STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455594	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at Kountze	604 Fm 1293 Kountze, TX 77625

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 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** 47612 Based on interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents, for 1 of 16 residents (Resident #144) reviewed for abuse. The facility failed to follow their policy to report to HHSC when Resident #144 alleged that CNA N had sat her down on the toilet too hard hitting her back on [DATE]. These failures could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of the facility's policy titled, Abuse, Neglect and Exploitation revised ,d+[DATE], indicated, The Nursing Facility strictly prohibits abuse, neglect, exploitation, or any mistreatment of residents by anyone at the facility including: staff, residents, volunteers, visitors, and others The facility administrator or designee serves as the abuse coordinator. In the temporary absence of an administrator, an appointed designee may temporarily serve as the abuse prevention coordinator. Reporting response .Immediately, but not later than two hours after the incident occurs or is suspected . Record review of a face sheet dated [DATE], indicated Resident #144 was a [AGE] year-old female, initially admitted on [DATE], and readmitted on [DATE] with the diagnoses Huntington's disease (an inherited disorder that causes nerve cells (neurons) in parts of the brain to gradually break down and die), anxiety disorder (a type of mental health condition), dementia, unspecified severity, with agitation (a symptom of the physical changes in the brain caused by dementia). Record review of the most quarterly MDS assessment dated [DATE], indicated Resident #144 usually understood others and was able to make herself understood. Resident # 144 had a BIMS score of 02, which suggest severe cognitive impairment. The MDS did not address Resident # 144 death on [DATE]. Record review of the comprehensive care plan dated [DATE] and indicated Resident #144 needed assistance with ADLs. The goal toilet extensive with one person assist. Record review of the progress notes dated [DATE] to [DATE], revealed no documentation of the alleged incident on [DATE]. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:29 p.m., CNA N stated she was in another resident's room when she heard the emergency call light go off. CNA N stated she went to see if Resident #144 needed help. CNA N stated Resident #144 was sitting on the commode in her bathroom saying help. CNA N stated when she tried to get her up, Resident # 144 started yelling no. CNA N stated she asked Resident #144 if she was done and ready to get into bed. CNA N stated Resident #144 started yelling again and the nurse came in and took over. During an interview on [DATE] at 8:08 a.m., LVN G stated all she knew was Resident #144 said CNA N sit her down hard her down on the toilet. LVN G stated when she assessed Resident #144, she had a red mark on her back. LVN G stated she was not sure if the marks were from the resident leaning back while sitting on the toilet. LVN G stated she immediately reported the incident to the DON and told CNA N not to go back into Resident #144's room. During an interview on [DATE] at 10:45 a.m., The DON stated Resident #144 had uncontrollable movements due to her Huntington's disease and when CNA N went in to get her off the toilet Resident #144 started saying no. The DON stated LVN G assessed Resident #144 and notified her of the incident. The DON stated when she investigated the incident Resident #144 kept changing her story as to who the person was that hurt her. The DON stated Resident #144 would give her different names when she asked her what happened. The DON stated Resident #144 gave the DON her own name. The DON stated when she contacted Resident #144's representative about the incident she stated something like this has happened before. The DON stated with Resident #144 Huntington's disease she had spastic movement and she felt like when CNA N went to get her off the toilet Resident #144 jerked backwards. The DON stated she was notified of the incident after 9:00 p.m. The DON stated she knew Resident #144 had static movement and did not feel like Resident #144 was abused at the time, that was why she did not report it to the administrator immediately and reported the incident the next day. During an interview on [DATE] at 11:10 a.m., the Administrator stated she was required to report an abuse allegation to the state within two hours. The Administrator stated she was informed of the incident late. The Administrator stated the incident was reported to her the next day and reported as soon as she found out. The Administrator stated once she found out she suspended CNA N and stated the investigation. The Administrator stated Resident #144 gave a different story every time she talked with her about the incident. The administrator stated during the investigation the red mark reported on Resident #144 could be from her leaning back on the toilet due to her disease and was gone the next day. The Administrator stated she did an abuse reporting in-service with the staff.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on interview, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, for 1 of 16 residents (Resident #144) reviewed for abuse and neglect reporting. The facility failed to investigate when Resident #144 alleged that CNA N let her sit down on the toilet too hard hitting her back on [DATE]. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Record review of a face sheet dated [DATE], indicated Resident #144 was a [AGE] year-old female, initially admitted on [DATE], and readmitted on [DATE] with the diagnoses Huntington's disease (an inherited disorder that causes nerve cells (neurons) in parts of the brain to gradually break down and die), anxiety disorder (a type of mental health condition), dementia, unspecified severity, with agitation (a symptom of the physical changes in the brain caused by dementia). Record review of the most quarterly MDS assessment dated [DATE], indicated Resident #144 usually understood others and was able to make herself understood. Resident # 144 had a BIMS score of 02, which suggest severe cognitive impairment. The MDS did not address Resident # 144 death on [DATE]. Record review of the comprehensive care plan dated [DATE] and indicated Resident #144 needed assistance with ADLs. The goal toilet extensive with one person assist. Record review of the progress notes dated [DATE] to [DATE], revealed no documentation of the alleged incident on [DATE]. During an interview on [DATE] at 8:29 p.m., CNA N stated she was in another resident's room when she heard the emergency call light go off. CNA N stated she went to see if Resident #144 needed help. CNA N stated Resident #144 was sitting on the commode in her bathroom saying help. CNA N stated when she tried to get her up, Resident # 144 started yelling no. CNA N stated she asked Resident #144 if she was done and ready to get into bed. CNA N stated Resident #144 started yelling again and the nurse came in and took over. During an interview on [DATE] at 8:08 a.m., LVN G stated all she knew was Resident #144 said CNA N sit her down hard her down on the toilet. LVN G stated when she assessed Resident #144, she had a red mark on her back. LVN G stated she was not sure if the marks were from the resident leaning back while sitting on the toilet. LVN G stated she immediately reported the incident to the DON and told CNA N not to go back into Resident #144's room. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:45 a.m., The DON stated Resident #144 had uncontrollable movements due to her Huntington's disease and when CNA N went in to get her off the toilet Resident #144 started saying no. The DON stated LVN G assessed Resident #144 and notified her of the incident. The DON stated when she investigated the incident Resident #144 kept changing her story as to who the person was that hurt her. The DON stated Resident #144 would give her different names when she asked her what happened. The DON stated Resident #144 gave the DON her own name. The DON stated when she contacted Resident #144's representative about the incident she stated something like this has happened before. The DON stated with Resident #144 Huntington's disease she had spastic movement and she felt like when CNA N went to get her off the toilet Resident #144 jerked backwards. The DON stated she was notified of the incident after 9:00 p.m. The DON stated she knew Resident #144 had static movement and did not feel like Resident #144 was abused at the time, that was why she did not report it to the administrator immediately and reported the incident the next day. During an interview on [DATE] at 11:10 a.m., the Administrator stated she was required to report an abuse allegation to the state within two hours. The Administrator stated she was informed of the incident late. The Administrator stated the incident was reported to her the next day and reported as soon as she found out. The Administrator stated once she found out she suspended CNA N and stated the investigation. The Administrator stated Resident #144 gave a different story every time she talked with her about the incident. The administrator stated during the investigation the red mark reported on Resident #144 could be from her leaning back on the toilet due to her disease and was gone the next day. The Administrator stated she did an abuse reporting in-service with the staff. Record review of the facility's policy titled, Abuse, Neglect and Exploitation revised ,d+[DATE], indicated, The Nursing Facility strictly prohibits abuse, neglect, exploitation, or any mistreatment of residents by anyone at the facility including: staff, residents, volunteers, visitors, and others The facility administrator or designee serves as the abuse coordinator. In the temporary absence of an administrator, an appointed designee may temporarily serve as the abuse prevention coordinator. Reporting response .Immediately, but not later than two hours after the incident occurs or is suspected .