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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observations, interviews, and record reviews, the facility failed protect and promote the rights of the residents for 1 of 16 residents (Resident #31) reviewed for resident rights. The facility failed ensure CNA M provided privacy when she assisted Resident #31 in getting dressed on 07/25/2024. This deficient practice could place residents at risk for loss of dignity. Findings included: Record review of Resident #31's face sheet dated 07/25/2024, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included moderate protein-calorie malnutrition (inadequate intake of protein and calories), dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems) and gastrostomy status (a tube inserted through the belly that brings nutrition directly to the stomach). Record review of Resident #31's quarterly MDS assessment dated [DATE], indicated Resident #31 was able to understand others and was able to be understood. The MDS assessment indicated Resident #31 had a BIMS score of 04, which indicated his cognition was severely impaired. The MDS assessment indicated Resident #31 required substantial/maximal assistance with toileting, showering, lower body dressing and personal hygiene. Resident #31 required partial/moderate assistance with upper body dressing. Record review of Resident #31's comprehensive care plan dated 06/19/2024, indicated Resident #31 had ADL self-care deficits and was at risk for further decline in ADL functioning and injury as evidenced by lower extremity weakness. The care plan interventions indicated to provide limited/extensive assistance of 1 support person for upper/lower body dressing. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 07/25/2024 at 08:41 AM, CNA M entered Resident #31's room to transfer resident to the wheelchair. CNA M assisted Resident #31 by applying his pants prior to transferring him to his wheelchair. CNA M failed to ensure Resident #31 had privacy when she left the door to his room open and did not pull the curtain around. Resident #31's roommate was in his bed awake. After Resident #31 was in his wheelchair, CNA M proceeded to change Resident #31's shirt. CNA M said she forgot to close the door and pull the curtain. CNA M said by closing the door and pulling the curtain Resident #31 could have had privacy and would have felt more comfortable with care. CNA M said she was responsible for ensuring privacy was maintained during care. CNA M said by not providing privacy anyone and could have walked in and seen Resident #31 undressed. During an interview on 07/25/2024 at 08:50 AM, Resident #31 said it would have bothered him if someone he did not know walked in while they were dressing him. During an interview on 07/25/2024 at 08:55 AM, the ADON said she expected privacy to maintained when providing care to a resident. The ADON said it was ultimately her responsibility for ensuring the staff maintained privacy when providing care. The ADON said failure to provide privacy, when care was being provided, would place residents at risk for being seen by other people. During an interview on 07/25/2024 at 09:58 AM, the DON said she expected CNA M to have closed the door and pulled the curtain when she assisted Resident #31 in being dressed. The DON said it was the aides, nurses, and management responsibility to ensure privacy was being maintained when providing care. The DON said it was a dignity and privacy issue by not maintaining privacy with care. During an interview on 07/25/2024 at 10:23 AM, the Administrator said she expected staff to close the door and pull the curtain around when providing care to a resident. The Administrator said the person completing the task was responsible for ensuring the resident's privacy was maintained. The Administrator said management staff was responsible for ensuring the staff was knowledgeable in providing privacy to the residents. The Administrator said failure to provide a resident with privacy while providing care, was a privacy and dignity issue. Record review of the facility's policy and procedure Dignity: Resident's Rights for revised on 06/2019, indicated . 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 . 23. Doors are closed or open per resident request and appropriateness .

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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** 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]. 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. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident status for 5 of 12 residents (Resident # 12, Resident #27, Resident 28, Resident #17, and Resident #40) reviewed for MDS assessment accuracy. 1. The facility failed to ensure Resident # 12's, Resident #27's, and Resident #28's, Plavix (an antiplatelet drug you can take to prevent blood clots) was coded correctly under antiplatelet on the MDS. 2. The facility failed to ensure Resident #28's Aspirin (a common drug for relieving minor aches, pains, fever an anti-inflammatory or blood thinner) was coded correctly under antiplatelet on the MDS. 3. The facility inaccurately coded Resident #17 as having received dialysis on her MDS assessment dated [DATE]. 4. The facility inaccurately coded Resident #40 as being discharged to the hospital instead of home on her MDS assessment dated [DATE]. These failures could place residents at risk of not receiving care and services to meet their needs. Findings included: 1.Record review of Resident #12''s face sheet, dated 07/25/24, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE] with the diagnoses which included stroke, Coronary artery disease, also called CAD (a condition that affects your heart), Diabetes (a condition that happens when your blood sugar (glucose) is too high), and anxiety (a feeling of fear, dread, and uneasiness). Record review of Resident #12's quarterly MDS assessment, dated 07/19/24, indicated Resident #12 was understood and understood others. Resident #12''s BIMS score was 15, which indicated she was cognitively intact. The MDS did indicate Resident #12 was on an anticoagulant medication. The MDS indicated Resident #12 required assistance with bathing, toileting bed mobility, dressing, personal hygiene, transfers, and supervision assistance for eating. Record review of Resident #12's physician's orders dated 03/01/24, indicated: Clopidogrel Bisulfate (Plavix) 75 MG tablet, give 1 tablet by mouth daily for CAD. Record review of Resident #12's comprehensive care plan revision dated 03/23/21 indicates she took an anticoagulant medication. The interventions were for staff to monitor for side effects of discolored urine, black tarry stool, sudden severe headache, nausea/vomiting, diarrhea, muscle/joint pain, lethargy, bruising, sudden changes in mental status or vitals, shortness of breath or nose bleeds. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.Record review of Resident #27's face sheet, dated 07/25/24, indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included stroke, Coronary artery disease, also called CAD (a condition that affects your heart), Bipolar(a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning). Record review of Resident #27's change in condition MDS assessment, dated 06/24/24, indicated Resident #27 was understood and understood by others. Resident #27's BIMS score was 03, which indicated he was cognitively severely impaired. The MDS indicated Resident #27 required extensive assistance with bathing, toileting bed mobility, dressing, personal hygiene, transfers, and eating. The MDS did indicate Resident #27 was on an anticoagulant medication. Record review of Resident #27's physician's orders dated 06/22/24, indicated: Aspirin 81MG chewable, Give 1 tablet by mouth in the morning for CAD. Record review of Resident #27's physician's orders dated 07/17/24, indicated: Clopidogrel Bisulfate (Plavix) 75 MG tablet, give 1 tablet by mouth at night for CAD. Record review of Resident #27's comprehensive care plan revision dated 03/28/24 revealed Resident #27 had CAD and took Aspirin and Plavix. The intervention was for staff to encourage compliance with the treatment regimen, follow up with the physician, and monitor labs. During an interview and observation on 07/25/24 at 10:09 a.m., the MDS Coordinator R said she was responsible for the completion of the MDS for Resident #12 and Resident #27. She looked at Resident #12's quarterly MDS assessment dated [DATE] and Resident #27 significant change in status MDS dated [DATE] on section N and said she coded them both as taking anticoagulant medication. The MDS nurse said she coded it that way because Plavix fell under the category of anticoagulant medication. She and the surveyor reviewed the RAI manual and saw that Plavix and aspirin should not be coded under anticoagulant. She said she coded Plavix wrong. She said she would fix both MDS assessments. She said it was important to code the MDS assessment correctly because it reflected the resident's care. During an interview on 07/25/24 at 11:00 a.m., the ADON said the MDS Coordinator was responsible for completing the MDS. She said she expected the MDS nurses to do an accurate assessment because it affects the resident's care and needs to be accurate. During an interview on 07/25/24 at 11:25 a.m., the DON said the MDS Coordinator was responsible for completing the MDS. The DON said she expected the assessments to be reflected in the MDS because it could be misleading if coded incorrectly. During an interview on 07/25/24 at 11:58 a.m., the Administrator said the MDS Coordinator was responsible for the completion of the MDS. She said she expected the MDS assessment, for any resident, to be completed thoroughly and correctly based on the resident assessment. 47612 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Record review of the face sheet, dated 07/23/2024, indicated Resident #28 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses of stenosis of coronary artery stent, initial encounter (scar tissue forms under the stent, causing a previously opened coronary artery to narrow again), ventricular tachycardia, unspecified (a type of abnormal heart rhythm), heart failure, unspecified (your heart cannot pump enough oxygen rich blood to meet your body's needs), hypertension (when the pressure in the blood vessels are too high). Record review of the quarterly MDS assessment dated [DATE], indicated Resident #28 usually understood others and was able to make herself understood. Resident # 28 had a BIMS score of 12, indicating moderate cognitive impairment. The MDS assessment indicated Resident #28 received an anticoagulant medication within the 7-day look-back period. Record review of the care plan, dated 02/05/2023, revised on 09/22/2023 revealed Resident #28 care plan did not address Clopidogrel for heart failure or Aspirin for hypertension. Record review of the order summary, dated 06/23/2024, indicated Resident # 28 was taking Aspirin for hypertension (when the pressure in the blood vessels are to high) with a revised date of 03/02/2024 and Clopidogrel for heart failure (your heart cannot pump enough oxygen-rich blood to meet your body's needs) with a revised date of 07/22/2024. Record review of the medication administration record, dated 07/24/2024, indicated Resident # 28 received Aspirin for hypertension (when the pressure in the blood vessels are high) with a start date of 02/29/2024 and Clopidogrel for heart failure (your heart cannot pump enough oxygen rich blood to meet your body's needs) with a start date of 02/29/2024. 4.Record review of the face sheet, dated 07/23/2024, indicated Resident #17 was a [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses of type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, was too high), chronic kidney disease, unspecified (occurs when a disease or condition impairs kidney function, causing kidney damage to worsen over several months or years), iron deficiency anemia secondary to blood loss (your body cannot produce enough hemoglobin). Record review of the quarterly MDS assessment dated [DATE], indicated Resident #17 usually understood others and was able to make herself understood. Resident # 28 had a BIMS score of 15, indicating cognition was intact The MDS assessment indicated Resident #17 received dialysis within the 7-day look-back period. Record review of the care plan, dated 11/17/2023, revised on 04/11/2024, did not indicate Resident #17 was receiving dialysis. Record review of the order summary, dated 07/23/2024, did not indicate orders for Resident # 17 to receive dialysis. During an interview on 07/22/2024 at 4:48 p.m., Resident #17 stated she had never been on dialysis. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5.Record review of the face sheet, dated 05/20/2024, indicated Resident #40 was a [AGE] year-old female with diagnoses of unspecified fracture of right femur (a traumatic or pathologic injury to the femur in which the continuity of the femur was broken, of type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, was too high), anemia(a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues. Record review of the quarterly MDS assessment dated [DATE], indicated Resident #40 usually understood others and was able to make herself understood. Resident # 40 had a BIMS score of 14, indicating cognition was intact The MDS assessment indicated Resident #40 was discharged to the hospital within the 7-day look back period. Record review of the progress notes dated 07/25/2024 indicated Resident # 40 discharged home with a family member on 05/28/2024. During an interview on 07/25/2024 at 10:26 a.m., the MDS Coordinator stated she was responsible for the residents MDS assessment. The MDS coordinator stated it was important for MDSs to be accurate so it could be reflected on the resident's care plan. The MDS coordinator stated the failure was the resident may not get the care they needed. During an interview on 07/25/2024 at 10:45 a.m., the DON said the MDS coordinator was responsible for coding resident diagnoses. The DON stated it was important for the MDS to be accurate to because it reflected on the resident's care plan. The DON stated the failure was an inaccurate MDS affected the resident's plan of care and the facility's billing. During an interview on 07/25/2024 at 11: 10 a.m., the Administrator stated she expected resident's MDS to be coded accurately. The Administrator stated the MDS coordinator was responsible for completing the MDS assessments. The Administrator stated the MDS should be accurate because it ensured care of the resident and proper medication and treatment. The Administrator stated corporate was monitoring the MDS coordinator. Record review of a facility's Nutrition Services Policies and Procedures subject Minimum Data Set (MDS) policy revised 06/2019, indicated The interdisciplinary team will complete the MDS for each patient/resident as part of the RAI process to assure data accuracy for its state specific version of such within the required timeframe according to applicable law and regulations. Each team member will note their liability for the accuracy of the data recorded by signing their name and identifying the MDS sections and questions to which they provided response . Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (used to complete resident assessments, MDS assessments) dated October 2023 indicated in Chapter 3 pg. N-8, . Do not code antiplatelet medications such as aspirin/extended-release, dipyridamole, or clopidogrel as N0415E, Anticoagulant .

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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** 45879 Based on interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs, for 1 of 6 (Resident #24) residents reviewed for the care plan. The facility failed to care plan Resident #24's coffee spill that resulted in a 2nd-degree burn. This failure could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. The findings included: Record review of Resident #24's face sheet, dated 07/25/24, indicated an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Syncope and collapse(a medical term for fainting or passing out), venous insufficiency (occurs when your leg veins don't allow blood to flow back up to your heart), Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning). Record review of Resident #24's quarterly MDS assessment, dated 06/13/24, indicated Resident #24 was understood and understood by others. Resident #24's BIMS score was 12, which indicated he was cognitively intact. The MDS indicated Resident #24 required assistance with bathing, toileting, bed mobility, dressing, transfers, and set up for personal hygiene and eating. Record review of an incident report dated 01/05/23 at 3:50 p.m., indicated Resident #24 was sitting up in the dining room in his wheelchair. No distress was noted. Resident #24 spilled his coffee on his left leg and floor. Resident #24 said he was getting a cup of coffee and spilled it down his leg. LVN Q accessed Resident #24 left leg and noted redness. No open areas or blisters were noted. LVN Q notified the wound care nurse the responsible party the nurse practitioner the DON and the Administrator. No measurements were indicated on the incident report. Record review of Resident #24's progress note dated 01/06/24 at 2:56 a.m., by LVN R, revealed, Resident #24 complained of discomfort to the left foot after spilling the hot coffee on it earlier yesterday morning. The resident had several blisters/fluid-filled pockets located to the top of the left foot and to the top of the pinky toe on the left foot. The blisters were intact and not opened or draining. The left foot was red. Record review of Resident #24's Physician order dated 01/05/24 revealed Resident #24 had an order for a start date of 01/05/24 and a stop date of 01/13/24 to monitor for any new signs or symptoms to the top of the left foot every shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #24's Physicians order dated 01/12/24, revealed Resident #24 had an order for a start date of 01/12/24 and stop date of 02/05/24 for Silvadene External Cream 1 % (Silver Sulfadiazine), Apply cream to his left top foot topically every day shift for redness. Record review of Resident #24's comprehensive care plan dated 07/12/24 did not reveal a care plan for the risk of injury from hot liquids. During an interview on 07/25/24 at 10:09 a.m., the MDS nurse said she was responsible for the care plans but the IDT team also helped. She said the care plan was done so the staff would know how to care for the resident. She said she was made aware of the residents' changes in the morning meeting. She said she brought her computer to the morning meetings and updated any changes during the meeting. She said she was unaware of how she missed adding Resident #24's hot liquid spill to his care plan. She said failure to do a care plan could cause staff not to know how to care for the residents. During an interview on 07/25/24 at 11:00 a.m., the ADON said the MDS nurse was responsible for the care plans. She said she could delegate to others if needed. She said the Administrator was the overseer of the MDS nurse. She said they discussed any new orders or changes to the resident's care during the morning meetings. She said the MDS nurse attended the morning meetings and any changes should have been updated during the meeting. She said care plans were done to capture how to take care of the resident. The ADON said Resident #24 should have had an at-risk care plan because he obtained a burn from the coffee on 01/05/24. During an interview on 07/25/24 at 11:25 a.m., the DON said the MDS nurse was responsible for the care plans. She said they talked about the resident's changes during the morning stand-up meeting and the nurse meeting. She said the MDS nurse would bring her computer to the morning meetings and update care plans as needed. She said she could not say why the MDS nurse had not updated the care plans. The DON said Resident #24 should have had a care plan for his coffee spill. She said the purpose of the care plans was to keep everyone informed of the resident's care. During an interview on 07/25/24 at 11:58 a.m., the Administrator said the MDS nurse was responsible for the care plans. She said she was the overseer of the MDS nurse. She said the facility had an internal survey in May of 2024 where they identified care plans were not being done accurately or consistently. She said she placed the MDS nurse on a PIP and although she had made some progress, she had not followed the PIP as planned. She said the coffee spill should have been on Resident #24's care plans. Record review of the facility policy titled, Care Planning, dated 6/2019 revealed It is the policy of this facility that the interdisciplinary team shall develop a comprehensive care plan for each resident. Procedure: A comprehensive care plan is developed within seven days of completion of the comprehensive 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** 45879 Based on interview, and record review the facility failed to review and revise the person-centered care plan to reflect the current condition for 3 of 16 (Residents #6, #27, and #19) residents reviewed for care plan revisions. The facility failed to update Resident #6's and #27's care plans for their Code status from Full Code to DNR. The facility failed to update Resident #27's and Resident #19's care plans for fall interventions. These failures could affect residents by placing them at risk of not receiving appropriate interventions to meet their current needs. Findings included: 1. Record review of Resident #6's face sheet, dated [DATE] indicated he was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included, Parkinson's (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), Anxiety(a feeling of fear, dread, and uneasiness), dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), hypertension (high blood pressure), and Depression(sadness). Record review of Resident 6's significant change in status MDS assessment, dated [DATE], indicated Resident #6 was understood and understood by others. Resident #6 BIMs score was 11 indicating she was cognitively moderately impaired. The MDS indicated Resident #6 required assistance with his ADLs. The MDS indicated she was receiving hospice service. Record review of Resident 6's Physician order dated [DATE] revealed Resident #6 had a Do Not Resuscitate order (DNR). Record review of Resident #6's comprehensive care plan, dated [DATE], revealed Resident #6 was a Full Code. The intervention was for staff to initiate CPR if the resident's heart stopped and to inform staff of the code status. 2.Record review of Resident #27's face sheet, dated [DATE], indicated a [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included stroke, Coronary artery disease, also called CAD (a condition that affects your heart), Bipolar(a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #27's significant change in status MDS assessment, dated [DATE], indicated Resident #27 was understood and understood by others. Resident #27's BIMS score was 03, which indicated he was cognitively severely impaired. The MDS indicated Resident #27 required extensive assistance with bathing, toileting bed mobility, dressing, personal hygiene, transfers, and eating. The MDS indicated he was receiving hospice service. The MDS indicated he had a fall during the look-back period. Record review of Resident #27's Physician order dated revealed Resident #6 had a Do Not Resuscitate order (DNR). Record review of Resident #27's comprehensive care plan dated [DATE] revealed Resident #27 was a Full Code. The intervention was for staff to initiate CPR if the resident's heart stopped and to inform staff of the code status. Record review of Resident #27's comprehensive care plan revision dated [DATE] revealed Resident #27 had a fall on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. The interventions for staff were dated [DATE] except [DATE] which indicated Resident #27 was already on therapy caseload. No other interventions were noted for each of Resident #27's falls. During an interview on [DATE] at 9:57 a.m., LVN G said if a resident was a DNR or Full Code it should be on their care plan. She said it was important to know the code status because she would not want to resuscitate someone who was a DNR. She said when a resident had a fall, they would try to put things in place such as encourage them to use their call light or place a fall mat on the floor. She said she was not responsible for updating care plans but if she had an issue, she would notify the DON/ADON and they would notify the MDS nurse, and she would update the care plan. She said it was important to care plan the resident's fall interventions and end-of-life wishes. During an interview on [DATE] at 10:09 a.m., the MDS nurse said she was responsible for the care plans but the IDT team also helped. She said the dietary manager, social worker, wound care, and infection control nurse did their parts for the care plan. She said the nurses on the floor did not do care plans. She said the care plan was done so the staff would know how to care for the resident. She said she was made aware of the resident's changes in the morning meeting. She said she brought her computer to the morning meetings and updated any changes during the meeting. She said she was not sure how Resident #6 and Resident #27's code status were not updated. She said that was a crucial oversite which could have cause a resident's wishes not to be granted. She said she was aware of all residents' falls because she pulled a fall list daily and they discussed it in the morning meetings. She said she updated Resident #27's falls but did not update his fall interventions. She said failure to do the interventions could cause staff not to know how to prevent further falls. During an interview on [DATE] at 10:39 a.m., the Social Worker said she worked part-time at the facility. She said if a resident wished to be full code, the nurses would write the order and the MDS nurses would update the care plan. She said if the resident wished to be a DNR, she would get the resident, two witnesses (if needed), and the doctor to sign the DNR form. She said that she would then notify the nurses of the DNR status and they would write the order. She said she or the MDS nurse would update the code status on the care plan. She said she was unaware why Resident #6 or Resident #27's code status had not been updated. She said the care plan should have been updated because it was part of their needs and care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:00 a.m., the ADON said the MDS nurse was responsible for the care plans. She said she could delegate to others if needed. She said the Administrator was the overseer of the MDS nurse. She said they discussed any new orders or changes to the resident's' care during the morning meetings. She said the MDS nurse attended the morning meetings and any changes should have been updated during the meeting. She said care plans were done to capture how to take care of the resident. The ADON said code statutes and fall interventions should have been on the care plan. During an interview on [DATE] at 11:25 a.m., the DON said the MDS nurse was responsible for the care plans. She said they talked about the resident's changes during the morning stand-up meeting and the nurse meeting. She said the MDS nurse would bring her computer to the morning meetings and update care plans as needed. She said she could not say why the MDS nurse had not updated the care plans. The DON said the code statutes and fall interventions should have been on the care plan. She said the purpose of the care plans was to keep everyone informed of the resident's wishes and care. During an interview on [DATE] at 11:58 a.m., the Administrator said the MDS nurse was responsible for the care plans. She said she was the overseer of the MDS nurse. She said the facility had an internal survey in May of 2024 where they identified care plans were not being done accurately or consistently. She said she placed the MDS nurse on a PIP and although she had made some progress, she had not followed the PIP as planned. She said the code status and the fall intervention should have been on the resident's care plans. 46928 3. Record review of Resident #19's face sheet dated [DATE], indicated a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #19's diagnoses included hypertensive heart disease (complications of high blood pressure that affect the heart) with heart failure (condition in which the heart does not pump as well as it should), essential hypertension (high blood pressure), Alzheimer's disease (progressive disease that destroys memory and other important mental functions), and cerebellar stroke syndrome (occurs when blood supply to the cerebellum, an area of the brain responsible for movement and balance, is stopped). Record review of Resident #19's annual MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. The MDS assessment indicated Resident #19 had a BIMS score of 10, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #19 required substantial/maximal assistance with toileting, showering, and personal hygiene. The MDS assessment indicated Resident #19 had 2 falls with no injury, 1 fall with injury, and 1 fall with major injury since the prior MDS assessment. Record review of Resident #19's comprehensive care plan revised on [DATE], indicated Resident #19 was at risk for falls and injuries as evidenced by walks with a walker and had a previous fall with fracture. The care plan indicated Resident #19 had the following interventions for falls: *Camera Monitor while in room/bed dated [DATE]. *Q1hr location status dated [DATE]. *Anticipate needs-provide prompt assistance dated [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Assure lighting is adequate and areas are free of clutter dated [DATE]. *Bed in lowest lock position dated [DATE]. *Encourage resident to ask for assistance of staff dated [DATE]. *Ensure call light is within reach and answer promptly dated [DATE]. *Fall mat on floor beside the bed; Only while in bed. Dated [DATE]. *Send to hospital per status post resident assessment if needed and per Physician order dated [DATE]. *Therapy to screen resident. Evaluate/Treat per order cognition only dated [DATE]. The care plan did not indicate the new interventions initiated when Resident #19 had falls on [DATE], [DATE], [DATE], [DATE] and [DATE]. Record review of Resident #19's fall incident report dated [DATE], indicated . Resident was observed sitting on the floor mat, leaning over calling for help. Bed was in low position. Patient was assessed and noted laceration to back of head. When asking resident what happened. Resident stated, 'I was trying to go to the bathroom when I fell ' . The incident report indicated Resident #19 had a laceration to the back of the head and was sent to the hospital. The incident report did not indicate any new interventions implemented regarding her fall. Record review of Resident #19's fall incident report dated [DATE], indicated Resident #19 was observed sitting on floor of dining room. Her W/C was about 5 feet behind her. She was sitting up. Fall was not observed by staff. No injury noted. Resident stated she slid out of her chair. She denied pain or discomfort. The incident report indicated Resident #19 had no injuries. The incident report did not indicate any new interventions implemented regarding her fall. Record review of Resident #19's fall incident report dated [DATE], indicated . RCS asked LVN to come to resident's doorway where resident and RCS were by wheelchair, RCS had just pushed the wheelchair in the doorway, Resident leaned forward and slid to the floor, witnessed fall, 1 cm x 1 cm skin tear to left middle finger. The incident report indicated Resident #19 had no injuries. The incident report did not indicate any new interventions implemented regarding her fall. Record review of Resident #19's fall incident report dated [DATE], indicated . Resident was found sitting on upright on the floor in doorway of her bathroom. Under resident description it stated, I don't know how or why I fell . I walked to the toilet. I used the toilet. I fell walking back to my bed. The incident report indicated Resident #19 had no injuries. The incident report did not indicate any new interventions implemented regarding her fall. Record review of Resident #19's fall incident report dated [DATE], indicated . Resident slid out of her wheelchair. Under resident description it stated, I started sliding and sliding next thing I know I was on the floor. The incident report indicated Resident #19 had no injuries. The incident report did not indicate any new interventions implemented regarding her fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #19's order summary report dated [DATE], indicated Resident #19 had and order for fall risk precautions, fall mat in place at all times with an order date of [DATE]. During an interview on [DATE] at 09:58 AM, the DON said she expected Resident #19's care plan to have been updated with the interventions they had discussed for each fall that Resident #19 had. The DON said they had implemented a bedside commode, camera, low bed, frequent monitoring and fall mat. The DON said the MDS nurse was responsible for ensuring the care plans were revised and updated as needed. The DON said failure to revise the care plans could cause Resident #19 to continue to fall since staff would not be aware of the interventions initiated to prevent her from falling. During an interview on [DATE] at 10:23 AM, the Administrator said she expected the care plans be updated on any new orders or changes. The Administrator said they had initiated fall interventions for Resident #19's falls. The Administrator said the MDS nurse was responsible for updating the care plans, when they talk about new changes or discussing interventions. The Administrator said failure to update and revise the care plans could cause staff to be unaware of the interventions put in place to prevent Resident #19 from falling. Record review of the facility's policy Careplan Revisions revised on ,d+[DATE], indicated . The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents within the facility . 2. Procedure of reviewing and revising the care plan is as follows: a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. c. The care plan will be updated with the new or modified interventions . e. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. f. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs . Record review of facility policy titled, Incidents/Accidents, dated ,d+[DATE], indicated, The facility will assess residents for risk factors of potential accidents/ hazard. The facility will recognize signs of incidents and accidents and assist residents, as indicated. The facility will conduct thorough investigations as indicated to determine underlying causes and contributing factors to incidents and accidents; and would put interventions in place from the investigative findings and IDT input Charge nurse procedure: the resident's care plan will be updated to reflect the incident or accident with interventions to prevent further occurrence as indicated Special considerations: the facility administrator should determine incidents or accidents that require thorough investigation and ensure completion.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 45879 Based on observation, interview, and record review, the facility failed to ensure an environment that was free of accident hazards for 1 of 43 residents (Resident #24) reviewed for accidents hazards. The facility failed to ensure safety measures were in place after Resident #24 received a second-degree burn (burns that involve the epidermis and part of the lower layer of skin, the dermis. The burn site looks red, blistered, and may be swollen and painful) from hot coffee that required treatment. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 9:33 a.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity of no actual harm with potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for diminished quality of life, injury, and burns. Findings included: Record review of Resident #24's face sheet, dated [DATE], indicated an [AGE] year-old male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Syncope and collapse(a medical term for fainting or passing out), venous insufficiency (occurs when your leg veins don't allow blood to flow back up to your heart), Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and Dementia (the loss of cognitive functioning - thinking, remembering, and reasoning). Record review of Resident #24's quarterly MDS assessment, dated [DATE], indicated Resident #24 was understood and understood by others. Resident #24's BIMS score was 12, which indicated he was cognitively moderately impaired. The MDS indicated Resident #24 required assistance with bathing, toileting bed mobility, dressing, transfers, and set up for personal hygiene and eating. Record review of Resident #24's comprehensive care plan dated [DATE] did not reveal a care plan for the risk of injury from hot liquids. Record review of Resident #24's Physician order dated [DATE] revealed Resident #24 had an order for a start date of [DATE] and a stop date of [DATE] to monitor for any new signs or symptoms to the top of the left foot every shift. Record review of Resident #24's Physicians order dated [DATE], revealed Resident #24 had an order with a start date of [DATE] and a stop date of [DATE] for Silvadene External Cream 1 % (Silver Sulfadiazine), Apply cream to his left top foot topically every day shift for redness. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #24's MAR dated [DATE] thru [DATE], revealed Resident #24 had an order with a start date of [DATE] and stop date of [DATE] for Silvadene External Cream 1 % (Silver Sulfadiazine), Apply cream to his left top foot topically every day shift for redness. Staff initialed they had applied the cream as ordered from [DATE] through [DATE]. Record review of incident report dated [DATE] at 3:50 p.m., indicated Resident #24 was sitting up in the dining room in his wheelchair. No distress was noted. Resident #24 spilled his coffee on his left leg and floor. Resident #24 said he was getting a cup of coffee and spilled it down his leg. LVN Q accessed Resident #24 left leg and noted redness. No open areas or blisters were noted. LVN Q notified the wound care nurse the responsible party the nurse practitioner the DON and the Administrator. No measurements were indicated on the incident report. Record review of Resident #24's SBAR dated [DATE] at 5:33 p.m., by LVN Q revealed Resident #24 spilled hot coffee on his left ankle and foot. No open areas or blisters were noted but the area was red and tender. Record review of Resident #24's skincare observation dated [DATE] at 5:59 p.m., revealed Resident #24 had redness to his left lower leg from the coffee spill but no blisters or open areas. The skin care observation failed to include the size of the redness on the left lower leg. Record review of Resident #24's incident report, pain assessment, skin assessment, and SBAR dated [DATE] was completed. Record review of Resident #24's progress note dated [DATE] at 2:56 a.m., by LVN R, revealed, Resident #24 complained of discomfort to the left foot after spilling the hot coffee on it earlier yesterday morning. The resident had several blisters/fluid-filled pockets located to the top of the left foot and to the top of the pinky toe on the left foot. The blisters were intact and not opened or draining. The left foot was red. Record review of Resident #24's progress note dated [DATE] at 9:26 a.m., by LVN Q Day ,d+[DATE] burn from coffee to Left foot. Redness and blisters noted. No drainage/bleeding at this time. Treatment was in place. Res able to voice all needs, no needs at this time. Call light in reach. Record review of Resident #24's progress note dated [DATE] at 2:49 a.m., by LVN R Day ,d+[DATE]: Resident continues to have fluid-filled blisters noted to the top of the left foot and the pinky toe on the left foot. No opened areas noted. The redness had decreased some with daily wound care completed. Record review of Resident #24's progress note dated [DATE] at 5:30 p.m., by LVN Q Day ,d+[DATE] burn from coffee to Left foot. Blister noted to top of the foot. No drainage/bleeding at this time. Tx in place. Res able to voice all needs, no needs voiced. Call light in reach. Record review of Resident #24's progress note dated [DATE] at 1:10 a.m., by LVN R Day ,d+[DATE] for a burn from coffee to the left foot. There continue to be blisters/fluid-filled pockets intact to the top of the left foot and pinky toe. No drainage noted at this time. No signs or symptoms of infection were noted. Continued daily wound care in place. No c/o pain verbalized. (continued on next page)

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Paradigm at Kountze	604 Fm 1293 Kountze, TX 77625

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #24's Occupation therapy note dated [DATE] revealed: a new goal, Patient will improve the ability to safely and efficiently perform eating tasks with setup or clean up assistance with use of to ensure adequate nutrition and hydration and no spillage target date of [DATE]. Record review of Resident #24's progress note dated [DATE] By the facility NP revealed an [AGE] year-old male resides at [facility] as a long-term resident. The resident was a DNR with a history of Diabetes, Dementia, and multiple other chronic conditions for which he was being monitored. The resident can get around by wheelchair. The resident continues working with PT/OT during the week. The Resident recently spilled coffee on himself. The resident had a blister to the top of the left foot that shows no signs of infection. Record review of Resident #24's skincare observation dated [DATE] at 3:34 p.m., revealed Resident #24 had redness to his left toe and scabbed area to the left front lower leg with Silvadene applied. The skin care observation failed to include the size of the redness on the left lower leg. Record review of Resident #24's skincare observation dated [DATE] at 3:22 p.m., revealed Resident #24 had redness to his left pinky toe with Silvadene applied. The skin care observation failed to include the size of the redness on the left pinky toe. Record review of Resident #24's skincare observation did not indicate a skin assessment for [DATE] and [DATE]. Record review of Resident #24's skincare observation dated [DATE] at 4:27 p.m., revealed Resident #24 had no skin concerns to his left lower leg or toe. The skin care observation failed to include the size of the redness on the left lower leg or toe. During an interview on [DATE] at 4:10 p.m., Resident #24 said he remembered spilling his coffee on his left leg sometime back. He said he remembered getting coffee from the coffee pot and then he went to his seat and somehow spilled his coffee on his leg. He said he was unaware at first, he had any skin problems related to the coffee spill until the unknown staff told him. He said he knew the unknown staff did treatments on his leg but could not remember how long. He said the area was healed. During an interview on [DATE] at 4:12 p.m., MA F said she thought they did an in-service after Resident #24 had a coffee spill but it had been so long ago, that she did not remember. She said the coffee remained in the dining room and the residents could get coffee at any time. During an interview on [DATE] at 4:15 p.m., CNA H said he was aware Resident #24 spilled coffee on his leg. He said he had some blisters and the nurses did treatment on them. He said Resident #24 got his own coffee and still did. He said they had cups sitting next to the coffee area. He said he could not remember if they have had an in-service or not on coffee spills. During an interview on [DATE] at 4:24 p.m., the treatment nurse said she was aware Resident #24 had spilled coffee on his left leg. She said she applied Silvadene cream until it healed. She said she could not remember what they looked like when she first started treating them but he did have blisters. She said she could not remember if they had an in-service on the coffee spill. She said she was unaware of any other coffee spills until today ([DATE]) when another resident spilled his coffee on his pants between lunch and supper. She said he was assessed and had no injuries. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 4:41 p.m., the DON said she had gone home on the day Resident #24 had spilled coffee on himself. She said the nurse at the facility called her and then she called her RNC. She said she explained what had happened and the RNC told her to have staff call the doctor and follow his directions. She said she asked the RNC if that incident needed to be reported to the State of Texas and was told no. She said the nurses called the doctor and obtained orders. She said they had OT to evaluate him to see if he had a dexterity problem and she did not remember them saying he did. The DON said she could not recall if she did an in-service related to the coffee spill. She said they had not had any more issues with coffee spills until today ([DATE]) when another resident spilled his coffee on his pants between lunch and supper. She said he was assessed and had no injuries. She said she thought they did everything they needed to do after Resident #24 obtained his coffee burn; she said they notified the RNC, and the doctor, obtained treatment orders, and had OT elevate him. She said she was not aware of any hot liquid assessment nor did she renotify the RNC after Resident #24 developed blisters on his foot. During an interview on [DATE] at 4:56 p.m., the rehab director- said she remembered when Resident #24 spilled coffee on himself. She said he had OT and they determined he did not need any special devices for his coffee. During an interview on [DATE] at 05:15 p.m., the Administrator said she was aware Resident #24 had spilled coffee on his leg. She said she was still in the facility at the time of the coffee spill. She said she went into the kitchen and looked at the temperature of the coffee. She said it was at 165 degrees. She said the DON called the RNC and explained what had happened and was given the directions to monitor Resident #24 because he was able to tell us what happened. She said to her knowledge the area on Resident #24's leg was just a reddened area. She said sometime later she became aware that Resident #24 had developed blister(s) and they treated them. She said after the blister(s) came up she did not renotify the RNC. She said she did not recall an in-service about the coffee spill but they discussed the coffee spill in the morning meeting and at-the risk meeting. She said they decided from the meeting that if any resident needed help with the coffee; then staff should assist them. She said they did not have any form of written communication with the at-risk residents. She said they communicated this process through word of mouth to the staff. She said she was unaware of any hot liquid assessments. She said she thought they did everything they needed to do after Resident #24 spilled his coffee and obtained a 2nd-degree burn. She said she checked the temperature of the coffee, had OT evaluate him, and the nurses did his treatment until the area resolved., She said they had not had any issues with coffee spills until today ([DATE]). She said another resident spilled his coffee on himself during lunch. She said they assessed him and he had no injuries. During an observation and interview on [DATE] at 4:26 p.m., a coffee pot and no lids were in the dining room unattended. MA F came into the dining room and verified the coffee pot was left unattended. She said as far as she knew the coffee stayed on all the time and residents were allowed to get coffee at any time. During an observation on [DATE] at 7:30 a.m., 12 residents were sitting in the dining room and 4 residents had coffee cups sitting in front of them with no staff in the dining area. Coffee pots and cups were available for any resident to obtain their own coffee. During an attempted phone interview on [DATE] at 07:48 a.m., the facility NP was unable to be reached; a message was left. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an attempted phone interview on [DATE] at 08:09 a.m., LVN R was unable to be reached; a message was left. During an interview on [DATE] at 8:25 a.m., the RNC said she was told Resident #24 had a coffee spill on his foot. She said the process was for the nurses to notify her, complete a head-to-toe skin assessment, notify the doctor, and if treatment was needed, complete an SBAR and incident report. The RNC said they should have completed an investigation to find the root cause, complete a hot liquid assessment, and update Resident #24's care plan. During an attempted phone interview on [DATE] at 08:37 a.m., LVN Q was unable to be reached; a message was left. During an interview on [DATE] at 09:35 a.m., Housekeeper U said she had been at the facility for 2 months and had seen residents coming up to get coffee by themselves. She said the coffee pot sat out all the time. During a phone interview on [DATE] at 10:55 a.m., the NP said she remembered Resident #24 having a coffee spill. She said she could not remember what it looked like. She said if he spilled coffee and then developed blisters then it would be classified as a 2nd-degree burn. Record review of facility policy titled, Incidents/Accidents, dated ,d+[DATE], indicated, The facility will assess residents for risk factors of potential accidents/ hazard. The facility will recognize signs of incidents and accidents and assist residents, as indicated. The facility will conduct thorough investigations as indicated to determine underlying causes and contributing factors to incidents and accidents; and would put interventions in place from the investigative findings and IDT input Charge nurse procedure: the resident's care plan will be updated to reflect the incident or accident with interventions to prevent further occurrence as indicated Special considerations: the facility administrator should determine incidents or accidents that require thorough investigation and ensure completion. Record review of the facility policy titled, Hot Liquids, dated ,d+[DATE] indicated, The facility will adhere to safe practice when preparing, handling, and serving hot liquids. The facility aims to prevent burns and injuries from hot liquids, ensuring the safety and well-being of residents and staff. #1 Procedure: preparation and handling hot liquids or prepared and served at a safe temperature to prevent scalding and burns. #2 Transportation: used insulated containers with secure lids for transporting hot liquids to prevent spills #3. Serving: if a resident is alert and able to follow commands, encourage them to exercise caution before consuming hot liquids, and do not overfill cups. #4 Safeguard: allow hot liquids to cool before serving. #5 Monitoring: the facility will routinely inspect the equipment used to prepare and serve hot liquids to ensure it is in good working order. #6 Residents at risk: provide appropriate assistance and supervision to residents consuming hot liquids considering risk factors such as cognition impairment, visual impairment, behavioral, tremors, and functional impairment. The resident care plan should reflect any assistive devices or interventions required to safely consume hot liquids. #7 Incident response: provider first aid cool the burn with running cold water do not use ice or greasy substances, conduct an investigation as needed, document the findings in the electronic medical records, and update the care plan with any interventions initiated to prevent reoccurring. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 9:33 a.m., the Administrator was notified. The Administer was provided with the IJ template on [DATE] at 9:34 a.m. and a POR was requested. The following Plan of Removal submitted by the facility was accepted on [DATE] at 6:20 p.m.: The facility failed to Implement measures to prevent other coffee spills with burns, monitor temperatures of hot liquids served to residents, identify at risk resident, and failed to assess Resident #24 for hot liquid safety. On [DATE], Resident #24 accidentally spilled hot coffee on his left foot/ankle, resulting in redness. The charge nurse completed SBAR, skin assessment, pain assessment, and an incident report on the same day. The MD was informed and ordered daily application of Sulfadiazine to the affected area. On [DATE]th, 2024, OT evaluated Resident #24 with a long-term goal of safely eating and drinking without injury, with a focus on handling hot beverages. Resident #24 was on caseload from [DATE]-[DATE] and met his goals. On [DATE], the Director of Nursing assessed Resident #24 regarding safely consuming hot liquids and noted that Resident #24 had no changes in prior assessments and could safely consume hot liquids. Resident # 24 was discharged from OT services on [DATE] being independent with feeding. Resident #24's care plan was reviewed and required no updates. The self-service coffee station in the dining room was promptly removed on [DATE], and all coffee distribution will be supervised. The Administrator notified the Medical Director of the Immediate Jeopardy on [DATE]. On [DATE], the Director of Nursing initiated education with all staff- topics included: safe practices for preparing, handling, and serving hot liquids, emphasizing no unsupervised pouring of hot liquids by residents. Completion Date [DATE]. On [DATE], the Director of Nursing initiated education with all licensed nurses- topics included: procedures to follow in the event of an adverse hot liquid incident, including providing first aid, notifying the physician and responsible party, implementing new orders, completing an incident report, documenting findings in the EHR, and updating the resident's care plan with interventions as needed to prevent recurrence. Licensed nurses will receive education before their next shift, with new hires receiving training during orientation. Completion Date [DATE]. The Dietitian initiated education with dietary staff on [DATE]- topics included: checking temperatures before serving hot liquids to residents and documenting them on a hot liquid temperature log. All dietary members will receive this education before their next shift, with new hires receiving training during orientation. Completion Date [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing initiated education with CNAs and Licensed Nurses on [DATE]- topics included: providing adaptive equipment (for example: specialized cups/lids) if indicated by the resident's care plan and how to use the equipment. CNAs and Licensed Nurses will receive the education before working their next shift, with new hires receiving the education on orientation. Completion Date: [DATE]. The Charge Nurse will identify residents with changes in condition that may affect their ability to safely consume hot liquids, such as cognitive or functional impairments, and update their care plans accordingly. New admissions and readmissions undergo screening through a baseline care plan process to screen for the safe consumption of hot liquids. On [DATE], the Director of Nursing and Assistant Director of Nursing reviewed all residents to ensure they could safely consume hot liquids, updating care plans as necessary for any special considerations. No adverse findings were noted. The Administrator reviewed the Hot Liquid Policy and Procedure on [DATE], with no adverse findings. The Administrator confirmed the availability of specialized cups/lids on [DATE] with no adverse findings. On [DATE] the surveyors confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of in-services done on [DATE] by the DON given to all staff on hot liquids, revealed Residents could no longer self-serve when getting coffee. They must ask dietary staff for a cup of coffee when a resident requests a cup. Please review the attached policy and procedure on hot liquids. Record review of in-services done on [DATE] by the DON given to nursing and CNAs on lids for beverages, revealed 5 residents at risk of hot liquid spills. It instructed staff to look at the Kardex card for resident care information. Record review of the in-service on burn (incident response) dated [DATE] given by the DON to the nurses revealed anytime a resident had a burn from hot liquids you must provide #1 provide first aid, #2. notify the doctor or NP, #3. implement any new orders, #4. complete risk management, #5. investigate if needed, #6. document findings in chart and #7 update the care plan. Record review of the facility QAPI meeting held on [DATE] in were they created a four-point plan to address issues to prevent coffee spills with fire the facility will continue to monitor training and will monitor residents for any issues or adverse effects. #1. Corrective action #2 Identification of others #3 Systematic changes and #4 Monitoring. Record review of the hot liquid assessments dated [DATE] revealed all 43 residents were assessed. Record review of hot liquid care plans dated [DATE] revealed that 5 of 43 residents were at risk for hot liquid spills. All 4 residents' care plans were reviewed and had an updated care plan with interventions related to hot liquids.1 resident expired today ([DATE]). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #24's care plan updated [DATE], revealed he was at risk for injury related to consuming hot liquid (not limited to coffee, tea, or soup) related to a history of spills with injury on [DATE]. His interventions were to encourage the resident not to carry hot liquids while self-propelling in the wheelchair, to keep coffee away from the edge of the table, and to exercise caution before consuming hot liquids. Observation of the coffee pot removed from the dining room on [DATE]. During Interviews on [DATE] from 9:00 a.m. until 12:20 p.m. with 1 RN 6 am-6 pm (RN B), 3 PRN RN (RN Z, RNAA,RN BB),1double weekend (RN Y) 6 am-6 pm 3 LVN (LVN G, LVN P, LVN A,), 1 PRN LVN (LVN X) 2 6p-6a (LVN O, LVN R,), 2MA (MA F, MA T)and 6 am-6 pm 4 CNAs (CNA S, CNA M, CNA DD), 2 CNAs 6 pm-6 am (CNA CC, CNA EE), 2 PRN CNA (CNA GG,) 2 Hospitality aide(HA V, HA W) Dietary staff 4 Cooks (Cook HH, dietary D, dietary C, and dietary II), housekeeping department 2 housekeepers (Housekeeper V, Housekeeper FF), Therapy Department 1 therapist (JJ) and the Administrator, DON ADON, MDS, BOM, HR, SW, Dietary manager, Maintenance supervisor, Rehab Supervisor, and activity director all who indicated they received a written in-service regarding the process of hot liquids. They said the coffee could no longer be left out and they must ask dietary for the coffee. They said they could look at the Kardex card for information. They were able to identify the 5 at-risk residents. Nurses said if a resident did get a burn, they were to apply a cool towel to the area, assess, notify the doctor, investigate what happened, complete an incident report, and document findings in the resident's chart. During a phone interview on [DATE] at 12:30 p.m., the facility Medical Director said he was aware of the IJ received and attended a QAPI meeting via phone over the hot liquid process. During an interview on [DATE] at 2:36 p.m. the DON said the failure was they did not immediately remove the source for the injury when Resident #27 spilled coffee on himself. She said the RNC reviewed the policy and procedure with her to ensure she had the correct understanding then she educated staff on their policy and procedure. She said the RNC said they could have done things differently but now she understood the process. During an interview on [DATE] at 12:14 p.m. the Administrator said they started the process by removing the coffee pot from the dining room . She said the nurses assessed all the residents and identified 5 residents who were at risk of hot liquid spills. She said those 5 residents' care plans were updated. She said they in-serviced staff on the correct hot liquid policy. She said the dietary staff had a list of the 5 at-risk residents. She said they also educated staff to report to the charge nurse if they saw any resident shaking or at risk of spilling coffee. She said the nurse would assess the resident and update the care plan if needed. She said she did feel assured that if an event such as a coffee burn occurred again, staff would know how to manage the situation. She said the RNC did say after Resident #27 developed blisters, she should have been renotified. The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 12:28 p.m. The facility remained out of compliance at a scope of isolated and a severity level of no actual harm with a potential for more than minimal harm that is not immediate jeopardy and due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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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** 46928 Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided with professional standards of practice for 1 of 3 residents reviewed for quality of care. (Resident #19) The facility failed to ensure Resident #19's oxygen order was changed to as needed or discontinued. This failure could place residents who receive respiratory care at risk for developing respiratory complications. Findings included: 1. Record review of Resident #19's face sheet dated 07/23/2024, indicated a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #19's diagnoses included hypertensive heart disease (complications of high blood pressure that affect the heart) with heart failure (condition in which the heart does not pump as well as it should), essential hypertension (high blood pressure), Alzheimer's disease (progressive disease that destroys memory and other important mental functions), and cerebellar stroke syndrome (occurs when blood supply to the cerebellum, an area of the brain responsible for movement and balance, is stopped). Record review of Resident #19's annual MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. The MDS assessment indicated Resident #19 had a BIMS score of 10, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #19 had received oxygen therapy within the last 14 days of the look back period. Record review of Resident #19's comprehensive care plan dated 04/18/2024 indicated Resident #19 had shortness of breath and was at risk for respiratory distress/failure and increased episodes of shortness of breath as evidenced by oxygen continuously at 2-3 liters per minute. The care plan indicated a resolved date of 06/27/2024. Record review of Resident #19's order summary report dated 07/23/2024, indicated Resident #19 had an order for oxygen at 2-3 liters per minute via nasal cannula continuously and monitor oxygen saturation every shift for shortness of breath with an order date of 01/13/2024. Record review of Resident #19's medication administration record dated 07/01/2024-07/31/2024, indicated Resident #19 had received oxygen 2-3 liters per minute via nasal cannula continuously for shortness of breath. During an observation and interview on 07/22/2024 at 3:32 PM, Resident #19 was sitting in her wheelchair in the dining room. Resident #19 was not receiving oxygen and she said she did not use oxygen. During an observation on 07/23/2024 at 7:43 AM, Resident #19 was in her wheelchair in the dining room drinking coffee. Resident #19 was not using oxygen and did not appear to be short of breath. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 07/23/2024 at 2:45 PM, Resident #19 was in her bed. Resident #19 was not using oxygen and did not appear to be short of breath. During an interview on 07/23/2024 at 2:53 PM, CNA H said Resident #19 did not use oxygen. He said she had needed oxygen in the past but was recently taken off. During an interview on 07/23/2024 at 2:57 PM, LVN A said Resident #19 was receiving oxygen only as needed. LVN A said the order read Resident #19 required oxygen continuously and should have been updated. LVN A said it was the nurse's responsibility to ensuring the Resident's orders were correct. LVN A said Resident #19 lungs could be damaged if they were administering oxygen and she did not need it. During an interview on 07/25/24 at 09:58 AM, the DON said she expected the nurses to follow the physicians' orders. The DON said they should have obtained an order to discontinue the oxygen. The DON said by not following the physician's orders and Resident #19 truly needed the oxygen, Resident #19 was at risk for having low oxygen saturations. The DON said the nurses were responsible for following the physician's orders and they should have caught it during their daily rounds. The DON said the nurses should have not marked on the medication administration record that Resident #19 was still receiving oxygen. During an interview on 07/25/24 at 10:23 AM, the Administrator said Resident #19 had not needed oxygen for a couple of months. The Administrator said the oxygen order should have been discontinued. The Administrator said the nurses should have not been checking it off on the medication administration record as she was still receiving it. The Administrator said the nurses should have caught it when it appeared on their MAR to check off. The Administrator said each nurse that worked the hall Resident #19 resided, was responsible ensuring Resident #19's order was correct. The Administrator said if Resident #19 needed the oxygen and she was not receiving it, her oxygen levels could have dropped and caused respiratory issues. Record review of the facility's policy and procedure Oxygen Therapy: General Administration and Care revised on 08/2019, indicated . It is the policy of this facility that the facility will provide oxygen therapy by means of various administration devices . Procedures: 1. Review physician's order on the chart for completeness: a Modality, Liters, Frequency . 8. Start o2 flow rate at the prescribed liter flow or appropriate flow for administration device . Record review of the facility's policy Medication and Administration and Management revised on 06/2019 indicated It is the policy of this facility that the facility will implement a Medication Management program that incorporated systems with established goals to meet the residents needs as well as regulatory requirements . The authorized licensed or certified/permitted medication aide or by state regulatory guidelines staff member follows the MAR prepared for the patient/resident by identifying the: A. The Right Patient/Resident B. The Right Drug C. The Right Dose D. The Right Time E. The Right Route F. The Right Charting G The Right Results H. The Right Reason . identifies that the following information but not limited to, is documented on the MAR: A. Correct physician's order B. Medication label are correct C. Label and physician's order are correct .

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	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

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on interview and record review, the facility failed to ensure residents were seen by a physician at least once every 30 days for the first 90 days after admission for 1 of 16 residents (Resident #245) reviewed for physician services. The facility failed to ensure Resident #245 was seen by a physician within the first 30 days of her admission to the facility. This failure could place the residents at risk for medical conditions not being identified, care needs not being met, and a decline in health status. The findings included: Record review of the face sheet, dated 07/24/2024, revealed Resident #245 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (a common lung disease causing restricted airflow and breathing problems), neurocognitive disorder with Lewy bodies (a type of progressive dementia that leads to a decline in thinking, reasoning and independent function), aneurysm of the ascending aorta, without rupture (an abnormal bulging and weakening in the aorta at the upward part of the arch). Record review of the admission MDS assessment, dated 06/04/2024, revealed Resident #245 had a BIMS score of 10, indicating cognition was moderately impaired. Record review of the physician progress notes, dated 07/25/2024, revealed Resident #245 was seen by the physician on 07/16/2024. During an interview on 07/25/2024 at 10:00 a.m., the ADON stated the initial visits should have been performed by the physician within 30 days of admission to the facility. The ADON stated it was the responsibility of the nursing staff to fax a list of new admissions to the physician to ensure the initial visit was completed by the physician. The ADON stated it was important to ensure the physician was performing the initial visits to make sure the orders were correct. The ADON stated she would monitor by making a binder for physician initial visits. During an interview on 07/25/2024 at 10:45a.m., the DON stated, per the guidelines, the initial visits should have been performed by the physician. The DON stated she the nursing staff was responsible for monitoring to ensure the initial visit was completed by the physician. The DON stated it was important to ensure the physician was performing the initial visits, so the resident was aware who was overseeing their care. During an interview on 07/25/2024 at 11:10 a.m., the Administrator stated the Medical Director was responsible for performing the initial visits for residents. The Administrators stated the nursing staff was responsible for monitoring to ensure the physician performed the initial visits for residents. The Administrator stated it was important to ensure the physician performed the initial visits for residents because he was the trained professional and he would know what the resident needs. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/25/2024 at 12:54 p.m., the Medical Director stated the initial visits for new admission should have been performed by the physician. The Medical Director stated follow up visits were able to be completed by the nurse practitioner. The Medical Director stated he depended on the staff to let him know who to see and the ball was dropped on Resident #245. The Medical Director stated it was important to ensure the initial visit was performed by the physician to he was able to go through the resident's history and develop a plan of care. Record review of the Physician Services policy, revised February 2022, revealed Each resident must be under the care of a licensed physician authorized to practice medicine in the state. All residents shall be provided with emergency and/or alternative physician care

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services, which included procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 8 resident (Resident #15) reviewed for pharmacy services. The facility did not ensure LVN A administered Resident #15's nasal spray according to the manufacturer's instructions. This failure could place the resident at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: Record review of Resident #15 face sheet, dated 07/24/2024, indicated Resident #15 was a [AGE] year-old female, readmitted to the facility on [DATE] with a diagnosis which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of the Resident #15's quarterly MDS, dated [DATE], indicated Resident #15 understood others, and made herself understood. Resident #15 had a BIMS score of 10, which indicated her cognition was moderately impaired. Record review of the Resident #15's care plan, revised 03/09/2024, indicated Resident #15 sometimes had a cough and SOB and will be taking Flunisolide Solution. The care plan interventions included nursing staff to administer and monitor nebulizer treatments and side effects. Record review of the medication review report, dated 07/24/2024, indicated Resident #15 had an order, which started on 01/02/2021, for Flunisolide Solution (used to treat year-round allergy symptoms) 25 mcg/act (0.025%), one spray into both nostrils two times a day for nasal spray. During an observation and interview on 07/23/2024 at 7:58 a.m., LVN A administered Resident #15's nasal spray without having her to blow her nose prior to administration. LVN A stated she should have asked Resident #15 to blow her nose prior to administering medication. LVN A stated, She was eating and honestly I didn't think about it. LVN A stated it was important to have resident blow their nose prior to administering nasal spray to prevent aspiration. During an interview on 07/25/2024 at 10:41 a.m., the DON stated LVN A should have asked Resident #15 to blow her nose prior to administering the nasal spray. The DON stated she was responsible for monitoring and overseeing by random medication pass. The DON stated she had not noticed any issues in the past. The DON stated it was important to ask the resident to blow their nose prior to ensure the medication was working properly. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/25/2024 at 11:25 a.m., the Pharmacist Consultant stated she comes once a month to the facility to look at medication rooms/carts/charts and watch a medication pass. The Pharmacist Consultant stated LVN A should ask the resident to blow their nose prior to administering the nasal spray. The Pharmacist Consultant stated she had not noticed in issues during her medication pass. The Pharmacist Consultant stated it was important to ensure residents blow their nose prior to administering nasal spray to clear the nasal passages. During an interview on 07/25/2024 at 11:34 a.m., the Administrator stated she expected LVN A to ask Resident #15 to blow her nose prior to administering the medication. The Administrator stated the DON was responsible for monitoring and overseeing medication administration. The Administrator stated it was important to ensure residents blow their nose prior to administration to clear nasal passages and medication effectives. Record review of a Licensed Nurse Competency indicated LVN A had completed her trainings for infection control and medication management on 02/29/2024. Record review of the facility's policy titled Nasal Administration last revised on 08/2020, indicated . medications will be administered in a safe and effective manner. The guidelines in this policy detail how to administer nasal sprays or drops . Nasal Spray/Pump/Inhaler 5. if possible, have the resident gently blow their nose to remove excess mucous . Record review of the manufacturer's guideline titled Flunisolide Prescribing Information revised 05/2019 indicated . gently blow nose to clear nostrils. If nose is blocked, use medicine your doctor has recommended to open nasal passages .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review, the facility failed to ensure that residents were free of significant medication errors for 1 of 9 residents reviewed for pharmacy services. (Resident #19) The facility failed to ensure Resident #19's amlodipine (blood pressure medication) was not administered when her blood pressure was outside of the ordered parameters on 07/06/2024, 07/15/2024, and 07/21/2024. The facility failed to ensure Resident #19's losartan (blood pressure medication) was not administered when her blood pressure was outside of the ordered parameters on 07/06/24 and 07/21/24. These failures could place the resident at risk of medical complications and not receiving the therapeutic effects of their medications. Findings included: 1. Record review of Resident #19's face sheet dated 07/23/2024, indicated a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE]. Resident #19's diagnoses included hypertensive heart disease (complications of high blood pressure that affect the heart) with heart failure (condition in which the heart does not pump as well as it should), essential hypertension (high blood pressure), Alzheimer's disease (progressive disease that destroys memory and other important mental functions), and cerebellar stroke syndrome (occurs when blood supply to the cerebellum, an area of the brain responsible for movement and balance, is stopped). Record review of Resident #19's annual MDS assessment dated [DATE], indicated she was able to make herself understood and understood others. The MDS assessment indicated Resident #19 had a BIMS score of 10, which indicated her cognition was moderately impaired. The MDS assessment indicated Resident #19 required substantial/maximal assistance with toileting, showering, and personal hygiene. Record review of Resident #19's comprehensive care plan revised on 04/18/2024, indicated Resident #19 has a history of hypertension and is at risk for fluctuations in blood pressure values, hypo/hypertension and other complications. The care plan indicated Resident #19 was taking amlodipine and losartan. The care plan interventions indicated to give medications as ordered. Record review of Resident #19's medication administration record dated 07/01/2024-07/31/2024, indicated Resident #19 had orders for amlodipine 10 mg tablet give one tablet in the morning with instructions to hold for SBP less than 140 or DBP less than 60 and Losartan 25 mg give one tablet by mouth two times a day with instructions to hold for SBP less than 130 or DBP less than 60. *On 07/06/2024 at 08:00 AM, Resident #19's blood pressure was 112/60. The medication administration record had a check mark which indicated Resident #19 was administered an amlodipine 10 mg tablet and a losartan 25 mg tablet outside the parameters. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*On 07/15/2024 at 08:00 AM, Resident #19's blood pressure was 128/67. The medication administration record had a check mark which indicated Resident #19 was administered an amlodipine 10 mg tablet outside of the parameters. *On 07/21/2024 at 08:00 AM, Resident #19's blood pressure was 120/64. The medication administration record had a check mark which indicated Resident #19 was administered an amlodipine 10 mg tablet and a losartan 25 mg tablet outside of the parameters. During an interview on 07/25/2024 at 4:45 PM, MA T said a check mark on the medication administration record indicated the medication was administered. MA T said Resident #19's losartan and amlodipine should have not been administered when her blood pressure was outside of the ordered parameters. MA T said Resident #19 was at risk for her blood pressure bottoming out. MA T said the medication aide, or the nurse was responsible for ensuring medications were being administered as ordered. MA T said she had been checked off on medication administration competency. During an interview on 07/25/24 at 4:54 PM, RN B said the check mark on the medication administration record indicated the medication was given. RN B said she expected Resident #19's blood pressure medications to not be given if the blood pressure was outside of the ordered parameters. RN B said since Resident #19 was given her blood pressure medication outside of the ordered parameters, she was at risk for her blood pressure to drop even more. RN B said the medication aide was responsible for ensuring the medications were being administered as ordered. RN B said the medication aide was responsible for notifying the charge nurse if a medication was not administered. During an interview on 07/25/2024 at 09:58 AM, the DON said she expected medications to be administered following the physician's orders. The DON said the medication aides and the nurses were responsible for ensuring the medications are being administered as ordered. The DON said since Resident #19's amlodipine and losartan were administered outside of the ordered parameters, she was at risk for her blood pressure dropping. The DON said she has provided the staff with in-services regarding medication administration they have been checked off on medication administration competency. During an interview on 07/25/2024 at 10:23 AM, the Administrator said she expected medications to be administered per the physician's orders. The Administrator said since Resident #19's blood pressure medications were administered outside of the ordered parameters, then Resident #19 was at risk for her blood pressure dropping and causing all kinds of issues. The Administrator said the person administering the medication was responsible for ensuring the medications were being administered as ordered. Record review of the facility's policy Medication and Administration and Management revised on 06/2019 indicated It is the policy of this facility that the facility will implement a Medication Management program that incorporated systems with established goals to meet the residents needs as well as regulatory requirements . The authorized licensed or certified/permitted medication aide or by state regulatory guidelines staff member follows the MAR prepared for the patient/resident by identifying the: A. The Right Patient/Resident B. The Right Drug C. The Right Dose D. The Right Time E. The Right Route F. The Right Charting G The Right Results H. The Right Reason . identifies that the following information but not limited to, is documented on the MAR: A. Correct physician's order B. Medication label are correct C. Label and physician's order are correct .

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on interview and record review, the facility failed to ensure laboratory services were obtained to meet the needs of 1 of 16 residents reviewed for laboratory services. (Resident #4) The facility did not ensure Resident #4's Keppra (a medication for seizure disorder) level was obtained and monitored. This failure could affect residents by placing them at risk for not having their medications at a therapeutic level and increasing their risk for seizures. Findings included: Record review of a face sheet dated 07/24/2024, indicated Resident #4 was a [AGE] year-old male, admitted on [DATE] with the diagnoses of seizures (a burst of uncontrolled electrical activity between brain cells (also called neurons or nerve cells) that causes temporary abnormalities in muscle tone or movements (stiffness, twitching or limpness), behaviors, sensations or states of awareness), unspecified convulsions (rapid, involuntary muscle contractions that cause uncontrollable shaking and limb movement), disorder of bone density and structure, unspecified (Osteoporosis a bone disease that develops when bone mineral density and bone mass decreases, or when the quality or structure of bone changes). Record review of the most quarterly MDS assessment dated [DATE], indicated Resident #4 had a BIMS score of 06, which suggest cognitive impairment. Under the section of active diagnoses, the MDS indicated seizure disorder. Record review of the comprehensive care plan dated 03/22/2024, indicated Resident #4 had a seizure disorder and receives Levetiracetam (Keppra). The goal was to give medication as ordered, monitor labs, report results / abnormalities to medical doctor. Record review of an order summary dated 07/24/2024, indicated Resident #4's Keppra level to be performed on admission and every three months, last Keppra level drawn on 07/22/2024. The prior Keppra level was drawn 12/17/2023. During an interview on 07/24/2024 at 4:35 p.m., RN B stated when the nurses receive new orders, they were responsible for putting the orders into the computer, RN B stated it was important put orders in the computer correctly to ensure the residents get the right care. RN B stated if the orders are not the failure was the resident may not get the proper treatment. During an interview on 07/25/2024 at 10:00 a.m., the ADON stated the nurse practitioner gave orders to a nurse that was no longer employed at the facility to change the orders to draw Keppra level every 6 months instead of every 3 months. The ADON stated it was important to draw labs to ensure the medication was at a therapeutic level. The ADON stated she would monitor during the morning meetings. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/25/2024 at 10:45a.m., the DON stated she did not have a lab tracking system in place. The DON stated medications should be monitored to ensure effectiveness of the medication. The DON stated the nurses were responsible for the order processing. The DON stated the nurses should review the medications requiring monitoring of levels and when there was not a laboratory order then the nurses should obtain an order and process the laboratory order. The DON stated the failure was the resident may be getting to much medication or not enough medication. During an interview on 07/25/2024 at 11:10 a.m., the Administrator stated the nurses were responsible for ensuring laboratory levels were drawn. The Administrator stated the laboratory level result were needed to ensure the appropriate amount of medication was prescribed. Record review of the Nursing Policies and Procedures, Laboratory Testing policy, revised 06/2019, revealed To provide laboratory services that are accurate and timely, ensuring the utility of the laboratory testing for diagnosis, treatment, prevention or assessment was maximized

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interviews, and record reviews, the facility failed provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service for 1 out of 7 dietary staff. The facility did not ensure [NAME] E had a current food handler permit. This failure could place residents who consumed food prepared from the kitchen at-risk of foodborne illness or nutritional deficiencies. Findings included: Review of the food handler's certificates of completion provided by the facility on [DATE] at 1:00 p.m., revealed the following: Cook E had a food handler certificate that expired on [DATE]. An attempted telephone interview on [DATE] at 3:49 p.m. with [NAME] E, was unsuccessful. During an interview on [DATE] at 9:45 a.m., the Dietary Manager stated she was responsible for ensuring staff completed their food handler certificate training upon hire and every 2 years. The Dietary Manager stated she was unsure why [NAME] E had not completed her food handler certificate training. The Dietary Manager said [NAME] E had been working her assigned schedule since her food handler certificate had expired. The Dietary Manager stated she relied on her staff to ensure their trainings were up to date. The Dietary Manager stated the failure could potentially put residents at risk for food borne illness and cross contamination. During an interview on [DATE] at 11:34 a.m., the Administrator stated she expected the Dietary Manager to ensure the dietary staff had their food handler certificates within 30 days of hire and before they expired. The Administrator stated the importance of obtaining and maintaining the food handler certificate training was to teach staff how to prevent food-borne illness and cross contamination. Record review of the facility's policy titled Food Handler Certification revised ,d+[DATE] indicated . all personnel involved in the preparation, handling, or serving of food must obtain a food handler certification from a Texas Department of State Health Services approved provider. This certification is a mandatory requirement to ensure adherence to food safety standards and regulations Food hander certificates are valid for two years. Employees are responsible for renewing their certification before it expires .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 43047 Based on observation, interview and record review, the facility failed to ensure the meals served met the nutritional needs of residents for 1 of 1 meal (the lunch meal) reviewed for nutritional adequacy. The facility did not ensure the correct scoop size was used for the ground chicken during the lunch meal on 07/22/2024 . This failure could affect all residents in the facility who require ground food consistency by placing them at risk of not receiving adequate nutritive food value needed to promote/maintain health. Findings included: Record review of the production sheet dated 07/22/2204 indicated a #12 scoop size should have been used for the ground chicken. During an observation and interview on 07/22/2024 at 11:51 a.m., revealed [NAME] D was preparing the lunch trays using a #8 scoop size for the ground chicken. After [NAME] D prepared the meals, the surveyor asked, How do you know what scoop size to use per food item? [NAME] D stated she should have reviewed the production sheet prior to preparing the trays. [NAME] D stated she used a different scoop size because the scoop size that should have been used did not have holes in to drain the broth off the chicken. [NAME] D stated she should have used the #12 and figured out how to drain the broth with that scoop instead of using a different scoop. [NAME] D stated the failure could potentially put residents at risk for malnutrition or weight loss/gain. During an interview on 07/25/2024 at 9:45 a.m., the Dietary Manager stated her, and the cook were responsible for ensuring the correct portions sizes were served for every meal serving. The Dietary Manager stated the cook was to check the production sheet for the correct scoop size per food item prior to serving each meal item. The Dietary Manager stated she observed the preparation and serving of meals every day. The Dietary Manager stated she did notice problems in the kitchen with the dietary staff not serving with the correct scoop sizes per food item. The Dietary Manager stated that she verbally trained the staff on the production sheet. The Dietary Manager stated she had in-serviced staff as well on the scoop sizes by asking them to go and present her with the scoop size that she asked for. The Dietary Manager stated it was important to serve with the correct scoop size to ensure the residents get the right portion size for nutrition for their meals. An attempted telephone interview on 07/25/2024 at 10:05 a.m. with the Dietician, was unsuccessful. During an interview on 07/25/2024 at 11:34 a.m., the Administrator stated she expected the correct service size scoop be used for each meal item. The Administrator stated the Dietary Manager was responsible for monitoring and overseeing. The Administrator stated it was important to serve with the correct scoop size to ensure the residents get the correct amount of food that was ordered. The Administrator stated the failure could potentially put residents at risk for weight loss or malnutrition. (continued on next page)

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy titled Portion Control approved 10/01/2018 indicated . the facility will use standard portion control procedures and utensils to ensure that adequate portions are served to residents 3. Portions for each food item should follow the specific portion size listed on the menus . 4. Food item should be served using standard size ladles, scoops, spoodles and spoons

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility did not ensure: 1. Food items were labeled and dated. 2. Hair restraints were worn. 3. The microwave was clean and free of food debris. 4. The outside of the ice machine was clean. 5. The condiment cart was free from a dark/light substance. 6. The plate domes were stacked without water pooled in between them. 7. [NAME] D's nails were clean and free of a black substance. 8. The iced tea maker cart was free from a brown substance. 9. The trash can used for food waste had a lid. These failures could place residents at risk for foodborne illness. Findings included: During the initial tour observation and interview with the Dietary Manager on 07/22/2024 between 9:21 a.m. and 9:50 a.m., the following was revealed: 1. 2 [NAME] Choice margarins open date missing. 2. A jar of minced garlic open date missing. 3. A bottle of vegetable oil open date missing. 4. The microwave with several food debris substances. 5. The trash can used for waste next to the preparation table and stove did not have a lid. 6. The outside of the ice machine had a brown and white substance. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. Around the tea maker cart had a brown substance. 8. The dome covers were stacked and remained wet with water pooling in between. 9. The Dietary Manager, [NAME] D, and Dietary Aide C's hairnets were not covering their entire head and had hair showing. 10. [NAME] D had black substance noted under her approximately half-inch fingernail and was cutting sweet potatoes and carrots without using gloves. Record review of the Quality Assurance Kitchen/Food Service Monitor sheet dated 06/07/2024 indicated the microwave was dirty, the trash can without a lid, and wet nesting observed between stacked cups. During an interview on 07/25/2024 at 9:10 a.m., Dietary Aide C stated whoever took the food products out of the original package should have labeled and dated the items with an open date. Dietary Aide C stated hairnets were supposed to cover all of the hair. Dietary Aide C stated a lid should be on the trash can, always. Dietary Aide C stated the cooks were responsible for cleaning the microwave once a week and the aides were responsible for cleaning the outside of the ice machine once a week. Dietary Aide C stated all staff were responsible for cleaning and wiping down items in the kitchen. Dietary Aide C stated the dome covers should be air dried first before stacking. Dietary Aide C stated the failures put residents at risk for foodborne illness and cross contamination. During an interview on 07/25/2024 at 9:19 a.m., [NAME] D stated all staff were responsible for dating items when taking them out of the original package or when opened. [NAME] D stated the hairnet should cover the entire head while in the kitchen. [NAME] D stated the trash can was supposed to always have a lid on it. [NAME] D stated the cooks were responsible for cleaning the microwave and all staff were responsible for cleaning the ice machine. [NAME] D stated all staff were responsible for cleaning and sanitizing the kitchen. [NAME] D stated gloves should always be worn while preparing food. [NAME] D stated the failures could put residents at risk for food borne illness and cross contamination. An attempted telephone interview on 07/25/2024 at 10:05 a.m. with the Dietician, was unsuccessful. During an interview on 07/25/2024 at 9:45 a.m., the Dietary Manager stated cleanliness was important in the kitchen, so her staff were not spreading germs or contaminating anything. The Dietary Manager stated she was responsible for making sure the kitchen was cleaned appropriately. The Dietary Manager stated all food should be labeled with the date received and the date it was opened. The Dietary Manager stated hairnets should completely cover the hair. The Dietary Manager stated the trash can as supposed to be always be closed unless been used. The Dietary Manager stated the aide that was working that shift was responsible for cleaning the microwave and all staff were responsible for cleaning the ice machine and kitchen. The Dietary Manager stated the dome covers should be air dried first before stacking. The Dietary Manager stated gloves should always be worn while preparing food. The Dietary Manager stated she was responsible for monitoring and overseeing by daily walk throughs and when there was an issue staff were verbally in-serviced immediately. The Dietary Manager stated if the issue continued a write up was given. The Dietary Manager stated the failures could potentially put residents at risk for cross contamination, foreign debris getting into food and food borne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 07/25/2024 at 11:34 a.m., the Administrator stated she expected the kitchen to be clean and staff preventing cross contamination. The Administrator stated she expected all food to be labeled and dated. The Administrator stated she expected a lid to be on the trash can, the microwave be cleaned after each use and hairnets always worn. The Administrator stated she expected the kitchen to be clean and items wiped down routinely by their cleaning schedule. The Administrator stated the dome covers should be air dried first before stacking. The Administrator stated gloves should always be worn while preparing food. The Administrator stated her and the ADON did walk throughs at least monthly and if they noticed an issue, it was addressed immediately. The Administrator stated the Dietary Manager was responsible for overseeing and monitoring. The Administrator stated the failures put residents at risk for cross contamination and food borne illness. Record review of the facility's policy titled, Food Storage, revised on 06/01/2019 indicated, . to ensure that all food served by the facility is of good quality and safe for consumption, all food will be stored according to the state, federal and US Food Codes . Refrigerators (d) date, label all refrigerated foods using clean, nonabsorbent, covered containers that are approved for food storage . Record review of the State Operation Manual, revised 02/03/23, indicated, According to the Food Code, food service staff must wear hairnets when cooking, preparing, or assembling food According to the Food Code, gloves are necessary when directly touching ready-to-eat food. Record review of the facility's policy titled, Safe Food Handling, revised 2/2022 indicated, .3. Staff should avoid wearing jewelry and keep nails clean and neat. Staff should utilize gloves when necessary .8. Anyone working in the kitchen during normal food production hours is expected to wear appropriate hair restraints . Food/Beverage Prepared and Served by facility staff for patients/residents . 7. The food preparation area and utensils used to prepare the food are cleaned and sanitized prior to each use . Record review of the facility's policy titled, Cleaning of Microwave Oven, revised 06/2019 indicated, the microwave oven will be maintained in a clean, odor-free condition . Record review of the facility's policy titled, Sanitation and Food Safety in Food Service, revised 06/2019 indicated, 1. Infection control and sanitization practices are followed to minimize the risk of contamination of food and prevent food borne illness .

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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** 43047 Based on observation, interview, and record review, the facility failed to ensure the medical record was complete and accurately documented for 1 of 8 residents (Resident #244) reviewed for resident records. The facility did not ensure LVN A documented physician notification when Resident #244 refused his Lasix (medication used to treat swelling). This failure could place the resident at risk for not receiving appropriate care due to incomplete/inaccurate information being documented. Findings included: Record review of Resident #244's face sheet, dated 07/24/2024, indicated Resident #244 was a [AGE] year-old male, admitted to the facility on [DATE] with a diagnosis which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs). During an interview on 07/25/2024 at 8:34 a.m., LVN A stated Resident #244 was admitted to the facility on [DATE] and his MDS is not due to be completed at this time. Record review of Resident #244's care plan, revised 07/22/2024, indicated Resident #244 had episodes of refusal to take medications and was at risk for complications and injury/side effects. The care plan interventions included, educating resident on the potential complications of refusal of medications, and offer medications at scheduled times and re-offer at a later time if refused. Record review of the medication review report, dated 07/24/2024, indicated Resident #244 had an order, which started on 07/21/2024, for Furosemide (Lasix) 20 mg, one tablet by mouth two times a day related to COPD. During an observation on 07/22/2024 at 3:10 p.m., revealed MA F prepared Resident #244's medications for administration. MA F went into his room to administer the medication and Resident #244 stated No. Record review of a progress note dated 07/22/2024 indicated MA F notified the charge nurse regarding Resident #244 refusing his Lasix. Record review of Resident #244's electronic records on 07/23/2024 did not indicate LVN A notified the physician on 07/23/2024. During an interview on 07/23/2024 at 9:42 a.m., LVN A stated she call the Nurse Practitioner about Resident #244 refusing his Lasix on 07/22/2024. LVN A stated she should have documented that she notified the Nurse Practitioner. LVN A stated, Honestly I don't know why I didn't document that. LVN A stated the failure could affect his care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 07/23/2024 at 10:53 a.m., the Nurse Practitioner stated she was notified of Resident #244's refusing his Lasix. The Nurse Practitioner stated NNO were given at that time. During an interview on 07/25/2024 at 10:41 p.m., the DON stated the moment Resident #244 refused his medication and LVN A was notified by MA F she should have contacted the doctor, wait for new orders, and completed a progress note. The DON stated every morning a daily summary report was reviewed that listed residents' refusals, etc. The DON stated during her morning review if she noticed a missing documentation she would go and address the issue with that nurse or MA. The DON stated she has not noticed any issues in the past regarding missing documentation. The DON stated it was important to ensure documentation was completed so that the entire team would be on the same page regarding his care. The DON stated the failure could potentially put him at risk for COPD exacerbation. During an interview on 07/25/2024 at 11:34 a.m., the Administrator stated LVN A should have documented in electronic medical records that she notified the physician. The Administrator stated the DON was responsible for monitoring and overseeing. The Administrator stated the failure could put Resident #244 at risk for swelling which could cause respiratory issues. Record review of the facility's policy titled, Documentation-Licensed Nurse, revised on 06/2019 indicated, .it is the policy of this facility that documentation pertaining to the resident will be recorded in accordance with regulatory requirements . Medication and Treatments: 2) If a scheduled medication is withheld or not given as ordered, the nurse documents this and lists the reason for the resident not receiving the medication. The attending physician or physician extender must be notified Record review of the facility's policy titled, Change in Condition Communication, revised on 06/2019 indicated, .3. Notify the physician of the change in medical condition. The nurse will document all assessments and changes in the patient's/resident's condition in the medical record.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 43047 Based on record review and interviews the facility failed to ensure the arbitration agreement contained all the required elements for 1 of 1 facility reviewed for Arbitration Agreements. The facility did not ensure the arbitration agreement did not contain language that prohibited or discouraged the resident or anyone else (e.g., resident's representative) to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long Term Care Ombudsman. This failure could place the residents or the residents' responsible parties in binding agreements not fully understood, have a loss of their legal rights, and cause negative psychological issues. Findings included: Record review of a sheet titled Arbitration Agreement between Facility and Resident revised 06/2021 indicated the agreement did not allow the resident or anyone else (e.g., resident's representative) to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long Term Care Ombudsman. During an interview on 07/24/2024 at 2:24 p.m., the Admission Director stated she was responsible for the admission agreements and was not aware of the requirements of the arbitration agreement. The Admission Director stated she had 35 residents that had entered a binding arbitration. The Admission Director stated if the arbitration agreement was not per the regulation, it could affect the resolution. During an interview on 07/25/2024 at 11:34 a.m., the Administrator stated she was not aware the federal, state, or local officials such as federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long Term Care Ombudsman needed to be addressed on the agreement. The Administrator stated corporate was the one monitoring and overseeing by reviewing the agreements to ensure it was completed. The Administrator stated the failure could affect the resolution. The Administrator stated there was not a policy and procedure regarding arbitration.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 2 of 3 residents (Residents #'s 10 and 6) reviewed for hospice services. The facility failed to obtain Resident #10's most recent updated hospice plan of care and hospice medication record. The facility failed to maintain Resident #6's hospice binder containing information related to hospice services provided for the resident. These deficient practices could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings included: 1. Record review of Resident #10's face sheet dated 07/25/2024, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included nontraumatic intracranial hemorrhage (bleeding withing the skull), unspecified protein-calorie malnutrition (inadequate intake of protein and calories), cerebrovascular disease (condition that affects blood flow to the brain), and atrial fibrillation (an irregular heart rhythm). Record review of Resident #10's quarterly MDS assessment dated [DATE], indicated Resident #10 was understood and understood others. The MDS assessment indicated Resident #10 had a BIMS score of 10, indicating her cognition was moderately impaired. The MDS assessment indicated Resident #10 received hospice care. Record review of Resident #10's comprehensive care plan revised on 07/10/2024, indicated Resident #19 required hospice services as evidenced by terminal diagnosis of dementia. The care plan interventions included to assist with ADL's and provide comfort measures as indicated. Record review of Resident #10's facility order summary report dated 07/25/2024, indicated she had the following orders: *May admit to [hospice company] with an order date of 08/05/2022. *Colace 100mg give 2 capsules by mouth in the morning for chronic constipation with an order date of 05/25/2024. *Hydroxyzine 25 mg give one tablet by mouth every 12 hours as needed for itching with an order date of 12/27/2023. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #10's hospice plan of care order dated 05/24/2024, indicated Resident #10 had the following orders on her hospice medication record that were not on her facility's order summary report: *Ondansetron 4mg give one tablet every 6 hours as needed for nausea and vomiting with a start date of 03/20/2024. *Hydroxyzine 25mg give 0.5 tablet twice a day as needed for itching with a start date of 12/26/2023 . There was not a recent hospice plan of care or medication record noted in the Resident #10's electronic medical record or her hospice binder. The facility failed to ensure Resident #10's hospice medication orders reflected what Resident #10 was currently receiving at the facility. During an interview on 07/24/2024 at 2:34 PM, the Hospice DON said they hand delivered hospice documents to the facility on ce a month. The Hospice DON said it was the Hospice Case Manager who ensured the hospice documents at the facility were kept up to date. The Hospice DON said he expected the updated care plan to be at the facility with the medication list reconciled and reflecting what the resident was currently taking. The Hospice DON said it was important for the most recent plan of care with correct medications to be at the facility for coordination of care. During an interview on 07/24/2024 at 3:01 PM, Hospice RN L said was instructed by her hospice manager that someone from their office would be sending all the required hospice documents to the facility. Hospice RN L said she was unsure of who was responsible for sending the documents to the facility since she was not trained. Hospice RN L said she was never instructed to check if the documents were being brought to the facility. Hospice RN L said the most recent IDG meeting they had completed for Resident #10 was on 07/19/2024 and believed that one should have been at the facility as it included the most recent hospice plan of care. Hospice RN L said it was important for the most recent hospice documents with current medication record to be at the facility for coordination of care. During an interview on 07/24/2024 at 3:12 PM, the Medical Records staff member said the last email she received from Resident #10's hospice company was on 06/24/24 with the last updated plan of care dated 05/24/24. 45879 2. Record review of Resident #6's face sheet, dated 07/25/24 indicated he was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included, Parkinson's (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves), Anxiety(a feeling of fear, dread, and uneasiness), dementia (the loss of cognitive functioning - thinking, remembering, and reasoning), hypertension (high blood pressure), and Depression(sadness). Record review of Resident 6's significant change in status MDS assessment, dated 05/21/24, indicated Resident #6 was understood and understood by others. Resident #6 BIMs score was 11 indicating she was cognitively moderately impaired. The MDS indicated Resident #6 required assistance with his ADL's. The MDS indicated she was receiving hospice service. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #6's comprehensive care plan, dated 03/18/24, revealed Resident #6 was admitted to hospice for a diagnosis of Parkinson's. The intervention was for staff to assist with activities of daily living as needed, adapt care to the resident's energy levels and preferences, and notify hospice of any changes. Record review of Resident 6's Physician order dated 05/22/24 revealed Resident #6 was admitted to hospice with a diagnosis of Parkinson's. Record review of Resident #6's hospice binder revealed it did not have the Physician certification and recertification of the terminal illness, care plan, medication list, or hospice election form. During a phone interview on 07/24/24 at 3:03 p.m., Hospice RN J said it was her responsibility to drop off the hospice updates when they visited the residents or had their bi-weekly IDT meeting. She said she could not say why Resident #6's book was not updated because she had brought the information to the facility. She said Resident #6 had a hospice aide three times a week and a nurse once a week. She said Resident #6 had her last hospice bi-weekly meeting on 07/19/24. She said Resident #6 was due to have her recertification around 11/22/24. Hospice RN J said it was important to have the hospice binder in the facility to help correlate with care. She said she would bring all her updated information when she made her next scheduled visit. During an interview on 07/25/24 at 9:57 a.m., LVN G said the hospice book was a way of communication between the hospice and the facility to manage Resident #6's care. She said the book should contain her diagnosis, care plan, and medication list. She said it was also helpful to see the documentation of the nurses or aides during their visits. She said she had never had a hospice nurse bring her any paperwork to place in the hospice book. She said the hospice company was responsible to ensure the hospice book was updated. During an interview on 07/24/2024 at 4:58 PM, the ADON said she expected the hospice medications to match with what the resident was receiving at the facility for coordination of care. The ADON said the hospice companies were responsible for ensuring the hospice documents were being brought to the facility and were the most recent. The ADON said it was also their responsibility to ensure the hospice documents were being brought since the residents resided in their building. The ADON said by not having the most updated hospice documents at the facility could cause a resident to miss certain orders or treatments. During an interview on 07/25/2024 at 09:58 AM, the DON said she expected the hospice documents to be at the facility with the most recent plan of care and current medication orders. The DON said failure to ensure those documents were at the facility was a lack of communication with the facility and the hospice companies. The DON said there had not been any monitoring in place to ensure the hospice documents were being brought to the facility. The DON said it was the responsibility of the hospice company to ensure their documents were being brought to the facility timely and then it was the facility's responsibility to ensure that was being completed. During an interview on 07/25/2024 at 10:23 AM, the Administrator said it was ultimately the facility's responsibility to ensure all hospice documents were up to date. The Administrator said not having the most updated hospice documents including the plan of care with the current medication record, could cause the hospice company to send the wrong medication. Therefore, the residents could receive the wrong medication and cause a medication error. (continued on next page)

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	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.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the hospice services agreement between the facility and [the hospice company] dated 07/14/2022 indicated . Hospice shall furnish the facility any updated or revisions to the assessments, orders, or the plan of care in writing. Record review of the facility's policy Hospice Services revised on 03/2019, indicated . It is the policy of this facility to administer hospice or palliative care, also known as comfort care, when medically appropriate for residents who wish to participate so such principle of care as ordered by the physician .2. Facility staff follow established procedures for ongoing assessment, communication, and care collaboration between hospice care providers, physicians and facility staff .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #35) and 2 of 2 staff (CNA S and RN B) reviewed for infection control. 1. The facility failed to ensure CNA S performed hand hygiene before providing incontinent care to Resident # 35 on 07/22/2024. 2. The facility failed to ensure CNA S changed her gloves when going from dirty to clean when she provided incontinent care to Resident #35 on 07/22/2024. 3. The facility failed to ensure CNA S transported the dirty linen properly when she was walking down the hall on 07/22/2024. 4. The facility did not ensure RN B used a 2x2 gauze instead of a disinfectant wipe to wipe Resident #12's finger while checking her blood sugar. 5. The facility did not ensure RN B had prepared a barrier to place her supplies on. 6. The facility did not ensure RN B disposed of the disinfectant wipe, used to clean Resident #12's blood from her finger, in a plastic bag. These failures could place residents and staff at risk for cross-contamination and the spread of infection. Findings included: 1. Record review of Resident #35's face sheet dated 07/23/2024, indicated a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included congestive heart failure (condition when the heard cannot pump blood enough to meet the body's needs), Parkinson's disease (progressive disorder that affects the nervous system and causes movement problems), Alzheimer's disease (progressive disease that destroys memory and other important mental functions), and muscle wasting and atrophy (loss of muscle leading to shrinking and weakening). Record review of Resident #35's quarterly MDS assessment dated [DATE], indicated Resident #35 was able to make herself understood and understood others. The MDS assessment indicated Resident #35 had a BIMS score of 13, indicating her cognition was intact. The MDS assessment indicated Resident #35 required substantial/maximal assistance with toileting and showering. The MDS assessment indicated Resident #35 was always incontinent of urine and bowel. Record review of Resident #35's comprehensive care plan revised 03/28/2024, indicated Resident #35 was incontinent of bowel and bladder. The care plan interventions indicated Resident #35 used disposable briefs and to clean the peri-area with each incontinent episode. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 07/22/2024 at 09:54 AM, revealed CNA S entered Resident #35's to provide incontinent care. CNA S applied gloves and proceeded to remove Resident #35's disposable brief. CNA S did not wash her hands prior to starting care. CNA S cleaned Resident #35's perineal area using disposable wipes. CNA S removed Resident #35's dirty brief and applied a clean brief. CNA S did not change her dirty gloves when removing the dirty brief and applying the clean brief to Resident #35. CNA S completed the task, removed her gloves and washed her hands. CNA S said she had used hand sanitizer not long before she went to Resident #35's room. CNA S said they had not taught her in school to change her gloves when she provided incontinent care. CNA S said she should have washed her hands prior to starting care and she should have removed her dirty gloves when she removed the dirty brief and applied the clean brief to Resident #35. CNA S said failure to perform hand hygiene and change gloves was an infection control issue. CNA S said she was responsible for ensuring hand hygiene was performed prior to initiating care and changing her gloves when going from dirty to clean. CNA S said she had been checked off on incontinent care and hand hygiene. Record review of CNA S's Resident Care Specialist Competency dated 2/29/2024, indicated she was competent in hand hygiene and incontinent care. 2. During an observation on 07/22/2024 at 09:22 AM, CNA S was observed coming out of a resident's room with the dirty bed sheets in her hand. The dirty bed sheets were unbagged. CNA S walked approximately 15 feet to the soiled utility room to dispose the dirty linen. During an interview on 07/22/2024 at 09:27 AM, CNA S said she had been working at the facility for a year. CNA S said she forgot to bag the soiled linens before transporting it out of the resident's room. CNA S said it was important for soiled linens to be bagged when transporting in case it fell on the floor and for infection control. CNA S said she had been in-serviced before by ADON on infection control and transporting of soiled linen. During an interview on 07/22/2024 at 08:55 AM, the ADON/Infection Preventionist said she expected soiled linens to be placed in a plastic bag and not opened. The ADON said by not carrying the soiled linens bagged was an infection control issue. The ADON said the nurse aide carrying the soiled linens was responsible for ensuring it was placed in a plastic bag before transport. The ADON said she expected hand hygiene to be performed prior to initiating care and gloves to be changed when going from dirty to clean. The ADON said failure to perform hand hygiene or change the gloves could cause residents to obtain a urinary tract infection. The ADON said the staff performing the task was responsible for ensuring they performed proper hand hygiene and incontinent care. During an interview on 07/25/2024 at 09:58 AM, the DON said she expected the dirty linens to be bagged when transporting out of a resident's room. The DON said she expected staff to perform hand hygiene prior to initiating care and incontinent care to be performed appropriately. The DON said CNA S should have placed the soiled linens in a bag prior to transporting it out of a resident's room. The DON said CNA S should have changed her gloves when she removed the dirty brief and applied the clean brief to Resident #35. The DON said by not transporting soiled linens correctly, not performing hand hygiene prior to care, and not changing gloves when going from dirty to clean was an infection control issue which could cause residents to get infections. The DON said the nurse aide was responsible for ensuring proper hand hygiene was performed prior to initiating care, transporting the soiled linens appropriately, and providing proper incontinent care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/25/2025 at 10:23 AM, the Administrator said she expected the dirty linens to be bagged when transporting them out of a resident's room, staff to perform hand hygiene prior to initiating care, and incontinent care to be performed appropriately. The Administrator said CNA S should have placed the soiled linens in a bag prior to transporting it out of a resident's room. The Administrator said CNA S should have changed her gloves when she removed the dirty brief, washed her hands and applied clean gloves prior to applying the clean brief to Resident #35. The Administrator said by not transporting soiled linens correctly, not performing hand hygiene prior to care, and not changing gloves when going from dirty to clean was an infection control issue. The Administrator said the nurse aide was responsible for ensuring proper hand hygiene was performed prior to initiating care, transporting the soiled linens appropriately, and providing proper incontinent care. 43047 3. During an observation on 07/23/2024 at 10:29 a.m., revealed RN B prepared to obtain fingerstick blood sugar for Resident #12. RN B pulled a glucometer, 1 test strip, 1 lancet, alcohol wipe, gloves, and a disinfectant wipe from the medication cart and entered the resident's room. RN B placed the supplies on Resident #12's bed. RN B performed hand hygiene and put on gloves and proceeded to obtain the blood sugar reading. RN B placed the disinfectant wipe that she used to wipe the blood from Resident #12's finger on Resident #12's bed. During an interview on 07/23/2024 at 10:33 a.m., RN B stated she should have prepared a barrier on Resident #12's bedside table instead of using her bed to place her supplied on. RN B stated she was told by the DON that she could use a disinfectant wipe instead of a gauze to wipe the blood off Resident #12's finger. RN B stated she should have thrown the wipe in the trash instead of putting it on the bed. RN B stated, Honestly I didn't think about it. RN B stated the failure could cause an infection control issue. During an interview on 07/25/2024 at 8:50 a.m., the ADON stated she was the Infection Control Preventionist for the facility. The ADON stated RN B should have prepared a barrier to place her supplies on. The ADON stated she should have gathered a 2x2 gauze and a plastic bag along with the other items she gathered. The ADON stated RN B should have wiped Resident #12's finger with a 2x2 gauze after she punctured the finger to get a droplet of blood. The ADON stated RN B should have disposed the gauze in a plastic bag not the resident trash can. The ADON stated she should have used the disinfectant wipe to wipe down the glucometer not Resident #12's finger. The ADON stated she was responsible for monitoring by spot checks once a month. The ADON stated there had not been any issues with RN B in the past. The ADON stated if she noticed an issue, it was addressed right then. The ADON stated the failure could cause spread of infection. During an interview on 07/25/2024 at 10:41 a.m., the DON stated she did not instruct RN B to use a disinfectant wipe on Resident #12's finger. The DON stated she expected RN B to gather a 2x2 gauze, lancet, glucometer, alcohol pad, gloves, and a small plastic bag. The DON stated after RN B punctured Resident #12's finger she should have wiped the blood using a 2x2 gauze and discard the gauze in the plastic bag. The DON stated RN B should gave prepared a barrier for her supplies. The DON stated the ADON was responsible for monitoring and overseeing. The DON stated the failure could cause spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/25/2024 at 11:34 a.m., the Administrator stated RN B should have used a 2x2 or 4x4 to wipe Resident #12's finger. The Administrator stated RN B should have prepared a barrier for her supplies and grabbed a plastic bag to dispose her material in. The Administrator stated the ADON was responsible for monitoring and overseeing the infection control program. The Administrator stated the issue could cause spread of infection. Record review of a Licensed Nurse Competency indicated RN B had completed her trainings for infection control and medication management on 02/29/2024. Record review of the facility's policy Hand Hygiene revised on 06/2019, indicated . It is the policy of this facility that proper hand hygiene/hand washing technique will be accomplished at all times that handwashing is indicated. Hand hygiene/ Hand washing is the most important component for preventing the spread of infection . Hand hygiene/hand washing is done: before: A. Before patient/resident contact . Record review of the facility's policy and procedure Perineal Care revised on 12/2023, indicated . The facility will provide perineal care in a manner that maintains privacy, reduces the risk of infection, and promotes skin integrity. Procedure. Preparation. Wash hands thoroughly and apply gloves . Applying clean brief. Remove soiled gloves and dispose of them properly. Perform hand hygiene thoroughly. Apply new clean gloves. Assist the resident in lifting their hips or turn them to the side to place a clean brief under them . Record review of the facility's policy and procedure Infection Control: Linen- Handling/Transport revised on 03/2022, indicated . To ensure proper care and transportation of linens while supporting infection control measures . Sort, package, transport, and store linens in a manner that prevents the risk of contamination by dust, debris, soiled linens or other soiled items . soiled linens should be bagged and placed in the soiled linen container. Record review of the facility's policy titled Blood Glucose Monitoring revised 06/2019 indicated .bedside blood glucose monitoring will be performed by qualified medical personnel with a physician's order . equipment: lancets, alcohol wipes, 2x2 gauze, disposable gloves, glucometer and disinfectant wipes . 3. Observe standard precautions .12. Wipe the resident's finger with a 2x2 .