

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455699	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/28/2024
NAME OF PROVIDER OR SUPPLIER  Paradigm at the Creek		STREET ADDRESS, CITY, STATE, ZIP CODE  1405 Valhalla Dr Wharton, TX 77488	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 16352</p> <p>35822</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet residents' mental and psychosocial needs, for 2 (Resident #49, Resident #63) of 8 residents reviewed for care plans.</p> <p>-The facility did not care plan Resident #49 for oxygen via nasal cannula PRN.</p> <p>- The facility failed to ensure Resident #63's Comprehensive Care Plan reflected a revision for his slit penis when he came back to the facility from hospital on 5/17/23 with indwelling Foley catheter.</p> <p>This failure placed resident at risk for not receiving oxygen as needed and decrease in quality of life.</p> <p>Findings:</p> <p>Record review of Resident #49's face sheet dated 03/27/2024 revealed a [AGE] year old male that was admitted to the NF on 12/08/2021 and again on 09/03/2023 with the following diagnosis that included metabolic encephalopathy (chemical imbalance in the blood that effects how the brain functions) and cerebral infarction (disrupted blood flow to the brain).</p> <p>Record review of Resident #49's quarterly MDS dated [DATE] revealed that the resident's BIMS score was 3 indicating the resident's cognition was severely impaired. Further review revealed for special treatments that the resident was not coded for oxygen therapy intermittent.</p> <p>Record review of Resident #49's Physician's Order Summary Report revealed the following order:</p> <p>-Dated 02/09/2022 O2 @ 2-3 LPM via nasal cannula as needed for Sat &lt;90%</p> <p>Record review of Resident #49's MAR for the month of March 2024 reflected that oxygen had not been administered.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #49's Comprehensive Care Plan revised 03/25/2024 did not reflect the resident was care planned for O2 via nasal cannula.</p> <p>Observation on 03/27/24 at 8:46AM revealed Resident #49 was resting in bed awake no distress observed .</p> <p>Interview on 03/27/24 at 4:10 PM the MDS Nurse said she had overlooked Resident #49's care plans for use oxygen. The MDS she tried to go back and review care plans to make sure she had captured all care areas and must have overlooked the resident not being care planned for O2. The MDS nurse said if a resident had an order to receive respiratory treatment, it should be care planned .</p> <p>Interview on 03/27/24 at 4:15PM the DON said it was the Regional MDS Nurse that ensured the MDS Nurse had completed all care plans. The DON was asked for NF policy on Care Plans.</p> <p>2. Review of Resident #63's Face sheet dated 03/27/2024 reflected a [AGE] year old male admitted to the facility on [DATE], and readmitted [DATE] with the following diagnoses bipolar disorder ( a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) benign prostatic hyperplasia (a benign ( not cancer) condition in which an overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine with lower urinary tract symptoms, retention of urine, type 2 diabetes mellitus with diabetic peripheral ( is a disease that occurs when your blood glucose, also called blood sugar, is too high) angiopathy ( disease of the blood vessels), acute cystitis ( infection of the lower urinary tract, or more specifically, the urinary bladder) without hematuria( blood cells in the urine).</p> <p>Record review of Resident #63's progress notes reflected he was readmitted with slit penis on 5/17/23 from the hospital to the facility.</p> <p>Review of Resident #63's annual assessment dated [DATE] reflected Resident #63 was assessed to have a BIMS score of 13 indicating cognition was impairment. Resident # 63 was assessed to be dependent on staff for all ADLs. Resident #13 was assessed to have an indwelling catheter.</p> <p>Review of Resident #63's comprehensive care plan dated 2/16/23 reflected no plan of care for Resident #63's indwelling catheter and the slit to the penis was addressed</p> <p>Review of Resident #63's consolidated physician's orders reflected an order with a start date 05/17/2023 Maintain urinary catheter. Monitor Cath care every shift and as needed . Monitor urine for odor, color, sediments, and amount of urine, etc. - report, Use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Rotate site of securement daily and PRN every shift for Patency, Dislodgement.</p> <p>Review of Resident #63's weekly skin assessment dated [DATE] reflected resident was assessed to not have any skin./ head to toe</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/27/2024 at 4:04 PM revealed Resident # 63 in her room sitting in a wheel chair. Resident #63 transferred to his bed. C.NA BB was setting up to preform indwelling catheter care. C.NA BB removed Resident #63's pants to reveal Resident #63 had a indwelling catheter. No catheter secure device was observed and the catheter tubing was not stabilized to Resident # 63's leg. Resident #63 had a slit under the penis. Observation while CNA BB was cleaning and moving the catheter tubing, revealed Resident #63 said the tubing always irritating when moving it.</p> <p>Review of Resident #63's comprehensive care plan dated 2/16/23 reflected no plan of care for Resident #63's indwelling catheter and the slit to the penis was addressed.</p> <p>Observation while C.NA BB was cleaning and moving catheter tubing, Resident # 63 said the tubing always irritating when moving it</p> <p>Interview with Resident #63 on 3/27/24 at 4:35 PM, when asked the leg strap for his catheter. He said he does did not about the leg strap.</p> <p>In an interview with Charge Nurse LVN O on 3/28/24 at 12:05PM she said she was responsible for monitoring the resident's catheters leg strap was in place and she also checked for Foley catheter if not leaking and catheter care. Tthe nurses should have a catheter secure device in place to ensure Resident #63's catheter was not pulled on during care which could cause pain, and trauma to the urethra. She said Resident #63 does did not like the indwelling catheter strap and she told the DON about it. LVN O measured the penis slit and it was 1cm in length. , LVN O said she was not aware of the penis slit till the surveyor A brought it to her attention.</p> <p>In an interview on 03/27/2024 at 1:50 PM the DON stated Resident #63 always tootake off his catheter leg strap and it should be care planned. The DON said the facility had no MDS nurse for couple of months and the corporate nurse was working on the MDS and care plan. She was not aware of the slit to Resident #63's penis. The DON stated she expected residents with indwelling catheters to have physician's orders for the catheters, plans of care for the catheter and they should have secure Cath'scatheters secured in place to prevent trauma or infection. DON then checked Resident #63's progress notes dated 05/17/23 that reflected on readmission resident had slit penis.</p> <p>In an interview on 03/29/2024 at 10:15 AM tThe DON stated she expected the resident's care plan to be updated whenever the residents hadve a change in their treatment plan to ensure they wereare receiving the proper care. She stated by not updating the plan of care it could lead to a decline in the resident's skin condition or the spread of infection.</p> <p>In an interview on 03/28/204 at 2:51 PM the MDS Coordinator stated Resident #63 did not have a plan of care for his indwelling catheter. The MDS Ccoordinator stated she just missed the changes and should have updated his care plan to ensure the nursing staff hadve the correct information to provide the proper care. She stated care could be missed by staff which could lead to a urinary infection.</p> <p>Review of the facility's policy Care planning policy and procedure revised date 5/2022 reflected .Each resident's care plan will remains current and inform staff of resident's needs, strengths, goals and approaches Resident's care plan will be reviewed with the resident, responsible party and interdisciplinary team quarterly and as needed .</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 16352</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of one resident reviewed for catheter care ( Resident #63).</p> <p>The facility failed to ensure Resident #63's catheter was secured as ordered by a physician.</p> <p>This failure to secure catheters placed residents with urinary catheters at risk for traumatic removal and catheter acquired infections.</p> <p>Findings included:</p> <p>Review of Resident #63's Face sheet dated 03/27/2024 reflected a [AGE] years- old male admitted to the facility on [DATE] readmitted [DATE] with the following diagnoses bipolar disorder ( a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), indwelling catheter, benign prostatic hyperplasia ( a benign ( not cancer) condition in which an overgrowth of prostate tissue pushes against the urethra and the bladder, blocking the flow of urine with lower urinary tract symptoms, retention of urine, type 2 diabetes mellitus with diabetic peripheral ( is a disease that occurs when your blood glucose, also called blood sugar, is too high) angiopathy ( disease of the blood vessels), acute cystitis ( infection of the lower urinary tract, or more specifically, the urinary bladder) without hematuria( blood cells in the urine).</p> <p>Record review of Resident #63 progress notes reflected he was readmitted with slit penis on 5/17/23 from the hospital to the facility.</p> <p>Review of Resident #63's annual assessment dated [DATE] reflected Resident #63 was assessed to have a BIMS score of 13 indicating cognition was not impairment. Resident # 63 was assessed to be dependent on staff for all ADLs. Resident was assessed to have indwelling catheter.</p> <p>Review of Resident #63's comprehensive care plan dated 2/16/23 reflected no plan of care for Resident #63's indwelling catheter and the slit to the penis was not addressed</p> <p>Review of Resident #63's consolidated physician orders reflected an order with a start date 05/17/2023 Maintain urinary catheter. Monitor Cath care every shift and as needed . Monitor urine for odor, color, sediments, and amount of urine, etc. - report, Use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Rotate site of securement daily and PRN every shift for Patency, Dislodgement.</p> <p>Review of Resident #63's Nursing MAR dated March 2024 reflected an entry to maintain the urinary catheter and to monitor the catheter every shift and PRN. The nursing MAR did not have any documented signatures for monitoring every shift.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of care plan (date initiated 03/28/2024 and revision on 3/28/2024) reflected the resident had a Foley catheter and is was at risk for increased UTIs and skin break down AEB patient occasionally does dud didown Foley-care. Foley Catheter ( F/C) will remain patent and Resident #63 will not develop an increased incidence of UTIs or have any noted skin break down due to F/C over the next 90 days. Change Foley catheter, tubing and bag per order by the doctor.</p> <p>Resident #63 will not develop increased incidence of UTIs or have any</p> <p>noted skin break down due to F/C over the next 90 days. Change Foley catheter, tubing and bag per order by the doctor.</p> <p>Observation on 03/27/2024 at 4:04 PM revealed Resident # 63 in her room sitting in a wheel chair. Resident #63 transferred to his bed. C.NA BB was setting up to preform indwelling catheter care. C.NA BB removed Resident 63's pant to reveal Resident #63 had a indwelling catheter. No catheter secure device was observed the catheter tubing was not stabilized to Resident # 63's leg. Resident #63 had a slit under the penis.</p> <p>Observation while C.NA BB was cleaning and moving catheter tubing, Resident # 63 said the tubing always irritating when moving it</p> <p>Interview with Resident #63 on 3/27/24 at 4:35 PM, when asked the leg strap for his catheter. He said he does not about the leg strap.</p> <p>In an interview on 03/27/2024 at 4:37 PM C.NA BB stated that Resident #63 always does did things for himself.</p> <p>In an interview with Charge Nurse LVN O on 3/28/24 at 12:05PM she said she was responsible for monitoring the resident's catheters leg strap was in place and she also checked for Foley catheter if not leaking and catheter care. Tthe nurses should have a catheter secure device in place to ensure Resident #63's catheter was not pulled on during care which could cause pain, and trauma to the urethra. She said Resident #63 does did not like the indwelling catheter strap and she told the DON about it. LVN O measured penis slit and it was 1cm in length.</p> <p>In an interview on 03/27/2024 at 1:50 PM the DON stated Resident #63 always take off his catheter leg strap and it should be care planned. The DON said the facility had no MDS nurse for couple of months and the corporate nurse was working on the MDS and care plan. She was not aware of the slit to Resident #63's penis. The DON stated she expected residents with indwelling catheters to have physician orders for the catheters, plans of care for the catheter and they should have secure Cath's in place to prevent trauma or infection.</p> <p>In an interview on 03/28/204 at 2:51 PM the MDS Coordinator stated Resident #63 did not have a plan of care for his indwelling catheter. The MDS coordinator stated she just missed the changes and should have updated his care plan to ensure the nursing staff have the correct information to provide the proper care. She stated care could be missed by staff which could lead to a urinary infection.</p> <p>Record review of facility policy of indwelling catheter 6/2019, did not address securing indwelling catheter.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy Catheter care, indwelling catheter policy and procedure, not dated, reflected Purpose 1. To prevent infection. 2. To reduce irritation .catheter care should be provided daily or as needed. Catheter should be changed according to CDC guidelines or as ordered by the physician Guideline for Prevention of Catheter-Associated Urinary Tract Infections (2009) (cdc.gov) .</p> <p>Review of the CDC guidelines for prevention of catheter associated urinary tract infections referred to in the policy dated 06/06/2019 reflected .Properly secure indwelling catheters after insertion to prevent movement and urethral traction.</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>35897</p> <p>Based on observation and interview the facility failed to dispose of garbage and refuse properly for 1 of 1 dumpster reviewed for</p> <p>Food and nutrition services.</p> <p>-The facility failed to ensure the dumpster lids and doors were secured.</p> <p>This failure could place residents at risk of infection from improperly disposed garbage.</p> <p>Findings included:</p> <p>Observation on 03-26-24 at 8:30 am, revealed the facility's dumpster area, which was in the lot behind the dietary department had a commercial -size dumpster 3/4 full of garbage and the door was wide open.</p> <p>In an interview on 03-26-24 at 8:35 am, with the Food Service Manager, she stated that the dumpster doors must always be closed to keep vermin, pests, and insects out of the dumpster and from entering the facility.</p> <p>Record review of facility's Nutrition Services Policies and Procedures on waste disposal dated 6-2019. Subject: Waste Disposal Policy: Waste will be disposed of in a manner to prevent transmission of disease, nuisance or breeding place for insects and feeding places for rodents and other animals. Procedure: Read in part.5. Cover waste containers and close dumpster at all times.</p>