV and she was shown where to hook up the IV and told to hang it above the resident's head for approximately one hour. The HCM further stated this was the only education the RP said she had received from the facility and added she was only sent home with medications and tubing, and that flushes and wound care supplies were not sent home with the resident. During an interview on 5/24/24 at 11:08 am LVN B said she asked the DON about home health or outpatient IV therapy services and was told Resident #1's RP said she had nurse friends that would help her take care of everything. LVN B said when a resident was discharged from the facility, she coordinated care with the outside agencies which included obtaining recommendations from the MD, communication with the receiving agency, and ensuring education was provided to the resident/RP prior to discharge. LVN B said she was told by the MD home health services were not needed because Resident #1's RP had friends to help her. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/24/24 at 11:28 am, LVN C said, to her knowledge, Resident #1's RP was not provided information regarding home health services, RP was going to take Resident #1 home and she had friends that would help her. She added the MD did not give orders for home health services and she said she assumed the MD knew what he was doing. LVN C said she was told by the physician to send Resident #1 home with all medications, including the IV Vancomycin. LVN C further stated asked Resident #1's RP if she knew how to do flush the line and all that stuff, adding she asked the RP if she knew how to prime the line, flush it, care for it and Resident #1's RP said she had some nurse friends that could help her and was eager to leave. LVNC said she told Resident #1's RP she could hang the IV on a curtain rod with a wire hanger above the resident's head and could go to the hospital if she needed help. LVN C she did not provide Resident #1's RP written discharge instructions because the MD said he only wanted an x-ray of the stump and to discharge with medications. LVN C further stated she did not provide instructions for wound care because she computers were down and she was unable to see what wound care was ordered and the RP repeated she had nurse friends that were going to help her. LVN C said Resident #1 was not sent home with saline flushes because she was unable to find any. She further stated she did not provide education regarding infection control and risk for infection because she did not know that Resident #1 had a midline until she was questioned by the DON about discharging the resident with a midline, adding if she had access to the computer, she would have seen that Resident #1 had a midline and would have provided education specific to a midline. LVN C stated the nurse on the prior shift had not told her Resident #1 had a midline. She further stated the facility did use 24-hour reports to communicate resident information, but she did not review this report until way later during the shift. Attempt to interview the MD on 5/24/24 at 1:33 pm was unsuccessful, investigator was told the MD did not take calls and a message would be relayed for call back. During an interview on 5/24/24 at 2:52 pm, the RP said when Resident #1 was discharged on [DATE], they were sent home with IV medications and IV stuff but no flush syringes, adding she told the facility staff she was not comfortable administering the IV medication. The RP said she was told by the facility all she had to do was connect the medication to his arm, open the clamps and it would drip, adding when she attempted to administer the medication it didn't go, the insertion site was wet beneath the clear window and she did not know what to do, adding she was told by the hospital case manager that the IV was probably backing up. Resident #1's RP said she had told the facility she had friends that could help with the administration of the IV medication, but they weren't able to assist. Resident #1's RP further stated neither the facility staff nor the MD mentioned home health or infusion services prior to discharge but was told to obtain x-ray and blood work in two weeks. Resident #1's RP said she was not provided education on how to reconstitute the IV Vancomycin but knew how to do it because she watched when the facility staff had done it. The RP further stated she did not receive education on infection control and risk for infection, what to do if the medication did not infuse, and was not given demonstrations just verbal instructions on how to connect the IV. Resident #1's RP said she did not receive supplies or education from the facility staff regarding wound care but already knew how to do because she had been taught during care for previous wounds. The RP further stated she had some left-over wound care supplies from the hospital and gauze she had purchased. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/24/24 at 4:06 pm the DON said the facility's discharge process began with obtaining orders for discharge and included determining if the resident required home health services and those services would then be arranged by the DON or MDS nurse. The DON said he was not sure if information regarding home health services was provided to Resident #1's RP because the discharge was abrupt and was not made aware of the discharge until 5/13/24 during the night shift. The DON said he questioned the MD about the discharge because Resident #1 received IV antibiotics and was told the resident was sent home with IV antibiotics and midline in place because according to the RP, she had a friend that was going to help her with the IV and he (the DON) just followed the physician's orders. The DON said Resident #1's RP was given written instructions for x-ray and managing the IV infusion. The DON said the documentation reflected LVN C advised Resident #1's RP about an appointment for x-ray but had not seen any documentation regarding education for wound care. The DON said written discharge instructions were not provided because the computers were down on 5/13/24. He added a discharge summary was usually documented on a progress note and a copy sent home with the resident but at the time the facility did not have the capacity to do that. The DON further stated he assumed the MD would follow up with Resident #1. The DON said discharging Resident #1 with a midline and IV antibiotics would have been appropriate if home health services had been arranged but the RP insisted on going home and the MD provided discharge orders. The DON said the nurse discharging the resident was responsible for providing complete and accurate resident education and added he randomly competed audits to ensure discharge instructions were provided. The DON said he was not sure why education regarding wound care was not provided or why the resident was not sent home with saline flushes. Attempt to interview LVN A on 5/24/24 at 4:25 pm was unsuccessful. Record review of the facility's policy titled Nursing Policies and Procedures, revised 6/2019, revealed: Subject: DISCHARGE/TRANSFER Policy: The patient/resident will be discharged /transferred (home/another entity) by order of his/her attending physician. Facility will include the patient/resident and family in developing a safe discharge plan to address the patient's/resident's individual needs. Procedures . Provide written Discharge Instructions for care .Develop a safe discharge plan, including but not limited to securing an alternate location .