

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455582	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2025
NAME OF PROVIDER OR SUPPLIER Paradigm at Bay City		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 13th St Bay City, TX 77414	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain medical records on each resident that are in accordance with accepted professional standards and practices and that are accurately documented for 2 (Residents #55 and #89) of 10 residents reviewed for medical chart documentation.</p> <p>-Resident #89's hospital records were not in her medical chart and was in Resident #55's medical chart.</p> <p>This failure could put residents at risk of privacy issues with their personal health information not being uploaded to the correct chart and health decisions made based off another resident's information.</p> <p>Findings included:</p> <p>Record review of Resident #55's face sheet dated 05/29/2025, she was a [AGE] year-old female originally admitted on [DATE] and last re-admitted on [DATE]. She was discharged on 08/29/2025. Her medical diagnoses included acute kidney failure, hypertension (high blood pressure), bipolar disorder (mental health condition characterized by extreme mood swings), Type 2 Diabetes Mellitus, and Obstructive Sleep Apnea,</p> <p>Record review of Resident #89's face sheet dated 05/28/2025, she was an [AGE] year-old female originally admitted on [DATE] and last re-admitted on [DATE]. Her medical diagnoses included Generalized Anxiety Disorder, Cauda Equina Syndrome (nerve roots at the end of your spinal cord become compressed), Hyperlipidemia (high fat in the blood), Hypertension (high blood pressure) and spinal stenosis (narrowing of the spinal cord).</p> <p>Record review of Resident #55's medical chart on 05/28/2025 at 11:23 am, revealed Resident #89's hospitalization dated 08/15/2024, prior to admission, was attached. Resident #89 did not have her hospitalization from 08/15/2024 uploaded to her medical chart.</p> <p>Interview with the DON on 5/29/2025 at 10:45 am, she said the survey team told her that Resident #89's hospital records were uploaded to Resident #55's medical chart. She said that it was a HIPAA violation (meaning it could violate the federal law protecting sensitive patient information from being disclosed with their consent), and that each resident's chart should only contain their records.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the MDS Nurse on 5/29/2025 at 11:41 am, she said Corporate, the ADON, DON, Administrator, and MDS could upload files. She said a risk of a resident's health information being uploaded to another resident's medical chart would be that nursing got the wrong information and staff should be checking resident names when uploading. If the MDS Nurse uploaded a document to the wrong resident's medical chart, she would let the Administrator know right away and then they would inform Corporate so they can go in right away to delete it.</p> <p>Interview with the RSC on 5/29/2025 at 1:00 pm, she said that any staff could upload documents and the scanned documents would show up with the name of the person in the resident's file. The RSC said that nursing staff were told to upload resident records as they received them to decrease the risk of the wrong upload. She said that if one resident's documents were in another resident's medical chart, it would be a privacy issue, but only those staff members with access to medical charts could see the documents.</p> <p>Record review of the facility's Electronic Protected Health Information Security policy, last revised June 1, 2019, read in part, Purpose: To ensure the security and integrity of medical records of residents at the Facility . Residents' medical records will be maintained in the computerized system in a manner that protects the Electronic Protected Health Information) from unauthorized use, access .</p>