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	05/30/2024

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice for 1 of 7 (Resident #1) reviewed for respiratory care. Resident #1's oxygen tubing, humidifier and nasal canula were not replaced within the facility's time frame for replacement (every Wednesday during the night shift (10:00 pm to 6:00 am). This failure could affect residents administered oxygen and could lead to infections if the tubing, humidifier and canula are not cleaned/ or replaced as common practice in the facility and per facility policy. The findings were: Record review of Resident #1's face sheet, dated 5/30/24 revealed, the resident was admitted on [DATE] with diagnoses that included: depression, dementia, COPD (respiratory disease) and anemia. The Resident was a Male; age 71. The RP was listed as: the resident. Record review of Resident #1's quarterly MDS dated [DATE] revealed, the residents BIMS score was 15 (cognitively intact). During an interview on 5/30/24 at 1:10 PM, the MDS LVN stated, the April 2024 MDS's Section O section c was not checked for oxygen because the resident was not on continuous O2 and did not receive O2 during the April 2024 time frame. The MDS LVN added that Section O section c was not checked in May 2024 although Resident #1 did receive PRN (as needed) O2. . Record review of Resident#1's Care Plan, dated 12/31/21 , revealed, the goal of oxygen therapy with interventions that included: monitor for signs and symptoms of distress and report to the MD PRN. Record review of Resident #1's MAR dated May 2024 , revealed 2 liters of oxygen every shift (PRN). Record review of Physician' Orders, dated 3/30/24, revealed: PRN O2 @ 2L(two liters) per nasal cannula to keep sats >92% and to observe the nebulizer two times a day. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 5/30/24 at 1:53 pm, Resident #1 revealed, he was in his room receiving oxygen at 2 liters per minute. Humidifier bottle was dated 5/23/24 and was empty. Nebulizer on bedside table revealed a date or 4/11/24. The Resident stated, .the humidifier is empty and it makes me bleed and have soreness in my nose .they have not checked that the bottle is empty .the nebulizer is dated 4/11/24 .it should be changed weekly .the mask needs to changed .and the tubing needs to be changed .I told them [did not specified who he told] this week to change the hose and check water in the humidifier .they (day and evening shifts) blamed the night nurse and the night nurse blames the day nurses During an interview on 5/30/24 at 2:04 pm, LVN C stated: the humidifier needed to be changed weekly to include tubing in order to prevent infections, un-sanitary conditions , and ensure O2 was humidified. LVN C stated the lack of humidified O2 could lead a nose bleed or irritation to the nose. LVN C stated she observed that the humidifier bottle was empty. LVN C also stated that her observation revealed that the tubing and the nebulizer had not been changed and the nebulizer was dated 4/11/24. LVN C stated, , I am as guilty as anyone else for not changing the tubing, nebulizer and humidifier. LVN C stated that the charge nurse was responsible to check the O2 apparatus and the changing of the humidifier and tubing was scheduled for every Wednesday. During an interview on 5/30/24 at 3:10 pm, the ADON stated: the humidifier needed to be changed when empty and the facility procedure was to the change humidifier, tubing and nebulizer every seven days on Wednesday by the night shift. The ADON stated changing of O2 apparatus was necessary to prevent infections and ensure a clean oxygen flow. The ADON stated she could not explain why the night shift on 5/29/24 did not follow facility's procedures on 02 therapy. The ADON stated that the nebulizer and tubing required changing every 7 days; she could not provide an explanation for the tubing and nebulizer not changed that was dated 4/11/24. The ADON added the nebulizer and tubing needed to be changed every seven days to avoid infections. The ADON stated that the charge nurse was responsible for checking on oxygen therapy to include the filling of the humidifier, changing the nebulizer and changing the tubing. Record review of the facility's Oxygen Therapy policy, dated, 8/20/19 read: .Exchange humidifier when empty .Change O2 tubing with any discoloration or contamination .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on observation, record review and interview the facility failed to provide the services of a Registered Nurse to serve as the director of nursing on a full-time basis for 1 of 1 facility reviewed for nursing services, in that: The facility failed designate a registered nurse to serve as the Director of Nursing on a full time basis on [DATE]th and 13th 2024. This failure affected residents who resided in the facility by putting them at risk of poor nursing care. The findings were: Record review of employee time sheet revealed during the month of [DATE] the facility employed two registered nurses: RN A and RN B. RN A and RN B did not clocked hours on [DATE]th and 13th, 2024. At the time of exit on [DATE], the Administrator had not provided a policy or procedure for the Director of Nurses. During an observation and interview on [DATE] at 5:40 pm, RN A was physically present and stated that she usually provided RN coverage on weekends. RN A stated that an RN was required 8 hours per day so as to provide mentoring to other nurses that were not RNs and to be available to declare a death when a resident died . RN A added that an RN allows LVNs to practice and to provide supervision to non-RNs. RN A stated she was not present on [DATE] on Mother's Day or on [DATE]. During an interview on [DATE] at 6:00 pm, the ADON stated: she could not produce time cards for [DATE] and [DATE] that documented RN 8 hour coverage. The ADON stated that an RN was required to provide supervision to non-RNs and be available to declare a resident deceased . During an interview on [DATE] at 6:05 pm, the Administrator stated: he was aware of the requirement for the facility to provide RN coverage every day at least for 8 hours per day. The Administrator had no explanation as to why the nurse staffing sheet revealed no nurse coverage (RN) on [DATE] and [DATE]. The Administrator stated he did have a policy on RN 8-hour coverage. During a joint interview on [DATE] at 6:10 pm, LVN C and CNA D stated: they stated an RN was necessary for guidance. LVN C stated the RN provided supervision and could pronounced a resident's death. CNA D stated the RN could help define the limits on what a certified nurse aide could do in terms of resident care. At the time of exit on [DATE], the Administrator had not provided a policy for 8- hour RN coverage.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on interview, and record review, the facility failed to maintain medical records, in accordance with accepted professional standards and practices, which are complete; and accurately documented for 1 of 7 residents (Resident #1) reviewed for completeness and accuracy: Resident #1 was prescribed PRN (as needed) O2 and the April and May 2024 MARs did not capture or document the resident's nebulizer, humidifier, and 02 tubing needed to be changed every seven days per facility's procedure. This failure could result in the facility not documenting in the medical record residents on oxygen therapy not having their O2 nebulizer, humidifier and tubing changed which could cause infections and a diminished quality of life. The findings were: Record review of Resident #1's face sheet, dated 5/30/24 revealed, the resident was admitted on [DATE] with diagnoses that included: depression, dementia, COPD (respiratory disease) and anemia. The Resident was a Male; age 71. The RP was listed as: the resident. Record review of Resident #1's quarterly MDS dated [DATE] revealed, the residents BIMS score was 15 (cognitively intact). During an interview on 5/30/24 at 1:10 PM, the MDS LVN stated, the April 2024 MDS's Section O section c was not checked for oxygen because the resident was not on continuous O2 and did not receive O2 during the April 2024 time frame. The MDS LVN added that Section O section c was not checked in May 2024 although Resident #1 did receive PRN O2. . Record review of Resident#1's Care Plan, dated 12/31/24 , revealed, the goal of oxygen therapy with interventions that included: monitor for signs and symptoms of distress and report to the MD (Medical Director) PRN (as needed). Record review of Resident #1's MAR dated May 2024 , revealed 2 liters of oxygen every shift (PRN). Record review of Physician' Orders, dated 3/30/24, revealed: PRN O2 @ 2L (two liters) per nasal cannula to keep sats >92% and to observe the nebulizer two times a day. Record review of Resident #1's April and May 2024 MARs did not capture any procedures for changing the humidifier, tubing and nebulizer. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/24 at 4:19 pm, the MDS LVN stated: the April and May 2024 MARS were not accurate for O2 therapy because the MARs did not direct nursing staff to change tubing, humidifier and nebulizer every seven days as per facility procedures. The MDS LVN stated the lack of information in the MDS could lead nursing staff not to check O2 therapy every seven days. The MDS LVN stated that the person responsible for accuracy of the MDS was the MDS nurse. The MDS LVN stated she was new to the job less than one month (4/18/24) and could not explain the inaccurate MDS for April and May 2024. The MDS LVN stated she could not update the MDS because there was no documentation on the MAR that O2 was given to ensure accuracy of the MDS. The MDS LVN stated that the nursing staff needed to communicate to her ether in a progress note, updated MAR or during an interdisciplinary team meeting that Resident #1 received PRN (as needed) O2 (oxygen). Record review of facility's Minimum Data Set policy dated 6/2019 read, .Interview, observe and physically assess the resident to obtain validation of items identified on the medical record and to collect information for items where not documentation exits. Documentation of participation must include direct observation and communication with the residents, as well as communication with licensed and non-licensed direct care staff members on all shifts .Each assessment must represent an accurate picture of the resident's status during the observation period of the MDS.