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	03/07/2025

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record review, the facility failed to ensure residents had the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 of 14 residents (Residents #6) reviewed for accommodation of needs. The facility failed to ensure Resident #6's call light was within reach while she was positioned on her bed in her room. This failure could place residents at risk for delay in care and services, and increased risk of falls and injuries. The findings included: Record review of Resident #6's face sheet, dated 03/07/2025, revealed the resident was a [AGE] year old female and an original admitted [DATE] with diagnoses that included: traumatic subdural hemorrhage with loss of consciousness of unspecified duration (a pool of blood between the brain and it outermost covering), dysphagia (difficulty swallowing), hypertension (high blood pressure), extrapyramidal and movement disorder (increase motor tone and changes in the amount and velocity of movement), difficulty in walking, and muscle wasting and atrophy (wasting or thinning of muscle mass). Record review of Resident #6's quarterly MDS assessment, dated 01/21/2025, indicated her BIMS score was 15 reflecting her cognition was intact. Further record review indicated the resident was independent to all daily activities such as toilet hygiene, dressing, personal hygiene, and chair-to-bed transfer. Record review of Resident #6's comprehensive care plan, dated 10/17/2023, reflected [Resident #6] has activities of daily living self-care deficits and is at risk of further decline in activities of daily living functioning and injury. For intervention - call light is within reach and answer in a timely manner. Observation on 03/04/2025 at 9:34 a.m. revealed Resident #6 was laying down on her bed in her room, and the call light was on the floor, which was beside her roommate's bed, and it was not within reach. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/04/2025 at 10:40 a.m. with Resident #6 stated she could use the call light when she needed to have help, but she did not know where the call light was. The resident said to the state surveyor, Please give to me the call light because I could not reach it now. Further interview with Resident #6 stated she did not know why the call light was located on the floor bedside her roommate's bed where she could not reach it. Interview on 03/04/2025 at 10:43 a.m. LVN-A stated Resident #6 was on her bed in her room, and the call light was on the floor beside the resident's roommate's bed. She stated Resident #6 could not reach her call light. The call light should have been within reach all the time. She stated Resident #6 could use the call light to get help. LVN-A did not know what reason the call light was on the floor beside the resident's roommate's bed. The resident might not have proper care. Interview on 03/06/2025 at 5:45 p.m. the DON stated Resident #6 could use the call light to get help. The call light should have been within reach at all times per the facility policy. If Resident #6 could not use the call light because it was not within reach, the resident's care might be delayed. Record review of the facility policy, titled Call Lights, revised 12/2023, revealed Accessibility - Call lights will be placed within reached of the resident's bed or sitting area in the resident's room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to provide a clean, comfortable, and homelike environment including a clean bed in good condition for 1 of 1 Resident (Resident #14) whose bed was observed for sanitation. The facility failed to replace Resident #14's mattress which was heavily soiled with urine and the urine stains covered at least 50% of the mattress. This deficient practice could affect any resident and result in dissatisfaction and poor self-esteem. The findings were: Review of Resident #14's face sheet, dated 3/7/25, revealed she was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus, Schizoaffective Disorder (according to Mayo clinic: mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania), Major Depressive Disorder, recurrent severe without psychotic, Anxiety Disorder, unspecified Dementia, and bed confinement status. Review of Resident #14's quarterly MDS assessment, dated 12/20/24, revealed her BIMS score was 4 of 15 reflective of severe cognitive impairment; she had impaired vision; and required substantial to maximal assistance with toileting. Review of Resident #14's Care Plan, revised 1/7/25, read: ADL SELF CARE DEFICITS: Resident #14 [name]has ADL self-care deficits and is at risk for further decline in ADL functioning and injury AEB (as evidenced by) bilateral leg amputations. One of the interventions read: Provide Total assistance of 1 support person for toileting/incontinent care. Observation and interview on 03/05/25 at 10:15 AM revealed Resident #14's mattress had been stripped of its linens. The mattress was heavily soiled with urine and there was a large stain on the middle of the mattress that covered at least half of the mattress. The stain was brown/red in color and the room smelled heavily of urine. Interview with the ADON revealed she commented, oh that's got to get thrown out. She stated it was severely stained and it smelled like urine. The ADON stated the CNA's should be cleaning and disinfecting the mattress when soiled after providing pericare. She stated usually a mattress was replaced when ripped, but in this case, it was so heavily soiled she did not believe it could be adequately cleaned for continued use. The ADON stated nursing staff should report when there was a problem, but stated no one had said anything to her. She stated she also made rounds but had not seen the condition of the mattress because it had always been covered. The ADON stated Resident #14 had not said anything to her either but couldn't imagine being ok with the condition of the mattress. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/05/25 at 10:57 AM with Resident #14 revealed she was sitting in a wheelchair by the nurse's station. Resident #14 stated usually she did not spend much time in her room once staff helped her to get out of bed. She stated she was not aware of the condition of her mattress. She stated she had not paid attention. Resident #14 reviewed the picture taken of the mattress she was using and immediately commented, Oh my God that doesn't look good. I would not want to lay on that. Interview on 03/05/25 at 11:15 AM with CNA D revealed she often worked with Resident #14 and stated today was her shower day. CNA D stated they would strip the resident's bed during shower days. CNA D stated she had not really paid attention to the condition of Resident #14's bed but stated she would wipe it down with disinfectant if soiled. CNA D looked at Resident #14's mattress and commented, I don't remember it looking that way. She stated it was really soiled and it smelled like urine. She further stated she was not sure if the mattress would come clean. CNA D stated any resident would probably not be happy sleeping on a mattress that was that dirty. Review of the facility policy, Dignity: Resident's Right for, revised 6/2019, read in relevant part: It is the policy of this facility that the Facility staff will provide the resident with the right to an environment that preserves dignity and contributes to a positive self-image. 7) Create a home-like environment for the resident that includes: c. Clean, orderly, comfortable, safe environment with clean bed and bath linen in good condition, and personal closet. Review of the facility policy, General Environment Cleaning Techniques, revised 2/2022 read in relevant part: The primary objective of this policy is to establish and maintain a standardized approach to environmental cleaning, minimizing the risk of infections and promoting clean and sanitary living and working environment. General Surface Cleaning Process. Thoroughly wet (soak) a fresh cleaning cloth in the environmental cleaning solution. Fold the cleaning cloth in half until it is about the size of your hand. This will ensure that you can use all surface area efficiently. Wipe surfaces using the general strategies as above (clean to dirty, high to low), making sure to use mechanical action and making sure the surface is thoroughly wetted to allow required contact time.

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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** 27520 Based on interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect and misappropriation for 1 of 5 staff (housekeeper-F) reviewed for criminal backround checks. The facility administrator and human resources completed checking housekeeper-F's criminal background on 03/06/2025, but the housekeeper was hired to the facility on [DATE]. This failure could place all residents at risk of abuse from facility staff. Findings included: Record review of housekeeper-F's employee's profile revealed the housekeeper was hired and started working to the facility on [DATE], but the housekeeper's criminal background was checked on 03/06/2025. Interview on 03/07/2025 at 3:12 p.m. with the administrator stated housekeeper-F was hired and started working at the facility on 02/05/2025, but the housekeeper's criminal background was checked on 03/06/2025. The facility did not have staff for human resources, so the staff from the ssociated facility came to the facility sometimes and checked the criminal backgrounds of newly hired employees. Along the way, the staff might have miss checking the housekeeper-F's background before the housekeeper was hired. The facility should have checked the housekeeper-F's criminal background before the housekeeper was hired. Housekeeper-F had clear criminal background when it was checked on 03/06/2025. However, not checking criminal backgrounds before hiring dates might cause resident's abuse due to inappropriate staff. Record review of the facility policy, titled Authorization and release form to obtain an investigative and/or consumer report used for pre- and post-employment evaluation for employee, undated, revealed prospective employees authorize the facility to obtain an investigative and/or consumer report. These reports may include but are not limited to personal credit history and criminal history.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure the assessment accurately reflected the resident's status for 2 of 7 Residents (Resident #16 and Resident #35) whose records were reviewed. 1. Resident #16's quarterly MDS did not reflect he used one 1/4 bed rail for mobility and transfers. 2. Resident #35's quarterly MDS did not reflect she had impaired vision. This deficient practice could affect any resident and could result in the inaccuracy of assessments and contribute to residents not receiving care for identified care needs. The findings were: 1. Review of Resident #16's face sheet, dated 3/4/25, revealed he was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting non-dominant side and Dementia in other Diseases classified elsewhere, severe, with psychotic disturbance. Review of Resident #16's quarterly MDS assessment, dated 1/22/25, revealed his BIMS score was 14 of 15 reflective of minimal cognitive impairment and he did not use a bed rail while in bed. Review of Resident #16's Care Plan last updated on 6/25/24 revealed there was no indication he used a bed rail while in bed. Review of Resident #16's physician orders for March 2025 revealed an order L side rail to assist with bed mobility and transfers. No directions specified for order. Active: 1/22/2025. Observation and interview on 03/04/25 at 11:27 AM revealed Resident #16 lying in bed holding on to 1/4 bed rail x1; on his left side. Interview with Resident #16 revealed he used the bed rail to help him sit up in bed and for transfers out of bed. Interview on 03/06/25 at 02:58 PM with the MDS Coordinator revealed Resident #16's quarterly MDS assessment, dated 1/22/25, did not reflect he used a bed rail for mobility and transfers. The MDS Coordinator revealed clinical assessments were used to update the Care Plan. The accuracy of assessments were important to ensure staff captured all assistive devices provided to help Resident #16 become as independent as possible. The MDS Coordinator stated the inaccuracy of the MDS assessment could contribute to the Care Plan not reflecting assistive devices that should be provided and could result in a decline in physical mobility or inability to assist with mobility to maintain independence as much as possible. 2. Review of Resident #35's face sheet, dated 3/5/25, revealed she was admitted to the facility on [DATE] with diagnoses included Type 2 Diabetes Mellitus without complications and Anxiety Disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #35's quarterly MDS assessment, dated 12/24/24, revealed her BIMS score was 15 of 15 which was reflective of no cognitive impairment and that she had adequate vision. Review of Resident #35's Care Plan, revised on 2/10/25, revealed there was no indication she had visual impairment. Interview on 03/05/25 at 01:49 PM with the facility Ombudsman revealed Resident #35 had complained about her vision; not being able to see like she used to and had been waiting to see an optometrist since the latter part of 2024. Interview on 03/05/25 at 04:13 PM with Resident #35 revealed her vision was blurry since before Thanksgiving 2024. She stated the staff told her they were trying to get an optometrist to come to the facility and provide care in-house. Interview on 03/05/25 at 5: 00 PM with the MDS Coordinator revealed Resident #35 had been waiting to see an optometrist for at least a couple of months. She stated Resident #35 had complained about blurry vision. Further interview revealed Resident #35's quarterly MDS assessment, dated 12/24/24 did not reflect that she had blurred vision. She stated furthermore, the Care Plan, would not include it as a care need because the quarterly MDS did not accurately reflect Resident #35's status. She stated it could result in Resident #35 not receiving vision services as needed. Review of a facility policy, Minimum Data Set revised 6/2019, read in relevant part: Policy: It is the policy of this facility that a registered nurse will conduct or coordinate each assessment with the interdisciplinary team. An MDS, which is a comprehensive, accurate, standardized reproducible assessment will be completed for each resident, using the RAI process. Facility staff complete a comprehensive assessment of each resident's needs, strengths, goals, life history, and preferences, and offer guidance for further assessment once problems have been identified.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that were identified in the comprehensive assessment, and described services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 14 residents (Resident #143) reviewed for care plans. The facility failed to ensure Resident #143's care plan reflected her bowel incontinence and included a care plan regarding how to take care of the resident's bowel incontinence. These deficient practices could place residents at risk for not receiving proper care and services due to inaccurate care plans. The findings included: Record review of Resident #143's face sheet, dated 03/07/2025, revealed Resident #143 was [AGE] years old, female, and originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included: encounter for other orthopedic aftercare (caring after muscle or bone surgery), hyperlipidemia (high level of fat), muscle wasting and atrophy (wasting or thinning of muscle mass), dementia (group of thinking and social symptoms that interfere with daily functioning), and muscle weakness. Record review of Resident #143's quarterly MDS assessment, dated 12/23/2024, revealed Resident #143's BIMS score was 0 which indicated she had severe cognitive impairment, and she had frequent bladder incontinence, but always had bowel incontinence. Record review of Resident #143's comprehensive care plan, dated 10/07/2024, revealed [Resident #143] has bladder incontinence. For interventions - Monitor for incontinent episodes and provide peri care as indicated. Further record review of the resident's comprehensive care plan revealed there was no care plan regarding bowel incontinent care. Observation on 03/06/2025 at 9:24 a.m. revealed CNA-B and CNA-C were providing bowel and bladder incontinent care to Resident #143. Interview on 03/06/2025 at 9:32 a.m. with CNA-B and C stated Resident #143 was bowel and bladder incontinent, and the CNAs provided perineal care to the resident whenever the resident had incontinent episode. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/07/2025 at 9:31 a.m. with the MDS nurse stated Resident #143 was incontinent of bowel and bladder and needed to have bowel and bladder incontinent care whenever she had an episode. She stated there were care plans regarding only bladder incontinent care, and the MDS nurse removed the resident's care plans regarding the resident's bowel incontinence because it was resolved. However, Resident #143's bowel incontinence was not resolved. She stated the resident still needed to have bowel incontinent care. It was the MDS nurse's mistake to remove the care plans related to Resident #142's bowel incontinence, and not developing and updating the care plan might cause lack of care to the resident. Record review of the facility policy, titled Minimum Data Set, revised 06/2019, revealed . 13. The quarterly MDS does not require the completion of care area assessment, however, the resident's care plan must be reviewed and revised by the interdisciplinary team after each assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure resident's care plans were revised by the interdisciplinary team after each assessment for 3 of 7 Residents (Resident #16, Resident #35 and Resident #19) whose records were reviewed. 1. Resident #16's Care Plan did not reflect he used one 1/4 bed rail for mobility and transfers. 2. Resident #35's Care Plan did not reflect she had impaired vision and needed optometry care. 3. Resident #19's Care Plan did not reflect she was receiving Depakote Sprinkles Delayed Release as a mood stabilizer. These deficient practices could affect any resident and could result in the inaccuracy of assessments and contribute to residents not receiving care for identified care needs. The findings were: 1. Review of Resident #16's face sheet, dated 3/4/25, revealed he was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting non-dominant side and Dementia in other Diseases classified elsewhere, severe, with psychotic disturbance. Review of Resident #16's quarterly MDS assessment, dated 1/22/25, revealed his BIMS score was 14 of 15 reflective of minimal cognitive impairment and he did not use a BR while in bed. Review of Resident #16's Care Plan last updated on 3/2/25 revealed there was no indication he used a BR while in bed. Review of Resident #16's physician orders for March 2025 revealed an order L side rail to assist with bed mobility and transfers. No directions specified for order. Active: 1/22/2025. Observation and interview on 03/04/25 at 11:27 AM revealed Resident #16 lying in bed holding on to left side 1/4 BR. Interview with Resident #16 revealed he used the BR to help him sit up in bed and for transfers out of bed. Interview on 03/06/25 at 02:58 PM with the MDS Coordinator revealed Resident #16's Care Plan, revised 3/2/25, did not reflect he used a bed rail for mobility and transfers. The MDS Coordinator stated failure to revise Resident #16's Care Plan could result in the Resident not being provided with assistive devices which could contribute to a decline in physical mobility or inability to assist with mobility to order to maintain independence as much as possible. 2. Review of Resident #35's face sheet, dated 3/5/25, revealed she was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus without complications and Anxiety Disorder. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #35's quarterly MDS assessment, dated 12/24/24, revealed her BIMS score was 15 of 15 which was reflective of no cognitive impairment; she had adequate vision; and was not receiving rehabilitation services. Review of Resident #35's Care Plan, revised on 2/10/25, revealed there was no indication she had impaired vision or that she was in need of optometry care. Interview on 03/05/25 at 01:49 PM with the facility Ombudsman revealed Resident #35 had complained about her vision; not being able to see like she used to and she had been waiting to see an optometrist since the latter part of 2024. Interview on 03/05/25 at 04:13 PM with Resident #35 revealed she had blurred vision since before Thanksgiving 2024. She stated the staff told her they were trying to get an optometrist to come to the facility and provide care in-house but expressed concern about the length of time she had waited. Interview on 03/05/25 at 5: 00 PM with the MDS Coordinator revealed Resident #35 had been waiting to see an optometrist for at least a couple of months. She stated Resident #35 had complained about blurred vision. Further interview revealed the MDS Coordinator stated Resident #35's Care Plan did not identify she had blurred vision and was in need of optometry services. The MDS Coordinator stated it could result in Resident #35 not receiving care and services as needed. 3. Review of Resident #19's face sheet, dated 3/6/25, revealed she was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, current episode depressed, severe with psychotic features, psychotic disorder with delusions due to known physiological condition, Anxiety Disorder, and Major Depressive Disorder, recurrent, severe with psychotic symptoms. Review of Resident #19's quarterly MDS assessment, dated 12/24/25 revealed her BIMS score was 14 of 15 reflective of minimal cognitive impairment and she received antidepressant, antianxiety and antipsychotic medications. Review of Resident #19's physician orders for March 2025 revealed an order for Depakote Sprinkles Oral Capsule Delayed Release Sprinkle (according to drugs.com it is used to treat manic episodes related to bipolar disorder). Review of Resident #19's Care Plan revised on 3/7/25 revealed it did not reflect she received Depakote Sprinkles Delayed Release (mood stabilizer). Interview on 03/07/25 at 2:43 PM with the MDS Coordinator revealed Resident #19 was receiving Depakote Sprinkles Oral Capsule Delayed Release Sprinkle as a mood stabilizer and stated the list of medications were not updated on Resident #19's Care Plan to reflect this medication. The MDS Coordinator stated it was important to revise the Care Plan to ensure Resident #19 received the care and services she needed. Review of the facility policy, CARE PLANNING, revised 6/2019, read in relevant part: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 27520 Based on interview and record review the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional to provide activities for 42 of 42 residents. The facility did not have a qualified Activities Professional to direct their activities program. This deficient practice could affect any resident and could result in residents not receiving approaches that were individualized to match the skills, abilities, and interests/preferences of each resident. The findings were: Review of the facility contract binder revealed they did not have a qualified Activity Director. Interview on 03/05/25 at 02:20 PM with the MDS Coordinator revealed the facility did not have a qualified Activity Director since she started working during April 2024. She stated the facility had an activities assistant but was not qualified to lead specialized activities. As a result, the resident's might not receive activities centered to meet their individual needs. Interview on 03/05/25 at 02:50 PM with the ADM revealed the facility did not have a certified Activity Director since she started working during December 2024. She stated they had an Activity Assistant but understood the activities program required a qualified Activity Director to direct the program so the resident's could receive specialized activities to meet their needs. Review of the facility policy, Activities, revised 6/2019, read in relevant part: The Facility's activity program shall provide meaningful, person-centered activities to meet each resident's physical, mental, and psychosocial well-being, per their comprehensive care plan. Offer a variety of activities that promote engagement and meet the diverse needs of the resident population. Schedule activities at various times of the day, including weekends and evenings, to accommodate different preferences. Ensure activities are adaptable for residents with physical or cognitive limitations. Assign a qualified Activity Director to oversee the program. This individual must meet CMS and HHSC qualifications (e.g., completion of a state-approved activity training course or related certification).

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to ensure residents received proper treatment to maintain vision; the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision for 1 of 1 Resident (Resident #35) whose records were reviewed for optometry care. Nursing staff failed to ensure Resident #35 received transportation in order to obtain optometry care as needed for more than 2 months. This deficient practice could affect any resident and contribute to the decline of the resident's vision. The findings were: Review of Resident #35's face sheet, dated 3/5/25, revealed she was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus without complications and Anxiety Disorder. Review of Resident #35's quarterly MDS assessment, dated 12/24/24, revealed her BIMS score was 15 of 15 which was reflective of no cognitive impairment and that she had adequate vision. Review of Resident #35's Care Plan, revised on 2/10/25, revealed there was no indication she had impaired vision or that she was in need of optometry care. Interview on 03/05/25 at 01:49 PM with the facility Ombudsman revealed Resident #35 had complained about her vision; not being able to see like she used to; and she had been waiting to see an optometrist since the latter part of 2024. Interview on 03/05/25 at 04:13 PM with Resident #35 revealed she had blurred vision since before Thanksgiving 2024. She stated the staff told her they were trying to get an optometrist to come to the facility and provide care in-house, but expressed concern about the length of time she had waited. Interview on 03/05/25 at 5: 00 PM with the MDS Coordinator revealed she had been assisting with securing ancillary services for the residents. She stated Resident #35 had been waiting to see an optometrist for at least a couple of months. She stated Resident #35 had complained about blurred vision. The MDS Coordinator stated the facility had been sending residents out for services in the community until they secured a contract to have an optometrist provide in-house services. Further interview revealed the MDS Coordinator stated one of the wheel's on the wheelchair Resident #35 was using for transportation broke. The plastic came off of the wheel. She stated the facility did not have another wheelchair that was suitable for Resident #35's weight and she had not been able to schedule an optometry appointment. The MDS Coordinator stated they had a sister facility within close proximity but did not think about calling to ask if they had a suitable wheelchair for Resident #35. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 03/06/25 at 10:30 AM with the DON and the ADM revealed the facility did not have an optometrist providing in-house care since they both started working at the facility. The ADM stated they had been sending residents out for optometry care. The DON stated it had been a collaborative effort made by all administrative staff to refer residents for ancillary services. She stated she was aware Resident #35 had been waiting since about December 2024 for optometry care. She stated Resident #35 reported she had blurred vision. The DON reiterated what the MDS Coordinator stated about the situation. She stated the wheelchair Resident #35 used for transport was broken and the facility did not have another wheelchair for Resident #35 to use. The DON stated she talked with the Rehabilitation Director who reported she had ordered a replacement wheel for the broken wheelchair. The ADM stated she had also secured a contract this week for an optometrist to provide in-house care and services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 39049 Based on the observations, interviews, and record review, the facility failed to ensure that the resident's environment remained free of accidents and hazards as was possible and each resident received adequate supervision to prevent accidents for 2 of 2 (Resident #19 and Resident #28) reviewed for mechanical transfers. 1. a. CNA K and CNA C failed to use safe technique when transferring Resident #19 from the bed to the wheelchair using a mechanical lift. b. Nursing staff failed to ensure a floor mat was at Resident #19's bedside while she was in bed. 2. When CNA-D and CNA E mechanically transferred Resident #28 from the bed to the wheelchair on 03/05/2025, CNA-E did not hold the spreader bar to prevent the spread bar from hitting the resident's head that was swinging while CNA-D was lowering the spread bar to connect it to the sling. These failures could place the residents at risk for avoidable falls and injuries as a result of a fall. The findings included: 1. a. Review of Resident #19's face sheet, dated 3/6/25, revealed she was admitted to the facility on [DATE] with diagnosis including Hemiplegia, unspecified affecting left non-dominant side. Review of Resident #19's quarterly MDS assessment, dated 12/24/25 revealed her BIMS score was 14 of 15 reflective of minimal cognitive impairment and she required substantial to maximal assistance with transfers from chair/bed -to-chair transfer. Review of Resident #19's Care Plan revised on 1/7/25 revealed Resident #19 was at risk for falling related to history of CVA (stroke). One of the interventions included Fall mat on floor next to bed. Review of Resident #19's physician orders for March 2025 revealed an order: Fall Mat: Place fall mat on the floor, beside the bed, while in bed. Bed to be in the lowest and safest position possible for frequent falls Active 9/23/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 03/04/25 at 11:11 AM revealed CNA C and CNA K transferring Resident #19 from the bed to a wheelchair using a mechanical lift. CNA K operated the lift on her own. She positioned the base of the lift under the bed; she did not widen the base or lock the lift when she parked it. CNA K and CNA C attached the sling to the spreader. CNA K pulled the lift backwards and away from the bed with Resident #19 in mid-air. She attempted to turn the lift in the direction of the wheelchair positioned at the foot of the bed. Resident #19 rocked from side to side. CNA K was struggling to get the lift to turn. CNA C walked over and helped to turn the lift by pulling on the sling with Resident #19. CNA K did not widen the base of the lift while turning the lift and did not lock the lift when she stopped in front of the wheelchair. CNA K then widened the base of the lift and positioned the legs of the lift around the wheelchair while CNA C held the wheelchair. CNA K lowered Resident #19 and her feet got stuck under the actuator of the lift. CNA K pulled on Resident #19's feet away from the actuator. Interview with CNA K and CNA C revealed the lift had been getting stuck during transfers but stated they had not said anything to the MS. CNA K stated she did not widen the base which stated would provide stability. She stated she did not lock the lift when she came to a stop but should have to keep the lift from moving. CNA K further stated she tugged on Resident #19's feet because they were stuck and did not know how else to get her feet loose. CNA C stated she did not assist CNA K until CNA K was unable to turn the lift. She helped to turn the lift and then walked back over behind the wheelchair. She stated she was supposed to guide Resident #19 to the wheelchair to help keep the resident steady on the lift so the lift did not tip over and the Resident did not fall. CNA K and CNA C stated they received training on operating a mechanical lift during February 2025, but both stated they did not follow the steps provided in training to safely transfer Resident #19. CNA K and CNA C stated she could have fallen and been injured. Interview on 03/06/25 at 10:30 AM with the DON revealed a mechanical lift required two staff; one staff operated the lift while the second staff guided the resident during the transfer. The DON stated the base should be widened when positioning it under the bed to provide stability when lifting the resident. The legs of the base should be put back to the original position when moving the resident back and away from the bed. Once the base was completely out then the base should be widened again making it easier to maneuver the lift. The staff guiding the resident should never leave the resident's side and continue to guide ensuring the resident did not hit any part of the lift. The DON stated the base of the lift should be locked anytime it came to a stop or was parked. The DON stated the rehabilitation department provided training on all transfers. Interview on 03/06/25 at 01:49 PM with the DOR revealed the rehabilitation department provided all training on all resident transfers including using a mechanical lift. She stated the base of the lift should be widened under the bed as much as the bed would allow when preparing for transfer from the bed to the wheelchair. She stated widening the base of the lift provided support/stability to keep a resident from tipping over. The DOR stated the lift should also be locked anytime it came to a stop. The DOR stated the second staff assisting should guide and keep her hands on the resident during the transfer for additional support. The second staff should also ensure the resident did not bump any part of their body on the lift. b. Observation on 03/05/25 at 09:30 AM revealed Resident #19 lying in bed. Interview with Resident #19 revealed the last time she fell she broke her hip and had not been able to walk since. Further observation revealed a mat propped up on the chest of drawers across the room from Resident #19. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/05/25 at 09:35 AM revealed MA J walking into Resident 19's room. MA J commented to Resident #19 I'm going to put the mat back down. Interview with MA J revealed whoever removed Resident #19's meal tray probably forgot to put it down. She stated the mat was used to prevent Resident #19 from being injured in case she fell out of bed and should be by her bedside whenever Resident #19 was in bed. Interview on 03/06/25 at 10:30 AM with the DON revealed Resident #19 was a fall risk related to confusion and debility. She stated a mat was used and placed beside the bed at all times when in bed. She stated the staff should ensure they put the mat back in place when removing for meals and or care to prevent injuries in case Resident #19 fell out of bed. The DON stated Resident #19 had not had any recent falls this year. 2. Record review of Resident #28's face sheet, dated 03/07/2025, revealed the resident was a [AGE] year old female and admitted to the facility on [DATE] with diagnoses of poly-osteoarthritis (degenerative multiple joint disease), cerebral palsy (congenital disorder of movement, muscle tone, or posture), spastic quadriplegia (muscle stiffness and weakness in the arms and legs), muscle weakness, severe intellectual disability (motor impairment, severe damage to or abnormal development), and other reduced mobility. Record review of Resident #28's annual MDS, dated [DATE], revealed the resident's BIMS score was 0 which indicated the resident had severe cognitive impairment and was dependent on all activities of daily living such as bed mobility, char-to-bed transfer, and toilet transfer. Record review of Resident #28's comprehensive care plan, dated 08/04/2023, revealed [Resident #28] has activities of daily living self-care deficits and is at risk for further decline in the functions and injury as evidence by cerebral palsy. For intervention - total assistance of 2 support persons for transfers - hoyer lift (mechanical lift) for transfers. Observation on 03/05/2025 at 4:13 p.m. revealed CNA-D was driving a mechanical lift toward Resident #28, who was laying down on her bed, to transfer the resident to a wheelchair. CNA-D was lowering a spread bar of the mechanical lift to connect it to the sling below Resident #28, and CNA-E was standing on the opposite side of CNA-D. When CNA-D was lowering a spread bar toward Resident #28's head, the spread bar was swinging, but CNA-E did not hold the spread bar that was swinging. CNA-E was waiting for connecting the spread bar to the sling. CNA-D and E transferred Resident #28 to the wheelchair with a mechanical lift, then disconnected the sling to the spread bar. In an interview on 03/05/2025 at 4:28 p.m. CNA-E stated when CNA-D was lowering the spread bar, it was swinging over Resident #28's head, but CNA-E did not hold it to prevent it from hitting the resident's head. Further interview with CNA-E stated she should have held the spread bar swing to prevent it from hitting Resident #28's head while CNA-D was lowering it. CNA-E stated she took training regarding how to transfer residents with the mechanical lift and passed it on a skill check-off evaluation in 2024. However, CNA-E was nervous and forgot to it. Resident #28 might receive an injury if the spread bar hit the resident's head. In an interview on 03/06/2025 at 5:45 p.m. the DON stated CNA-E should have held the spread bar swing to prevent it from hitting Resident #28's head while CNA-D was lowering it. Resident #28 might have had an injury if the spread bar hit the resident's head. The previous DON conducted CNA-E's skill check-off on 10/30/2024, and the CNA passed the check-off. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CNA-E's Resident Care Specialist Competency for Annual, dated 10/30/2024, revealed CNA-E received training and passed the skill check-off regarding mechanical lift on 10/30/2024. Record review of the facility policy, titled Transfer/Lifts, revised 01/2024, revealed The purpose of this policy is to ensure the safety, dignity, and well-being of residents during transfers and lifts within the nursing home facility. This policy aims to minimize the risk of injury to both residents and staff while promoting efficient and respectful care practice. Review of OWNER'S MANUAL for the mechanical lift, undated, read in relevant part: SAFETY INSTRUCTIONS: During lifting or lowering, whenever possible, always keep the base of the lift in the widest position. The base of the lift should be closed before moving the lift. Do not roll casters over any object while the user/patient is in the sling. While being lifted in a sling, always keep the user/patient centered over the base.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 2 of 2 residents (Resident #11 and #143) reviewed for incontinence care. 1. When CNA-C was providing incontinent care to Resident #11 on 03/05/2025, CNA-F did not clean the resident's suprapubic area (the area of the abdomen located below the umbilical region). 2. When CNA-B was providing incontinent care to Resident #143 on 03/06/2025, CNA-G did not separate and clean the resident's labia area. These failures could place residents who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections. The findings included: 1. Record review of Resident #11's face sheet, dated 03/07/2025, revealed the resident was a [AGE] year old male and admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus (uncontrolled blood sugars), cerebral infarction (lack of blood flow to an area of the brain), chronic obstructive pulmonary disease (restricted airflow and breathing problem), muscle wasting and atrophy (wasting or thinning of muscle mass), reduced mobility, and benign prostatic hyperplasia (prostate gland enlargement). Record review of Resident #11's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 3 which indicated the resident had severe cognitive impairment and always incontinent of bowel and bladder. Resident #11 required substantial/maximal assistance (helper does more than half the effort) to chair-to bed transfer and was dependent (helper does all of the effort) to toilet transfer. Record review of Resident #11's comprehensive care plan, dated 08/01/2023, revealed [Resident #11] has bowel and bladder incontinence related to resident does not voice need to toilet. For intervention - Clean perineal area with each incontinence episode and monitor for signs and symptoms of urinary tract infection such as pain, burning, blood-tinged urine and cloudiness. Observation on 03/05/2025 at 4:32 p.m. revealed CNA-C opened Resident #11's old and dirty brief and cleaned the resident's penis, and then cleaned the left and right groin area. CNA-C turned the resident to his left side without cleaning the suprapubic area, which was the area of the abdomen located below the umbilical region, and CNA-C cleaned the resident's buttock area, then put a new and clean brief on the resident. In an interview on 03/05/2025 at 4:46 p.m. CNA-C stated she did not clean Resident #11's suprapubic area, which was the area of the abdomen located below the umbilical region because she was nervous and forgot to clean the area. CNA-C said she should have cleaned the area when providing peri-care to Resident #11 and had peri-care training last year. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review of Resident #143's face sheet, dated 03/07/2025, revealed Resident #143 was [AGE] years old, female, and originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included: encounter for other orthopedic aftercare (caring after muscle or bone surgery), hyperlipidemia (high level of fat), muscle wasting and atrophy (wasting or thinning of muscle mass), dementia (group of thinking and social symptoms that interfere with daily functioning), and muscle weakness. Record review of Resident #143's quarterly MDS assessment, dated 12/23/2024, revealed Resident #143's BIMS score was 0 indicated she had severe cognitive impairment, and she frequently had bladder incontinence, but always had bowel incontinence. Record review of Resident #143's comprehensive care plan, dated 10/07/2024, revealed [Resident #143] has bladder incontinence. For interventions - Monitor for incontinent episodes and provide peri care as indicated. Observation on 03/06/2025 at 9:24 a.m. revealed CNA-B opened Resident #143's old and dirty brief and cleaned her suprapubic area, left and right groin area, then turned the resident to left side without separating and cleaning Resident #143's labia area. The CNA-B cleaned her buttock area and put a new and clean brief on Resident #143. In an interview on 03/06/2025 at 9:32 a.m. CNA-B stated she did not separate and clean Resident #143's labia area because she was nervous and forgot to separate and clean the area. CNA-B said she should have separated and cleaned Resident #143's labia area and she had peri-care training last year. In an interview on 03/06/2025 at 5:45 p.m. the DON stated CNA-C should have cleaned Resident #11's suprapubic area when providing peri-care to Resident #11, and CNA-B should have separated and cleaned Resident #143's labia area to prevent possible infection. The DON and the ADON were responsible for providing training related to peri-care and monitoring skill check-offs and conducting skill check-offs on 10/2024. Record review of the facility policy, titled Perineal care, revised 12/2023, revealed The facility will provide perineal care in a manner that maintain privacy, reduced the risk of infection, and promote skin integrity. Cleaning - for female residents, separate the labia and clean from front to back using a clean wipe for each stroke. For male residents, retract the foreskin (if applicable) and clean the penis from the tip down to the base, then the scrotum.

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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** 27520 Based on observation, interview and record review the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan for 2 of 2 Resident (Resident #16, Resident # 13) whose records were reviewed for oxygen therapy. 1. Nursing staff failed to ensure Resident #16's oxygen concentrator filter was clean while he was receiving oxygen via nasal cannula. 2. Resident #13's nebulizer mask was observed on the resident's dresser on 03/04/2025, and it was not covered in a plastic bag when it was not used. This deficient practice could affect any resident receiving oxygen therapy and could cause the resident to develop an upper respiratory infection. The findings were: 1. Review of Resident #16's face sheet, dated 3/4/25, revealed he was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction (paralysis after having a stroke) affecting non-dominant side and Chronic Obstructive Pulmonary Disease. Review of Resident #16's quarterly MDS assessment, dated 1/22/25, revealed his BIMS score was 14 of 15 reflective of minimal cognitive impairment and he received oxygen therapy. Review of Resident #16's Care Plan last updated on 3/2/25 revealed he was at risk for respiratory distress/failure and increased episodes of SOB AEB pulmonary emphysema (according to may clinic emphysema is a long-term lung condition that causes shortness of breath) . One of the interventions included to apply oxygen per order. Review of Resident #16's physician orders for March 2025 revealed an order Oxygen @ 2.5 L/min per nasal cannula continuously every shift, Active 6/1/2024 06:00, 11/15/2024, Change Oxygen Humidifier, tubing, and cannula weekly Label with date and initial every night shift every Wed, Active 4/3/2024 18:00 (4:00 p.m.). Observation and interview on 03/04/25 at 11:27 AM revealed Resident #16 lying in bed holding on to 1/4 bed rail on his left side and oxygen infusing at 3 liters via nasal cannula. Further observation revealed the oxygen concentrator filter was covered with white residue/lent. Interview with Resident #16 stated he had been on oxygen for years for shortness of breath. He stated it helped him breath better. Interview on 03/04/25 at 11:27 AM with LVN G revealed she stated it looked like dust. LVN G scratched a layer of back from the filter. She commented it doesn't even have a back on it.: Further interview revealed LVN G stated the dust had also collected into the oxygen vent which the filter covered. LVN G stated Resident #16 was inhaling lint into his lungs and could result in an upper respiratory infection. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/04/25 at 11:50 AM with LVN G revealed she was told to wash the filter and replace it on Resident #16's oxygen concentrator. She stated the filter was covered in dust and she cleaned out the vent opening as well. Interview on 03/07/25 at 11:00 AM with the DON revealed nursing staff should be the checking oxygen concentrators every day/shift to ensure it was operating as it should; it was providing the liters of oxygen per physician orders; that the filter was clean and the tubing was secured in plastic and dated when it was last changed. The DON stated a dirty filter could result in a resident developing an upper respiratory infection. The DON stated if Resident #16 was inhaling lint into his lungs it could lead to a decline in physical health and possible hospitalization . Review of the facility policy, Respiratory Training - Oxygen Therapy, undated, read in relevant part: Oxygen Concentrator 10) Routine Maintenance a. Filter i. Clean when visibly soiled 1. Remove the filter. 2. Wash in solution of warm water and clear liquid detergent. 3. Rinse filter thoroughly with warm water. 4. Gently squeeze water from the filter, then pat dry with a clean towel. 5. Once filter is dry, reattach. 2. Record review of Resident #13's face sheet, dated 03/07/2025, revealed the resident was [AGE] years old female, originally admitted to the facility on [DATE], and readmitted [DATE] with diagnosis of sepsis (body responds improperly to an infection), acute respiratory failure (blood not having enough oxygen), pneumonia (infection to the lung), type 2 diabetes mellitus (not control blood sugar), and sleep apnea (breathing stops and restarts many times while sleeping). Record review of Resident #13's quarterly MDS, dated [DATE], revealed the resident's BIMS was 15 indicated the resident's cognitive was intact and required substantial/maximal assistance (Helper does more than half the efforts) to sit to stand, chair-to-bed transfer, and toilet transfer. Record review of Resident #13's comprehensive care plan, dated 04/30/2024, revealed [Resident #13] is at risk for developing viral respiratory illnesses such as flu. For intervention - follow physician orders and monitor resident for signs and symptoms of respiratory illnesses. Record review of Resident #13's physician order, dated 05/08/2024, revealed the resident had the order of Albuterol Sulfate inhalation Nebulization Solution (2.5 mg/3 ml) 0.083% one vial inhale orally via nebulizer every 6 hours as needed for short of breathing or wheezing. Record review of Resident #13's medication administration record, from 02/01/2025 to 02/28/2025, revealed the resident was receiving Albuterol Sulfate inhalation Nebulization Solution (2.5 mg/3 ml) 0.083% one vial inhale orally via nebulizer every 6 hours as needed for short of breathing or wheezing on 02/26/25 at 1:30 p. m. as ordered. Observation on 03/04/2025 at 10:10 a.m. revealed Resident #13 was not in the room. The mask connected to a nebulizer was on the dresser in Resident #13's room. It was not used, but it was not covered in a plastic bag. Interview on 03/04/2025 at 10:52 a.m. LVN-A stated Resident #13's mask connected to a nebulizer was on the dresser in Resident #13's room. It was not used, but it was not covered in a plastic bag. Further interview with the LVN-A said a mask for breathing treatment with a nebulizer should have been covered in a plastic bag when it was not used to prevent possible infection. (continued on next page)

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Paradigm at Stevens	204 Walter St Yoakum, TX 77995

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/06/2025 at 5:45 p.m. the DON said Resident #13's mask for breathing treatment with a nebulizer should have been covered in a plastic bag when it was not being used to prevent possible infection.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 Based on observation, interview and record review the facility failed to assess the resident for risk of entrapment from bed rails prior to installation; to review the risks and benefits of bed rails with the resident and obtain informed consent prior to installation for 1 of 3 Residents (Resident #16) who were reviewed for bed rail use. Nursing staff failed to take the necessary steps prior to allowing Resident #16 to use a bed rail; complete an assessment; attempt the use of alternatives; review risks vs benefits; and to obtain a consent. These deficient practices could affect the residents who used a bed rail and could contribute to avoidable accidents. The findings were: Review of Resident #16's face sheet, dated 3/4/25, revealed he was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis (paralysis) following Cerebral Infarction (stroke) affecting non-dominant side and Dementia in other Diseases classified elsewhere, severe, with psychotic disturbance. Review of Resident #16's Side Rail assessment, dated 8/19/22 revealed not every section was answered in regards to his diagnoses, alternatives attempted, what type of side rail or how the side rail would be used. Review of Resident #16's quarterly MDS assessment, dated 1/22/25, revealed his BIMS score was 14 of 15 reflective of minimal cognitive impairment and he did not use a bed rail while in bed. Review of Resident #16's Care Plan last updated on 3/2/25 revealed there was no indication he used a bed rail while in bed. Review of Resident #16's physician orders for March 2025 revealed an order L side rail to assist with bed mobility and transfers. No directions specified for order. Active: 1/22/2025. Observation and interview on 03/04/25 at 11:27 AM revealed Resident #16 lying in bed holding on to left side 1/4 bed rail. Interview with Resident #16 revealed he used the bed rail to help him sit up in bed and for transfers out of bed. He stated he did not remember staff talking to him about the risks of using a bed rail or signing a consent. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/06/25 at 02:58 PM with the MDS Coordinator revealed the most current clinical risk assessment was completed on 1/22/25. It reflected Resident #16 did not use a bed rail. The MDS Coordinator stated the importance of completing risk assessments was to ensure staff included all assistive devices provided to help a resident become as independent as possible and to ensure the device was not harmful for the resident. The MDS Coordinator stated when staff did not assess residents for the use of bed rails, they missed the opportunity to assess the resident's ability to use bed rails correctly could result in a major injury. The MDS Coordinator stated Resident #16's assessment completed 1/22/25 revealed he did not use a bed rail when in fact he did use a 1/4 bed rail. Interview on 03/06/25 at 10:30 AM with the ADM and DON revealed the use of side rails required nursing staff to obtain a physician order, completion of an assessment and a signed consent which included a discussion of the risks vs. benefits with the resident/resident representative. The DON stated the purpose was to determine the resident could use the side rail safely so the resident did not sustain any injuries. The DON stated Resident #16 used one 1/4 side rail on one side of the bed for bed mobility. Review of the facility policy, revised 12/2023, read: Side Rails The Facility will ensure the safe and appropriate use of side rails as part of resident care, minimizing risks associated with their use while promoting resident autonomy and safety. Assessment o Routinely assess the residents' need for side rails. o Consider medical condition, cognitive status, mobility, and risk of falls. o Document resident's side rail needs/preference in the resident's care plan. Consent o Obtain informed consent from the resident or responsible party before the installation of side rails. o Provide information about the benefits and risks associated with side rails. Use of Side Rails o Use side rails primarily for mobility assistance and to promote independence. o Consider alternatives to side rails whenever possible, unless requested by the resident. Monitoring o Monitor residents regularly to ensure their safety and well-being. o Document any incidents or issues related to side rail use.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27520 39049 Based on observation, interview, and record review, the facility failed to ensure that licensed staff were able to demonstrate the specific competencies and skill sets necessary to care for resident's needs for 3 of 6 nursing staff(CNA C, CNA-E and CNA K) reviewed for competencies. 1. a. CNA C and CNA K failed to use safe technique when transferring Resident #19 from the bed to the wheelchair using a mechanical lift. 2. When CNA D and E mechanically transferred Resident #28 from the bed to the wheelchair on 03/05/2025, CNA E did not hold the spreader bar to prevent the spread bar from hitting the resident's head that was swinging while CNA D was lowering the spread bar to connect it to the sling. These failures could place the residents at risk for avoidable falls and injuries as a result of a fall. The findings included: 1. Review of Resident #19's face sheet, dated 3/6/25, revealed she was admitted to the facility on [DATE] with diagnosis including Hemiplegia, unspecified affecting left non-dominant side. Review of Resident #19's quarterly MDS assessment, dated 12/24/25 revealed her BIMS score was 14 of 15 reflective of minimal cognitive impairment and she required substantial to maximal assistance with transfers from chair/bed -to-chair transfer. Review of Resident #19's Care Plan revised on 1/7/25 revealed Resident #19 was at risk for falling related to history of CVA (stroke). One of the interventions included Fall mat on floor next to bed. Review of Resident #19's physician orders for March 2025 revealed an order: Fall Mat: Place fall mat on the floor, beside the bed, while in bed. Bed to be in the lowest and safest position possible for frequent falls Active 9/23/24. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 03/04/25 at 11:11 AM revealed CNA C and CNA K transferring Resident #19 from the bed to a wheelchair using a mechanical lift. CNA K operated the lift on her own. She positioned the base of the lift under the bed; she did not widen the base or lock the lift when she parked it. CNA K and CNA C attached the sling to the spreader. CNA K pulled the lift backwards and away from the bed with Resident #19 in mid-air. She attempted to turn the lift in the direction of the wheelchair positioned at the foot of the bed. Resident #19 rocked from side to side. CNA K was struggling to get the lift to turn. CNA C walked over and helped to turn the lift by pulling on the sling with Resident #19. CNA K did not widen the base of the lift while turning the lift and did not lock the lift when she stopped in front of the wheelchair. CNA K then widened the base of the lift and positioned the legs of the lift around the wheelchair while CNA C held the wheelchair. CNA K lowered Resident #19 and her feet got stuck under the actuator of the lift. CNA K pulled on Resident #19's feet away from the actuator. Interview with CNA K and CNA C revealed the lift had been getting stuck during transfers but stated they had not said anything to the MS. CNA K stated she did not widen the base which stated would provide stability. She stated she did not lock the lift when she came to a stop but should have to keep the lift from moving. CNA K further stated she tugged on Resident #19's feet because they were stuck and did not know how else to get her feet loose. CNA C stated she did not assist CNA K until CNA K was unable to turn the lift. She helped to turn the lift and then walked back over behind the wheelchair. She stated she was supposed to guide Resident #19 to the wheelchair to help keep the resident steady on the lift so the lift did not tip over and the Resident did not fall. CNA K and CNA C stated they received training on operating a mechanical lift during February 2025, but both stated they did not follow the steps provided in training to safely transfer Resident #19. CNA K and CNA C stated she could have fallen and been injured. Interview on 03/06/25 at 10:30 AM with the DON revealed a mechanical lift required two staff; one staff operated the lift while the second staff guided the resident during the transfer. The DON stated the base should be widened when positioning it under the bed to provide stability when lifting the resident. The legs of the base should be put back to the original position when moving the resident back and away from the bed. Once the base was completely out then the base should be widened again making it easier to maneuver the lift. The staff guiding the resident should never leave the resident's side and continue to guide ensuring the resident did not hit any part of the lift. The DON stated the base of the lift should be locked anytime it came to a stop or was parked. The DON stated the rehabilitation department provided training on all transfers. Interview on 03/06/25 at 01:49 PM with the DOR revealed the rehabilitation department provided all training on all resident transfers including using a mechanical lift. She stated the base of the lift should be widened under the bed as much as the bed would allow when preparing for transfer from the bed to the wheelchair. She stated widening the base of the lift provided support/stability to keep a resident from tipping over. The DOR stated the lift should also be locked anytime it came to a stop. The DOR stated the second staff assisting should guide and keep her hands on the resident during the transfer for additional support. The second staff should also ensure the resident did not bump any part of their body on the lift. 2. Record review of Resident #28's face sheet, dated 03/07/2025, revealed the resident was [AGE] years old female and admitted to the facility on [DATE] with diagnosis of poly-osteoarthritis (degenerative multiple joint disease), cerebral palsy (congenital disorder of movement, muscle tone, or posture), spastic quadriplegia (muscle stiffness and weakness in the arms and legs), muscle weakness, severe intellectual disability (motor impairment, severe damage to or abnormal development), and other reduced mobility. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #28's annual MDS, dated [DATE], revealed the resident's BIMS was 0 indicated the resident had severe cognitive impairment and was dependent to all activities of daily living such as bed mobility, char-to-bed transfer, and toilet transfer. Record review of Resident #28's comprehensive care plan, dated 08/04/2023, revealed [Resident #28] has activities of daily living self-care deficits and is at risk for further decline in the functions and injury as evidence by cerebral palsy. For intervention - total assistance of 2 support persons for transfers - hoyer lift (mechanical lift) for transfers. Observation on 03/05/2025 at 4:13 p.m. revealed CNA-D was driving a mechanical lift toward Resident #28 laying down on her bed to transfer the resident to a wheelchair. CNA-D was lowering a spread bar of the mechanical lift to connect it to the sling below Resident #28, and CNA-E was standing apposite side of CNA-D. When CNA-D was lowering a spread bar toward Resident #28's head, the spread bar was swing, but CNA-E did not hold the spread bar that was swing. CNA-E was just waiting for connecting the spread bar to the sling. CNA-D and E transferred Resident #28 to the wheelchair with a mechanical lift, then disconnected the sling to the spread bar. Interview on 03/05/2025 at 4:28 p.m. with CNA-E stated when CNA-D was lowering the spread bar, it was swing over Resident #28's head, but CNA-E did not hold it to prevent hitting the resident's head. Further interview with CNA-E stated she should have held the spread bar swing to prevent it from hitting Resident #28's head while CNA-D was lowering it. CNA-E stated she took training regarding how to transfer residents with mechanical lift and passed on skill check-off evaluation in 2024. However, CNA-E was nervous so forgot holding it. Resident #28 might have injury if the spread bar hits the resident's head. Interview on 03/06/2025 at 5:45 p.m. with DON stated CNA-E should have held the spread bar swing to prevent it from hitting Resident #28's head while CNA-D was lowering it because Resident #28 might have injury if the spread bar hits the resident's head. The previous DON conducted CNA-E's skill check-off on 10/30/2024, and the CNA passed the check-off. Record review of CNA-E's Resident Care Specialist Competency for Annual, dated 10/30/2024, revealed CNA-E received training and passed the skill check-off regarding mechanical lift on 10/30/2024. Record review of the facility policy, titled Transfer/Lifts, revised 01/2024, revealed The purpose of this policy is to ensure the safety, dignity, and well-being of residents during transfers and lifts within the nursing home facility. This policy aims to minimize the risk of injury to both residents and staff while promoting efficient and respectful care practice. Review of OWNER'S MANUAL for the mechanical lift, undated, read in relevant part: SAFETY INSTRUCTIONS: During lifting or lowering, whenever possible, always keep the base of the lift in the widest position. The base of the lift should be closed before moving the lift. Do not roll casters over any object while the user/patient is in the sling. While being lifted in a sling, always keep the user/patient centered over the base.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39049 Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 2 medication rooms (3-side medication room) reviewed for pharmacy services. There were total eighteen (18) syringes of 0.9 % sodium chloride injection for flush 10 milliliters expired on 02/28/2025 found inside 3-side medication room on 03/05/2025. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings included: Observation on 03/05/2025 at 11:28 a.m. revealed a total of eighteen (18) syringes of 0.9 % sodium chloride injection for flush 10 milliliters expired on 02/28/2025 found inside the 3-side medication room. Interview on 03/05/2025 at 11:46 a.m. with DON acknowledged there were total of eighteen (18) syringes of 0.9 % sodium chloride injection for flush 10 milliliters expired on 02/28/2025 found inside the 3-side medication room. The DON said she did not know what the reason the expired syringes for flush were inside the 3-side medication room, and nurses should discard all expired medications and syringes for flush from the medication rooms as per the facility policy. The facility did not have any resident with intravenous therapy for using normal saline syringes for flush. Potential harm was nurses might use the expired normal saline syringes for flush, and the expired normal saline syringes for flush might not have therapeutic effects. Record review of the facility policy, titled Consultant Pharmacist Services Provider Requirements, revised 08/2020, revealed 6 d. checking the medication storage areas and the medication carts for proper storage and labeling of medications, cleaning, and removal of expired mediations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 2 medication rooms (the 4-side medication room) and 1 of 3 medication carts (the medication aide cart) review for storage and medication carts. 1. The narcotic box located inside a refrigerator in the 4-side medication room was not affixed permanently to the refrigerator, and there were total 12 capsules of Resident #144's Dronabinol 5 mg inside the narcotic box. 2. There were brand new and unopened two eye drop bottles of Latanoprost 0.005% ophthalmic solution stored inside medication aide cart at the room temperature, but the label of the two eye drop bottles said Keep refrigerator unopened. Store opened at room temperature. This failure could place residents at risk of misappropriation of medications or harm due to not having appropriate therapeutic effects. The findings were: 1. Record review of Resident #144's face sheet, dated 03/07/2025, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] with diagnosis of acute and chronic respiratory failure (not have enough oxygen when breathing), dysphagia (difficulty swallowing), type 2 diabetes mellitus (not control blood sugars), bronchus of lung (lung cancer), and nausea with vomiting. Record review Resident #144's admission MDS, dated [DATE], revealed the resident's BIMS was 9 indicated the resident had moderate cognitive impairment and required partial/moderate assistance (Helper does less than half the effort) to most activities of daily living, such as chair-to-bed transfer and toilet transfer. Record review Resident #144's physician order, dated 12/27/2024, revealed the resident had the order of Dronabinol oral capsule 5 mg Control Drug Give 1 capsule by mouth one time a day for appetite. Record review of Resident #144's medication administration record, dated from 03/01/2025 to 03/31/2025, revealed the resident was receiving Dronabinol oral capsule 5 mg Control Drug Give 1 capsule by mouth one time a day for appetite as ordered, and it was scheduled at every 9 am. Observation on 03/05/2025 at 11:51 a.m. revealed there was one refrigerator inside the 4-side medication room, and inside the refrigerator, there was one narcotic box, but the box was not affixed to the refrigerator permanently. Inside the narcotic box, there was one bottle of Resident #144's Dronabinol 5 mg, and the bottle had total 12 capsules. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/05/2025 at 11:59 a.m. the DON acknowledged there was one refrigerator inside the 4-side medication room, and inside the refrigerator, there was one narcotic box, but the box was not affixed to the refrigerator permanently. Inside the narcotic box, there was one bottle of Resident #144's Dronabinol 5 mg, and the bottle had total 12 capsules. Further interview with the DON said the narcotic box should have been affixed to the refrigerator permanently to prevent somebody from taking the box from the refrigerator. Not having an affixed narcotic box could cause drug diversion. 2. Observation on 03/05/2025 at 12:36 p.m. revealed there were brand new and unopened two eye drop bottles of Latanoprost 0.005% ophthalmic solution stored inside medication aide cart at the room temperature, but the label of the two eye drop bottles said Keep refrigerator unopened. Store opened at room temperature. Interview on 03/05/2025 at 12:42 p.m. the DON stated there were brand new and unopened two eye drop bottles of Latanoprost 0.005% ophthalmic solution stored inside medication aide cart at the room temperature, but the label of the two eye drop bottles said Keep refrigerator unopened. Store opened at room temperature. Further interview with the DON said one was delivered to the facility on [DATE], and the other was delivered on 02/18/2025, and nurses who received these medications should have stored these two eye drops inside refrigerator per the label until the eye drops was opened. The DON did not know what reasons facility nurses stored these brand new and unopened eye drops in the medication aide cart at the room temperature, instead of storing them in the refrigerator. Not storing them in a refrigerator might cause no longer good for use. Record review of the facility policy, titled Storage of medications, revised 08/2020, revealed . 4. medications requiring refrigerator are kept in a refrigerator at temperature between 36 F and 46 F with a thermometer to allow temperature monitoring. Record review of the facility policy, titled Storage of controlled substances, revised 08/2020, revealed . 3. Controlled substances that require refrigerator are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator and/or in accordance with state regulations and facility policy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 27520 Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety from 1 of 1 kitchen and 1 of 1 Resident (Resident #2) reviewed for food sanitation and preparation. 1. [NAME] H failed to remove her gloves, wash her hands and put on clean gloves, after opening a drawer of utensils (dirty surface) and continuing with preparing beef tacos with the same gloved hands (she went from dirty to clean). 2. DA I left 2 pans of cake on the prep table to cool off. She did not cover them. 3. CNA used her bare right hand to give Resident #2 two slices of bread during a lunch meal. These deficient practices could affect any resident and could contribute to the spread of food-borne illnesses. The findings were: 1. Observation on 03/06/25 at 4:59 PM revealed [NAME] H plating flour beef tacos, rice and refried beans for the dinner meal. She plated about 18 meals. [NAME] H would take a flour tortilla with her hands, put a scoop of beef on it, put a scoop of lettuce/tomatoes mix and then a scoop of cheese. Further observation revealed [NAME] H walked over from the steam table to a prep table. She opened the drawer of utensils (dirty surface) and then closed it. [NAME] H asked DA I to wash a scoop with a lever to continue meal preparation. [NAME] H commented the refried beans were sticking to the scoop she was using. Observation on 03/06/25 at 5:12 PM revealed DA I handing [NAME] H a scoop with a lever. [NAME] H proceeded with plating the resident meals. [NAME] H did not remove her gloves and did not wash her hands before continuing with meal service. She plated the remaining resident meals using the same procedure: she would take a flour tortilla with her hands, put a scoop of beef on it, put a scoop of lettuce/tomatoes mix and then a scoop of cheese. Further observation revealed [NAME] H placing the scoop she used for the lettuce/tomatoes mix and the scoop she used for the cheese falling onto the food after she put it back in the bowl. [NAME] H continued with this same procedure until she plated all meals for the residents. Interview on 03/07/25 at 12:45 PM with [NAME] H revealed she had already analyzed her meal prep and service completed on 03/06/25. She stated she realized she contaminated her gloves at the point she opened the drawer to look for a different scoop. She stated she should have removed her gloves, washed her hand and put on clean gloves. [NAME] H stated everything she touched afterwards she contaminated including the tortillas, the scoop handles which landed on top of the cheese and on top of the salad mix. [NAME] H stated contaminating the food could result in transmission of food-borne illnesses like salmonella causing the residents to get sick with stomach viruses which could result in nausea and diarrhea. (continued on next page)

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	03/07/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 03/07/25 at 2:45 PM with the DM revealed on 03/06/25, during meal prep, she saw [NAME] H walk over to the prep table and open the drawer looking for a scoop. She stated [NAME] H went from clean to dirty and should have removed her gloves, washed her hands and put on clean gloves before proceeding with meal prep. The DM stated [NAME] H contaminated the tortillas. She stated she did not realize the scoops were landing on top of the lettuce/tomatoes mix and the cheese. She stated if that was the case the salad mix and the cheese were also contaminated. The DM stated any contaminated food could cause the residents to get sick. 2. Observation on 03/06/25 at 3:34 PM revealed two large baking pans with cooked cake mix on top of a prep table. Interview 03/06/25 at 3:40 PM with DA I revealed she had placed the pans on top of the prep table for cooling about 10 to 15 minutes ago. Interview on 03/06/25 at 3:43 PM with the DM revealed the cake pans should be covered with foil during the cooling period to avoid being contaminated. The DM stated if contaminated it could get the residents sick. 3. Observation on 03/05/25 at 12:09 PM revealed the meal trays arrived on hallway 300 A. Further observation revealed CNA E passing out meal trays. Observation on 03/05/25 at 12:18 PM revealed Resident #2 sitting on the side of her bed eating her lunch meal. Further observation revealed CNA E delivered two slices of bread in a sandwich bag to Resident #2. She removed the bread out of the sandwich bag with her right hand. CNA E did not put on a glove before removing the bread from the sandwich bag. Interview with on 03/05/25 at 12:20 PM with CNA E revealed she removed the two slices of bread with her right hand; she did not wash or put on gloves prior to removing the bread. She stated she should have either sanitized or washed her hands and put on a glove before removing the two slices of bread to prevent cross contamination. CNA E stated contaminated food could cause the resident to get sick. Review of facility policy, Nutrition Services Policies and Procedures, undated, read in relevant part: SUBJECT: SAFE FOOD HANDLING Goals: Food acquisition, storage, and distribution will comply with accepted food handling practices. Proper food handling is essential in preventing food-borne illness. Unsafe food handling practices can increase the risk of pathogen exposure to residents. Sanitary conditions must be present to promote safe food handling. 6. Follow all local, State, and Federal Regulations when handling food. Food/Beverages Prepared and Served by Facility Staff for Patients/Residents: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. Food is served with clean, sanitized utensils. There is no bare hand contact.

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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** 39049 Based on interview and record review, the facility failed to maintain medical records that were complete and accurately documented for 1 (Resident #7) of 14 residents reviewed for clinical records, in that: Resident #7's psychiatric provider indicated the resident had Depakote one tablet 125 mg two times a day for mood disorder, but the facility made an entry in the order incorrectly by Depakote one tablet 125 mg two times a day for dementia. These deficient practices could result in in errors in care and treatment. The findings were: Record review of Resident #7's face sheet, dated 03/06/2025, revealed the resident was [AGE] years old male, originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with diagnosis of heart failure (hear not pumping enough), muscle weakness, mood disorder (disturbance in the person's mood), dementia (loss of cognitive functioning), type 2 diabetes mellitus (not control blood sugar), and hypoxemia (low level of oxygen in the blood). Record review of Resident #7's significant change MDS, date 01/17/2025, revealed the resident's BIMS was 4 indicated severe cognitive impairment and required supervision or touching assistance (helper provides verbal clues or touching/steading assistance as resident completes activity) to chair-to-bed transfer and toilet transfer. Record review of Resident #7's comprehensive care plan, dated 08/08/2023, revealed [Resident #7] uses antidepressant medication Depakote. For intervention - Administered it as ordered and monitor adverse reactions such as change in mood. Record review of Resident #7's physician order, dated 01/10/2025, revealed Depakote oral tablet delayed release 125 mg. Give 1 tablet by mouth two times a day related to dementia. Record review of Resident #7's medication administration record, dated from 03/01/2025 to 03/31/2025, revealed Resident #7 was receiving Depakote oral tablet delayed release 125 mg. Give 1 tablet by mouth two times a day related to dementia as ordered, and it was scheduled at 8 am and 6 pm. Record review of Resident #7's psychiatric subsequent assessment, dated 03/03/2025, revealed the resident was receiving Depakote oral tablet delayed release 125 mg. Give 1 tablet by mouth two times a day related to mood disorder and Resident #7's dementia is not being treated with medications. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/06/2025 at 4:19 p.m. with ADON said Resident #7's physician order of Depakote oral tablet delayed release 125 mg. Give 1 tablet by mouth two times a day related to dementia was inaccurate. The resident was receiving Depakote for mood disorder, not dementia. The facility nurse made an entry incorrectly in the order when they received the order from psychiatric provider verbally. The ADON had the responsibility for reviewing and auditing all orders and failed in finding out this order was inaccurate. Inaccurate order might cause errors in care and treatment. Record review of the facility policy, titled Minimum Data Set, revised 06/2019, revealed The facility is responsible for addressing all needs and strengths f each resident. Each staff member will note their liability for the accuracy of the data recorded.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public on 1 of 14 residents (Resident #31) reviewed for environmental concerns. There was a hole sized width 20 cm and length 3 cm on Resident #31's bathroom door in the resident's room. These failures could place residents at risk of a diminished quality of life due to exposure to an environment that is unpleasant, unsanitary, and unsafe. The findings included: Record review of Resident #31's face sheet, dated 03/07/2025, revealed the resident was [AGE] years old female, originally admitted to the facility on [DATE], and readmitted on [DATE] with diagnosis of adjustment disorder with anxiety (feeling worked, anxious, and overwhelmed), schizophrenia (mental illness that affects how a person think), muscle weakness, traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers it), and Parkinsonism (tremor, rigidity, and postural instability). Record review of Resident #31's annual MDS, dated [DATE], revealed the resident's BIMS was 15 indicated Resident #31's cognitive was intact and was independent (resident completes the activity by herself with no assistance from helper) to all daily activities such as sit to stand, chair-to-bed transfer, and toilet transfer. Record review of Resident #31's comprehensive care plan, dated 04/17/2023, revealed [Resident #31] has Parkinson's disease and is at risk for injury from increased tremors and involuntary muscle movements. For intervention - monitor for increased tremors and unsteady gait and assist with activities of daily living as needed. Observation on 03/04/2025 at 9:53 a.m. revealed there was a hole sized width 20 cm and length 3 cm on Resident #31's bathroom door in the resident's room. Interview on 03/04/2025 at 9:55 a.m. with Resident #31 stated she knew there was a hole on her bathroom door, and she would like to have somebody to fix the hole. Interview on 03/04/2025 at 10:49 a.m. the maintenance stated there was a hole sized width 20 cm and length 3 cm on Resident #31's bathroom door in the resident's room. The hole should have been fixed to prevent possible injury to Resident #31. He stated hitting to the bathroom door by the room door when opening the room door might make the hole. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, titled General environmental cleaning techniques, revealed the primary objective of this policy is to establish and maintain a standardized approach to environmental cleaning, minimizing the risk of infections and promoting a clean and sanitary living and working environment.