

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/23/2026
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)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 4 of 26 (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) resident rooms observed for environmental conditions. The facility failed to ensure rooms 150 bed A&B and 152 bed A&B had intact paint, no holes in drywall, and no dead bugs in shared restroom. The facility failed to ensure room [ROOM NUMBER] bed A&B had intact floor tiles. The facility failed to ensure room [ROOM NUMBER] bed A&B had running hot water in restroom sink. These failures could place residents at risk for diminished quality of life, discomfort, and safety. Findings included: During an observation and interview on 07/21/2026 at 12:15 p.m., adjoining jack and [NAME] restroom to rooms [ROOM NUMBERS] had peeling paint on both interior restroom doors and some paint chips were seen on the restroom floor. There was a whole in the drywall about 2 inches long and 1/4 inch wide where the drywall met the restroom vent in the ceiling. There was a sticky bug trap under the sink with different dead bugs in the trap. The resident in room [ROOM NUMBER] was lying in bed. There were visitors in the room who stated they did not like that the restroom was in disrepair. They stated the peeling paint on the doors and the dead bugs upset them when they came to visit the resident in room [ROOM NUMBER]. They stated it made them sad to see the resident in room [ROOM NUMBER] living in such an environment even though he did not get out of his bed. During an observation on 07/22/2026 at 8:25 a.m., room [ROOM NUMBER] had a missing tile in the floor and there were many cracked floor tiles in the room. The resident that resided in room [ROOM NUMBER] could not answer questions and she was sitting in a recliner in the room. During an observation and interview on 07/22/2026 at 9:51 a.m., room [ROOM NUMBER]'s restroom sink hot water knob would not move and no hot water came out of the faucet. The resident residing in room [ROOM NUMBER] stated the water was cold at first but would warm up when asked about hot water function in their restroom. They did not complain about not having access to hot water in restroom. During an interview on 07/22/2026 at 10:00 a.m., RN A stated she had worked in the facility for about two years. She stated that if there was something wrong in resident rooms, the staff notified the Maintenance Director through a computer program. During an interview on 07/23/2026 at 9:09 a.m., the Director of Support Services stated he was the Maintenance Director and had been working in the facility for about 2 months. The Maint D stated he had been working with the staff to make sure they used the computerized system to report maintenance issues to him. The Maint D stated room [ROOM NUMBER] should have hot water working in the restroom sink. He stated he had not been informed about the hot water part of the faucet not working prior to today. He stated room [ROOM NUMBER] should have tiles that were intact and not cracked. He stated room [ROOM NUMBER]'s air condition had been leaking and was recently (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fixed and could have caused the tiles to be loose and crack. He stated rooms [ROOM NUMBERS] should not have peeling paint on the bathroom doors, should not have a gap between the drywall and the restroom vent, and the bug trap should not have various bugs dead in it. He stated not having rooms repaired could make the residents feel that it was not homelike and could cause them to be upset about the appearance of the rooms. He stated tiles missing and cracked could make it difficult for the floor to be cleaned. He stated he would look at the maintenance log to see if any of the items were reported there to be fixed. During a follow-up interview on 07/23/2026 at 9:18 a.m., the Maint D brought in a copy of the computerized maintenance log report. He stated the peeling paint on the restroom door for room [ROOM NUMBER] was on the log dated 07/11/2026 and was waiting to be repaired. He stated the other issues were not reported to him. He stated the facility had a remodeling company repair several rooms in the last two weeks and the repairs were slow because they did not have more than one worker working on the rooms at a time. He stated Rooms 105, 134, 150, and 152 were not any of the rooms that were repaired. During an interview on 07/23/2026 at 11:25 a.m., the ADMN stated she expected for the shared restroom for rooms [ROOM NUMBERS] to be bug free, the paint to be intact and not peeling and the drywall to not have any holes in it. She stated she expected for the tiles in residents' rooms to be intact and not have missing / cracked tiles. She stated she expected for there to be working running hot water in residents' restrooms. She stated Maint D was responsible for making repairs and would be told about issues through the computerized system. She stated she did not know why there was no documentation about the concerns for the tiles, water, and gap in drywall on the computerized report. She stated the issues could make the residents feel the environment was not homelike and stated the residents had a right to a homelike environment. Record review of the facility document titled, Work Orders, reviewed on 07/23/2026, reflected open and in progress work orders of room [ROOM NUMBER] Bathroom walls need attention dated 07/11/2026. There was no evidence of any drywall repair, tile repair, or faucet repair in progress prior to 07/23/2026. Record review of facility policy titled, Resident Rights, Dignity and Privacy Handout, no date, reflected: 8. Right to Safe and Clean Environment Live in a facility that is safe, clean, and comfortable. Have accommodations that promote your quality of life and meet your needs.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that residents were free of a med error rate of 5% or greater for 1 of 4 (Resident #15) residents reviewed for medication administration. The facility failed to ensure the medication error rate of 26.67% (30 opportunities with 8 medication errors) was less than 5%. This failure placed residents at risk of incorrect doses of medications and optimal therapeutic response. Findings included: Record review Resident #15's electronic face sheet, dated 07/23/2026, reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. He had active diagnoses including: hypotension (low blood pressure), Acute Kidney Failure (inability of the kidneys to filter out toxins from the blood), esophagitis (inflammation of the tube that carries food and drink from the mouth to the stomach), dementia (condition where the brain gradually loses its ability to think, remember, and make decisions affecting daily life), major depressive disorder (persistent feeling of sadness and loss of interest in activities) and abdominal hernia (soft tissue that pushes through a weak spot in the muscle or connective tissue of that abdomen). Record review of Resident #15's electronic physician orders, dated 07/22/2026, reflected an order for: Aspirin EC tablet delayed release 81mg one time a day for heart health start date 02/26/2026; Ferrous Sulfate 325mg tablet one time a day for anemia (low iron level in blood) start date 02/26/2026; Multi-Vitamin with Minerals 1 tablet one time a day for supplement start date 02/26/2026; Protonix delayed release 40mg one time a day for GERD (when stomach contents regurgitate up into the tube that carries food and drink from the mouth to the stomach causing inflammation) start date 02/26/2026; Thiamine hcl 100mg table one time a day for supplement start date 02/26/2026; Vitamin B-12 1000mcg tablet one time a day for vitamin deficiency start date 04/07/2026; Risperdal 0.5mg tablet two times a day for brief psychotic disorder start date 06/23/2026; Carafate 1gm tablet before meals for ulcer start date 02/26/2026. Further review of physician orders revealed there was no order that medications could be crushed. During an observation and interview on 07/22/2026 at 9:40 a.m., MA B was performing medication pass for Resident #15. She took the tablets out of their packages and crushed the medications together. The Aspirin 81mg that was crushed was a chewable Aspirin and was not an Enteric Coated Aspirin. The crushed medications were mixed with vanilla pudding. MA B stated she had tried to give Resident #15's medications to him whole after he had first admitted into the facility, but he had requested for them to be crushed and she started crushing them for him after. Resident #15 took the medications mixed with vanilla pudding and drank some water after. MA B documented in the MAR that medications were given. During a follow-up interview on 07/22/2026 at 11:10 a.m., MA B stated she crushed Resident #15's medications because he wanted her to. She stated there should be an order to crush his medications before the medications were crushed. She stated she was unsure what medications could be crushed and stated she should have told the nurse he wanted the medications crushed so the nurse could have instructed her on if she could crush the medications or not. She stated that Carafate should have been given before meals if that was what the order stated. She stated she did not notice that the Aspirin was not coated per the order. She stated she did not know there was no physician order to crush Resident #15's medications and had not noticed that the Carafate was to be administered before meals until now. She stated Resident #15 has had difficulty in the past swallowing medications and that was why he requested her to crush them she thought. During an interview on 07/22/2026 at 11:39 a.m., RN A stated the MAs should not crush medications without an order to crush medications. She stated if she had been informed that Resident (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#15 did not have an order to crush medications, she would have called the physician to get his orders clarified. She stated she was unaware that MA B was crushing Resident #15's medications. She stated medications that have a delayed release should not be crushed including Protonix. She stated medications with an enteric coating should not be crushed including Aspirin. She stated if the order was for the resident to get Aspirin EC then a chewable Aspirin would not be the same. She stated crushing the Aspirin and Protonix could cause the medication to be absorbed in the body more rapidly than it would have otherwise. She stated Carafate should be given before meals to help it work more effectively in coating the stomach and could cause other medications to be absorbed if given with them. She stated the pharmacist was in the building monthly to watch medication pass and she knew that they watched the MA pass medications during that time. She stated the MA had been working for about a year and she needed more training on passing medications. She did not state any negative impact on a resident receiving crushed Ferrous Sulfate, Multi-vitamin with minerals, thiamine, B-12, or Risperdal. During an interview on 07/22/2026 at 12:50 p.m., the DON stated medications should not be crushed without an order. She stated usually there was an order put into the system when a resident could have medications crushed on admission. She stated EC medication should not be crushed because it could cause gastric distress by the coating being compromised. She stated DR medication should not be crushed because it could make the medication be absorbed more rapidly. She stated Carafate should not be administered in between meals because it needed to be given before meals to help coat the stomach to decrease gastric distress. She stated the orders needed to be reviewed, clarified about administration times, and if it was okay to crush medications by the charge nurse. She stated she expected the MA to tell the nurse prior to crushing medications for the nurse to get clarification from the physician. She stated she felt more education was needed on passing medications. She did not state any negative impact on a resident receiving crushed Ferrous Sulfate, Multi-vitamin with minerals, thiamine, B-12, or Risperdal. She stated she would have to review the Do Not Crush Medication guide that was provided to the facility by the pharmacy to see if those medications should be crushed. Record review of facility policy titled Oral Medication Administration, revised on 08/2020, reflected Medications will be administered in a safe and effective manner. Special Considerations 1. Refer to crushing guidelines prior to crushing any medication for confirmation that it can be pulverized. 3. For solid medications: .b. Crush medication, if indicated by the prescriber's order for the resident, only after checking the Medication Crushing Guidelines. Record review of facility document, titled Medications Not To Be Crushed, revised on 03/21, revealed: Aspirin EC listed and Protonix listed. Review of drugs.com https://www.drugs.com/cdi/carafate-sucralfate-tablets.html accessed 07/23/2026 revealed: Carafate tablets Generic name: Sucralfate Tablets. Take on an empty stomach. Do not take antacids 30 minutes before or after taking Carafate (sucralfate tablets). Try to space other drugs from this one by 2 hours. This medicine stops many drugs from getting into the body.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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, for 1 of 1 kitchen as evidence by: The facility failed to ensure:A. [NAME] C washed the food processor between use.B. Dietary Aide D and [NAME] E wore hair restraints properly covering all of their hair. C. The water machine used by the residents in the dining room was clean. These failures could place residents at risk for altered taste of food, foodborne illness and compromised health status and hair in food.The findings included:In the initial observation of the kitchen on 07/21/2026 at 9:30 am, Dietary Aide D was observed with his mustache exposed and not covered with a beard restraint or hair net. The water machine used by the residents in the dining room was soiled with water standing in the basin. In an observation on 07/21/2026 at 10:34 am, [NAME] C was preparing food for the 3 residents that received a puree diet. [NAME] C used the food processor to prepare the puree zucchini, placed the zucchini in a pan, failing to get all of the zucchini out of the food processor. [NAME] C did not wash the food processor between use. [NAME] C placed the main dish, beef macaroni casserole, in the food processor and pureed it with the remaining zucchini in the food processor together.In an observation on 07/21/2026 at 11:45 am, Dietary Aide D was observed with his mustache exposed and not covered with a beard restraint or hair net as he assisted preparing the food trays for the residents. In a follow-up observation of the kitchen on 07/22/2026 at 11:36 am, [NAME] E was observed with his mustache exposed and not covered with a beard restraint or hair net as he was assisting preparing the food trays for the residents. The water machine used by the residents in the dining room remained soiled with brown water standing in the basin. In an observation and interview on 07/22/2026 at 1:02 pm, [NAME] E was observed with his mustache exposed and not covered with a beard restraint. [NAME] E said he did not know if his moustache should be covered or not. He said a potential negative outcome could be hair in the residents' food. In an interview on 07/22/2026 at 1:04 pm, [NAME] C said she did not know why she did not clean the food processor between use but should have done so. She said a potential negative outcome is that it could alter the taste of the food. In an observation and interview on 07/22/2026 at 1:06 pm, Dietary Aide D said all hair should be covered by the hair net including his moustache. He did not know why his moustache was not covered. He said a potential negative outcome was the residents could have hair in their food. In an interview on 07/22/2026 at 1:30 pm, the Dietary Manager said all hair should be covered including moustaches. She said there was a potential negative outcome that there would be hair in the residents' food. The Dietary Manager said the food processor should be cleaned between each use. She said a potential negative outcome would be that it could alter the taste of the food. The Dietary Manager said she did not know who was responsible for cleaning the residents' water machine. In an interview on 07/22/2026 at 1:33 pm. The Administrator said any staff that goes into the kitchen should have hair nets that cover all hair, including moustaches. The Administrator said she was not sure who was responsible for cleaning the resident's water machine. Record review of the facility policy Kitchen Sanitation, dated as revised 5/2025, revealed the following [in part]:Policy: The facility will maintain a clean, sanitary, and safe dietary environment in accordance with federal, state, and local regulations. All food will be stored, prepared, and served in a manner that prevents contamination, foodborne illness, and environmental hazards.Procedure: General Sanitation Standards. Surfaces, shelves, and equipment will be kept free of food debris, grease, and liquids.Staff Hygiene & Infection Control: Dietary staff will wear hair restraints (e.g., hair nets or caps) and beard (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	guards when applicable to prevent contamination. Record review of the Food and Drug Administration Food Code, dated 2022, specified [in part]: 2-402 Hair Restraints(A) Food Employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from FDA Food Code 2022 Chapter 2. Management and Personnel Chapter 2 - 22 contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 of 6 (Resident #14) reviewed for ADL care. The facility failed to ensure Resident #14's nails were trimmed, cleaned, and filed on 07/21/2026, and 07/22/2026. This failure could place residents at risk of loss of dignity, at risk of infection, and a decreased quality of life. Findings included: Record review of Resident #14's face-sheet dated 07/23/2026 revealed the resident was an [AGE] year-old female with an admission date of 12/25/2025. The face-sheet listed the following diagnoses: Seizure disorder (a brain disorder characterized by recurrent, uncontrolled body movements caused by abnormal electrical activity in the brain), cerebral infarct (the death of brain tissue caused by a blocked blood vessel that cuts off oxygen and nutrient supplies), Atherosclerotic Heart Disease (a buildup of fats, cholesterol, and other substances on the artery walls which cause the arteries to narrow and harden resulting in blocked blood flow. The plaque that forms can break off and cause a blood clot), and Foot Drop to Right and Left foot (a condition caused by nerve impairment, and damage to brain regions controlling movement to the leg muscles that lift the feet). Record review of Resident #14's Quarterly MDS dated [DATE] revealed a BIMS score of 15, indicating the resident was cognitively intact. Under Section GG- Functional Abilities, the MDS revealed Resident #14 required supervision or touching assistance with personal hygiene, meaning the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently, and Resident #14 required substantial/maximal assistance to Shower/bathe self which means helper lifts or holds trunk or limbs and provides more than half the effort. Record review of Resident #14's care plan 01/19/2026 revealed Resident #14 required assistance with extensive assistance of one person with bathing and grooming and was bedbound. The goal was Resident #14 would be well dressed, groomed, clean, and her dignity maintained with no further decline in ADL functioning or injury. An observation and interview were done on 07/21/2026 at 10:55 AM of Resident #14's nails of both hands. The fingernails of both hands were observed to be approximately 1/4 inch long, the nails were jagged and a brown substance was noted underneath the third and fourth fingernails of her left hand. She stated it bothered her to have long nails. Resident #14 stated she would like to have her nails cut and filed, because she was going to get new dentures and she was afraid she would cut her gums with her fingernails when she put the teeth in her mouth. She stated she had asked staff to cut her nails, but they had not done it. She stated she could not remember the name of the staff that she asked. During an interview on 7/22/26 at 12:30 PM with CNA F she stated that nails should have been cut, filed, and trimmed when doing a resident's shower. She stated if a resident asked for their nails to be done an aide should have done it unless the resident was a diabetic, and then they should have told the Charge Nurse and she would have cut them. She stated if a CNA noticed unkempt nails or long nails, they should have asked the resident if they wanted them cut or cleaned and do it if the resident requested it be done regardless of whether it was their bath day or not. During an observation and interview on 07/22/2026 at 1:00 PM Resident #14 was in her bed. Resident #14 stated her fingernails had not been cut and she would like to have them cut and filed. She stated she had asked someone to cut them, and they said they would do it when they had time. She stated she could not remember the name of the staff that she asked. During an interview on 07/23/2026 at 10:20 AM with the DON, she stated the nurses were responsible for monitoring and maintaining residents' nails. The DON stated (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the CNAs provided nail trimming and grooming during shower days or as needed, such as residents being observed with long nails. She stated the potential risk of long and dirty fingernails included risk of injury from scratching selves or others, and it could be a potential portal of entry for bacteria which could place residents at risk for infections. During an interview on 07/23/2026 at 11:51 AM, the Administrator stated the charge nurses and staff providing care to residents were responsible for ensuring residents' fingernails remained trimmed and filed. The Administrator stated residents were at risk of infection if fingernails were not properly maintained. Record review of the facility's policy and procedure titled Nail Care, not dated, stated in part:Subject: Nail Care Policy: It is the policy of this facility that the facility staff will assist the residents with nail care as needed. Residents who are unable to care for their own finger or toenails require assistance in keeping nails clean and trimmed. Procedure: Before staff cares for any resident's nails, check with the nurse to be sure that cutting nails is within the scope of duties for a nurse's aide. (Note: Before you begin nail care, staff wash their hands and put gloves on. Ensure equipment such as scissors or trimmers are clean to prevent infection. Staff are to ensure there are no sharp or jagged edges. Sharp edges can cause cuts to the resident's skin, increasing the risk of infection transmission through breakage in the skin. Staff should inspect the resident's nail beds as you work to look for signs of inflammation or fungal growth. If facility staff observe discoloration or signs of infection, it should be reported to the nurse. Proper nail care can reduce the transmission of disease because the hands and feet are often exposed to many microorganisms which can grow quickly in the nail beds. This procedure will also help the patient to remain comfortable and allow facility staff to look for signs of infection that can lead to complications.) Steps to Perform Skill:Enters room and identifies self. Wash hands and put on disposable gloves. Explain procedure, respond to comments / questions. Assist to comfortable and safe position. Fill basin with warm water. Soaks nails. Clean under nails with orange stick. Groom nails with nail scissors, clippers or file. Avoid cutting or nicking resident's skin. Finishes with nails smooth and free of rough edges.		

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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** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 1 (Resident #41) of 13 residents reviewed for quality of care. The facility failed to ensure oxygen use orders were obtained prior to Resident #41 receiving oxygen therapy. The facility failed to ensure Resident #41's nasal cannula was discarded when discoloration or contamination was present on 07/21/2026, 07/22/2026, and 07/23/2026. The facility failed to properly store Resident #41's nasal cannula when oxygen was not in use on 07/21/2026, 07/22/2026, and 07/23/2026. The facility failed to ensure there was an oxygen in use sign posted on Resident #41's room door. These failures could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health. Findings included: Record review of Resident #41's electronic face sheet, dated 07/23/2026, revealed a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses including: COPD (a long-term lung disease that makes it hard to breathe because the airways and air sacs in the lungs are damaged or blocked). Record review of Resident #41's History and Physical, dated 11/19/2025, revealed Resident #41 had a history of COPD and would continue current respiratory medications and monitor oxygen saturation. There was no mention of oxygen therapy. Record review of Resident #41's Progress notes dated 06/23/2026 - 07/23/2026. There was no mention of oxygen therapy. Record review of Resident #41's Quarterly MDS assessment, dated 06/01/2026, revealed a BIMS score of 15 indicating he was cognitively intact. Further review of the MDS assessment revealed Resident #41 did not receive oxygen therapy. Record review of Resident #41's electronic physician orders reviewed on 07/23/2026 revealed no evidence for an order for oxygen therapy. Record review of Resident #41's comprehensive care plan reviewed on 07/23/2026 revealed Resident #41 had COPD related to smoking with interventions including Oxygen via nasal cannula at 3-4 L/min as needed for wheezing / SOB Date Initiated: 06/25/2026. During an observation on 07/21/2026 at 11:15 a.m., Resident #41 was not in his room. There was an oxygen concentrator in the room. The oxygen tubing was lying on top of the concentrator not in a bag and the n/c had brown discoloration with a crusty substance on it. There was no oxygen in use sign on the door entering the room. During an observation and interview on 07/21/2026 at 11:53 a.m., Resident #41 was lying in the bed in his room. Resident #41 was wearing the oxygen via n/c and the concentrator was set to 5 L/Min. He stated his oxygen tubing was changed out once a month by the nursing staff but could not state the last time it was changed. There was no date on the oxygen tubing. He stated he turned on the oxygen concentrator and put on his tubing when he came back into his room because he got short of breath. He stated he only wore oxygen when he needed it and he did not need it when he left his room. During an observation on 07/22/2026 at 9:53 a.m., Resident #41 was not in his room. The oxygen concentrator was turned off and the oxygen tubing was lying on top outside of the bag. The n/c continued to have a crusty substance and was discolored brown. There was no oxygen in use sign on his door. During an observation on 07/23/2026 at 10:00 a.m., Resident #41 was not in his room. The oxygen concentrator was turned off and the oxygen tubing was lying on top outside of the bag. The n/c continued to have a crusty substance and was discolored brown. There was no oxygen in use sign on his door. During an interview on 07/23/2026 at 10:45 a.m., the MDS nurse stated there should be an order for oxygen if a resident was receiving oxygen therapy. She stated she was not aware that Resident #41 received oxygen therapy because there was no order for oxygen therapy and no documentation from the nurses that he had received oxygen therapy. She stated the nurses would (continued on next page)		

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 07/23/2026
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.			
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document oxygen therapy on the MAR, but an order would be needed for that documentation to be available. She stated the progress notes could have oxygen therapy documentation as well. She stated oxygen tubing should be stored in a bag when not in use. She stated she could not code oxygen use on the MDS unless she had evidence Resident #41 utilized oxygen therapy for at least 15 minutes. She stated she never knew he utilized oxygen therapy in the past and stated he had refused oxygen before. She stated the nurse who initiated the oxygen therapy or did an admission with oxygen orders was responsible for making sure there was a physician order for oxygen. She stated Resident #41 had been hospitalized recently and he did not come back with an order for oxygen therapy that she could see. She stated she developed comprehensive care plans and no one else updated her care plans. She did not know why the care plan had an intervention for Resident #41 to receive oxygen use when she had not coded the oxygen therapy on the MDS assessment. She stated the MDS assessment drove the items added on the care plans. She stated not putting the oxygen tubing in a bag when not used and changing the tubing out when discolored or contaminated could cause infection spread. She stated Resident #41 continued to smoke cigarettes which could have led to the n/c having brown discoloration. She stated there should be an oxygen in use sign posted when a resident utilized oxygen therapy. During an interview on 07/23/2026 at 11:22 a.m., the DON stated if a resident was utilizing oxygen there should be an order for the oxygen, there should be documentation of oxygen saturations and therapy dose, and there should be an oxygen in use sign on the door to the room. She stated the nurse should be documenting the oxygen administration in the MAR. She stated she did not know if Resident #41 ever came back from the hospital with an order for oxygen and he had refused oxygen in the past so did not know where the oxygen concentrator came from in his room. She stated if he did refuse care, it should be documented on the care plan. She stated she would look at care plans, but the MDS nurse was responsible for the care plans and had corporate oversight. She stated oxygen tubing should be stored in a bag when not in use and the tubing should be changed out when visibly soiled. She stated not storing or changing out the tubing could cause infection spread. She stated she monitored that nurses were documenting appropriately and did not know Resident #41 was using oxygen. She stated Resident #41 may have gotten the concentrator himself and put it in his room, but she did not know where he would have gotten it from. Review of the facility's policy, titled Respiratory Treatment, Care and Services, revised on 6/2019, revealed: 2. The facility has policies and procedures for the types of respiratory services provided, which may include but are not limited to: A. Oxygen therapy, including safe handling, humidification, cleaning, storage and dispensing. 6. Infection control practices including standard and transmission-based precautions are followed during: A. Provision of respiratory care, treatment and services. B. Handling of equipment, including cleaning, storage and disposal of regular and biohazardous waste. 7. Documentation for Respiratory Care, Treatment and Services: Depending on the type of respiratory services received, licensed independent practitioner orders and the individualized plan of care, documentation includes the following, as appropriate and necessary: A. Vital signs, including respiratory rate. II Instructions for resident on how to participate or assist in respiratory care, treatment and services, if applicable. Review of the facility's policy, titled Oxygen Therapy: General Administration & Care, revised on 8/2019, revealed: Procedures: 1. Review physician's order on the chart for completeness: s. Modality, Liters, Frequency 2. Gather necessary equipment. 3. Follow relevant infection control procedures as appropriate. 4. Wash hands prior to setting up equipment. 5. Assess the resident. Establish baseline respiratory rate and heart rate. 6. Attach humidifier or nebulizer to flowmeter if indicated. A. Exchange Humidifier when empty i. Dating/Timing Humidifier not required as longevity varies according to multiple factors. 7. Attach administration device to flowmeter or (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Paradigm at Bay City		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 13th St Bay City, TX 77414	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	humidifier/nebulizer outlet if indicated. 8. Start O2 flow rate at the prescribed liter flow or appropriate flow for administration device. 9. Place administration device on the resident. 10. Observe color, pulse rate, blood pressure, ventilatory rate/depth, and sensorium for any adverse reactions; remain with the patient/resident until they are accustomed to the therapy. 11. Monitor respiratory rate and heart rate. 12. Post Oxygen in Use sign on the patient/resident's room door. 13. Wash hands prior to leaving the resident's room. 14. Document initiation of therapy in medical record, per documentation standards. 15. Change O2 tubing with any discoloration or contamination.		