

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  05/28/2024
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 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 26454</p> <p>Based on observation, interview, and record review, the facility failed to ensure personnel provided basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel for 1 of 19 residents (CR #1) reviewed for CPR.</p> <ol style="list-style-type: none"> <li>1. Laundry Aide D failed to call a code blue or express CR #1 experienced a medical emergency when she requested assistance in the locked memory care unit after CR #1 was noted to be unresponsive on [DATE]. This led to a delay of at least three minutes before nursing staff arrived to assess CR #1, who died shortly after arrival to the ER.</li> <li>2. CNA A initiated CPR with improper chest compressions prior to knowing if CR #1 was full code and prior to checking for a pulse while he was still sitting unresponsive in his wheelchair on [DATE].</li> <li>3. Staff failed to immediately retrieve and ensure the crash cart and AED were unlocked and readily accessible after CR #1 was noted to be unresponsive. This led to a delay of approximately ,d+[DATE] minutes before oxygen was administered to CR #1.</li> <li>4. CPR was initiated on CR #1 when he still had a pulse and nursing staff stated this was appropriate emergency care.</li> </ol> <p>An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 1:14 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with the severity level at a potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on [DATE].</p> <p>These failures placed residents at risk of experiencing worsening of condition, extended pain, and death from possible delays in the initiation of an emergency response and improper implementation of CPR.</p> <p>Findings include:</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 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of CR #1's face sheet dated [DATE] revealed he was an [AGE] year-old male who was admitted to the facility on [DATE]. He was diagnosed with COPD (a group of lung conditions that cause breathing difficulties), vascular dementia (brain damage caused by multiple strokes), diabetes (a group of metabolic diseases that cause persistently high blood sugar levels), psychosis (a mental disorder characterized by a disconnection from reality), gastro-esophageal reflux (a digestive disease in which stomach acid or bile irritates the food pipe lining), metabolic encephalopathy (a group of neurological disorders that cause temporary or permanent brain function disturbances), and essential hypertension (high blood pressure that occurs when there is no identifiable cause). He was discharged to a funeral home after he died on [DATE].</p> <p>Record review of CR #1's quarterly MDS dated [DATE] revealed he had a BIMS score of 6 (severe cognitive impairment); CR #1 ambulated via walker and wheelchair; CR #1 required supervision or touching assistance from staff for eating and oral hygiene; CR #1 required partial/moderate assistance from staff for toileting hygiene, shower/bathing, dressing, and personal hygiene; and CR #1 was frequently incontinent of bowel and bladder.</p> <p>Record review of CR #1's care plan, revised [DATE] revealed the following care areas:</p> <p>* CR #1/Responsible Party have requested a code status of Full Code. Goals included: CR #1's code status will be maintained/honored. Interventions/Tasks included: If the resident's heart stops, initiate CPR, and call 911 for transfer to the hospital. Inform staff of code status. Monitor for any changes in the resident's code status. Monitor for decline or change of condition and report to physician and responsible party.</p> <p>* CR #1 was at risk for respiratory distress/failure and increased episode of shortness of breath due to diagnosis of COPD. Goals included: CR #1 will be free from any respiratory distress/failure and will have minimal/no further episodes of shortness of breath. Interventions/Tasks included: Allow breaks when performing tasks, do not rush. Minimize stress/anxiety and allow him to verbalize feelings when appropriate.</p> <p>* CR #1 Was an elopement risk/wanderer related to history of attempts to leave the facility unattended, impaired safety awareness, and diagnoses of dementia. Goals included: The resident will not leave the facility unattended. Interventions/Tasks included: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Provide structured activities. The resident's triggers for wandering/elopeing are thinking that he wants something from the store. The resident's behaviors are de-escalated by reminding him that staff will assist him with his shopping needs weekly.</p> <p>* CR #1 resided in the Memory Care Unit related to impaired cognition secondary to his diagnosis of dementia, elopement risk, need for controlled environment, need for reduced stimuli, and wandering. Goals included: CR #1's dignity will be maintained, and he will be safe in the memory care secured unit. Interventions/Tasks included: Call resident by name when giving care, involve him in care as much as possible. Keep environment free of possible hazards. Provide activities that accommodate the resident's abilities.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>* CR #1 required a regular mechanical soft diet with regular thin liquid for nutritional support and was at risk for unplanned weight loss and nutritional complication. Goals included: CR #1 will have adequate nutrition/fluid intake and will be free from unplanned weight loss or other nutritional complication. Interventions/Tasks included: Dietary Manager to monitor/discuss food preferences. Give medications as ordered. Give supplements as ordered by physician. Weigh every month and as needed. Report 5% loss/gain to physician and responsible party.</p> <p>Record review of CR #1's Progress Notes for [DATE] revealed the following:</p> <p>* Effective Date: [DATE] at 1:15 p.m. Type: SBAR Summary. Author: LVN B - Change of Condition Identified: Absence of respirations. Vital Signs: Blood Pressure - ,d+[DATE] ([DATE] at 1:15 p.m.) - Position: Other. Pulse - 0 ([DATE] at 1:15 p.m.) - Pulse Type: unable to determine. Respirations - 0 ([DATE] at 1:15 p.m.). Oxygen - 0% ([DATE] at 1:15 p.m.) - Method: Room Air. What do you think is going on with the resident? Stopped breathing. Physician Notified: [DATE] at 2:10 p.m. Responsible Party Notified: [DATE] at 1:28 p.m.</p> <p>* Effective Date: [DATE] at 1:15 p.m. Type: Nursing Note. Author: LVN B - Housekeeper notified nursing that CNA needed a nurse and that it was an emergency. Upon assessment noted that resident was unresponsive. Noted with no respirations but resident had a pulse. 1:16 p.m. EMS called, and CPR initiated. AED in place. Shock was not advised. 1:18 p.m. supervisor notified. 1:19 p.m. Weekend nursing supervisor arrived and took over CPR. 1:22 p.m. EMS arrived, and RP notified of change of condition. EMS took over CPR. 1:28 p.m. Administrator and DON notified of change of condition. 1:45 p.m. Resident left facility to hospital. 2:02 p.m. received a phone call from ER stating resident had passed away. 2:05 p.m. RP notified of resident's passing. Stated name of funeral home. 2:06 p.m. spoke with hospital letting them know what funeral home the RP was wanting to use. 2:10 p.m. NP and MD notified of resident passing. 2:14 p.m. Spoke with mortuary/funeral home.</p> <p>Record review of CR #1's EMS Report dated [DATE] revealed: . Primary Impression: Cardiac arrest . Signs and Symptoms: Cardiac arrest . Call Received - 1:13 p.m. Dispatched - 1:15 p.m. On Scene - 1:20 p.m. At Patient - 1:22 p.m. Depart Scene - 1:47 p.m. At Destination - 1:48 p.m. Patient Transferred 1:55 p.m. Condition at Destination - Unchanged. End of Event - Expired in ED. Narrative: Dispatched to facility for a cardiac arrest. Arrived to find the patient supine on the floor of the dining room. CPR was being performed by facility staff, AED was attached, staff stated there were no shocks advised, patient was on a nonrebreather attached to O2. Staff member stated that she went to collect the patient's food tray and found him unresponsive. Staff placed patient on the floor, started CPR and applied the AED. Compressions taken over by EMS, placed pads on patient, rhythm showed asystole (flatline, the heart's electrical and mechanical activity completely stopped). Ventilated patient with bag-valve-mask (a basic airway management technique used to provide oxygenation and ventilation to patients in emergency situations) with oxygen. IV access established in the left proximal tibia and secured. Started normal saline drip. Two unsuccessful intubation attempts were performed, a laryngeal mask airway device was placed, continued ventilations with bag-valve-mask. Patient lifted onto the stretcher via a sheet . Moved patient to ambulance. Scene delay due to treatment . No change in patient status while enroute . Vital Signs: Pulse - (1:25 p.m. - blank), (1:29 p.m. - 101), (1:34 p.m. - 101), (1:43 - 127), 1:49 p.m. - 40), 1:54 p.m. - 98) . ECG: 1:25 p.m. - (Artifact (a signal that is not related to the heart's electrical activity), Asystole), 1:34 p.m. - (Ventricular Fibrillation [a life-threatening heart rhythm that results in a rapid, inadequate heartbeat]), 1:43 p.m. (Pulseless Electrical Activity) .</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of CR #1's hospital records dated [DATE] revealed he was admitted to the ER on [DATE] at 1:54 p.m. for non-traumatic cardiac arrest. The document read in part, . Patient arrived by EMS from the facility, active CPR in progress . EMS states patient has been unresponsive 20 minutes during active CPR, unknown downtime. Asystole on monitor entire time . Triage start: [DATE] at 1:54 p.m. Triage stop: [DATE] at 1:54 p.m. [DATE] at 1:57 p.m.: Expired .</p> <p>Observation of the facility's crash cart on [DATE] at 2:50 p.m. revealed it was located between the Administrator's office and the employee breakroom, approximately ,d+[DATE] yards away from the nurse's station. There was an oxygen tank attached to the outside of the crash cart. The crash cart was unlocked. The oxygen tubing and the AED were located inside the drawers of the crash cart. There was a set of two keys on a small keyring hanging on a hook on the back of the crash cart. After locking the crash cart, neither of the two keys unlocked the crash cart. Unidentified staff who were sitting at the nurse's station stated the keys were located on a keyring which hung from a hook on the wall behind the nurse's station. They key behind the nurse's station unlocked the crash cart.</p> <p>(continued on next page)</p>

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with CNA A on [DATE] at 11:30 a.m., she stated she always worked in the locked memory care unit. She said she usually worked the night shift (10:00 p.m. - 6:00 a.m.), but she moved to the evening shift (2:00 p.m. - 10:00 p.m.) and also picked up additional shifts. She stated CR #1 was alert and could have a conversation. She said he could walk but used a wheelchair. She said when she arrived for her shift on Saturday ([DATE], she worked 6:00 a.m. - 2:00 p.m.) morning, CR #1 was in the shower with a staff from the night shift. She said after CR #1's shower, he went to his room, then he went to the dining room for breakfast, then went back to his room, and then he eventually went back to the dining room for lunch. She said CR #1 ate his lunch with no issues. She said CR #1 ate everything off his lunch tray and he asked her for water after he finished eating. She said CR #1 was on a mechanical soft diet, so he normally had soft meats. She said he required set-up assistance, but he fed himself. She said she only had to watch him to make sure he did not eat too fast. She said she picked up CR #1's lunch tray and gave him water as he requested. She could not recall what time each event occurred that day. CNA A said she left the dining room and went to the hallway (still inside the locked unit) when Housekeeper E said CR #1 was unresponsive. She said she ran back into the dining room and Laundry Aide D, who was in the locked unit closer to the door to the outside, ran to get a nurse. She said CR #1's head was leaned back, and she started CPR. She said CR #1's mouth was open and there was nothing in his mouth. She said she started pressing on CR #1's chest while he was still in his wheelchair. CNA A demonstrated how she pressed on CR #1's chest and it appeared she was pressing underneath his rib cage while she stood in front of him. She said other residents who were nearby kept telling her to keep going (keep doing compressions) because it looked like he was coming back (regaining consciousness). She said while she was doing compressions, CR #1's head and feet started moving. She said when the nurses (LVN B and LVN C) arrived in the dining room, they were just looking around like they did not know what they should do. She said LVN B said they had to determine if CR #1 had a DNR and then asked her if she looked at CR #1's POC. She said she told LVN B she did not have time for that. She said LVN C ran back out to the nurse's station (located outside the locked unit) and looked at CR #1's POC. She said Laundry Aide D told the nurses CR #1's name before they went into the locked unit, so she thought they should have checked his POC before they went in. She said LVN C came back and said CR #1 was full code. She said at that point, she was thinking, Are they going to help me? She said Laundry Aide D told her the nurses were walking and did not react fast when she told them CR #1 needed help. She said more than three minutes, but less than five minutes passed before the nurses arrived in the dining room to assess CR #1. She said one of the nurses ran back out of the unit to get the crash cart and the other said she needed oxygen. She said at the time, CR #1 was still sitting in his wheelchair. CNA A said she kept asking the nurses if they were going to help get CR #1 on the floor, but LVN B said to leave him in his wheelchair because he still had a pulse. She said she thought CR #1 needed CPR, so she ran out of the locked unit to find other CNAs to help get him to the floor. She said when she and the other CNAs (CNA F and CNA G) returned to the unit, they put CR #1 on the floor. She said about three minutes passed from the time LVN C said she needed the crash cart and when returned to the unit with it. She said one of the nurses eventually initiated CPR and the RN (RN Weekend Supervisor) used the AED pads. She said LVN C called 911 and the ambulance and police arrived quickly. She said CR #1 did not cough or choke at all. CNA A said she was certified to do CPR and the Heimlich Maneuver at a class not associated with the facility. She said she was also educated on what to do if a resident was choking at the facility. She said she did not know if CR #1 had a DNR or not, she just acted. She said she did not do any breaths or check his pulse. She said she thought the facility had a mask in the crash cart for the breaths, but the crash cart was locked, and they had to find the key. She said she guessed LVN C had the wrong key when she brought in the crash cart because she was new to the facility. She said the key to the crash cart was located behind nurse station. She said she was told where the key was during training.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In a telephone interview with LVN B on [DATE] at 1:26 p.m., she stated nurses worked 12-hour shifts and she normally worked the 6:00 a.m. - 6:00 p.m. shift. She stated on Saturday, [DATE], she was responsible for D hall, C hall, and the right side of B hall (B hall was the locked memory care unit). She said on that day, she was at the nurse's station charting after lunch when the housekeeper (Laundry Aide D) said they needed a nurse back there in the unit. She said that was all Laundry Aide D said. She said she asked Laundry Aide D what was going on, and she just said they needed a nurse. She said once she got to the dining room, she saw CR #1 laying back in his wheelchair with his mouth and eyes open and he was unresponsive. She said she did her ABC's and saw he was not breathing, but he did have a pulse. She said she asked the other nurse to get the crash cart and AED. She said the other nurse (LVN C) called 911 on her way out of the unit. LVN B said she monitored CR #1's pulse while she waited on the crash cart. She said 1 to 2 minutes passed before the crash cart arrived. She said RN Weekend Supervisor came in and assisted. She said once the crash cart was there, she got the AED out, got O2 on CR #1 and assessed him. She said the AED indicated no shock was advised. She said RN Weekend Supervisor started CPR and then they switched, and she (LVN B) took over. She said the ambulance arrived and the EMS took over CPR. She said shock not advised meant they had to do CPR and there was no shockable heart rhythm. She said there was a CNA on the unit and two additional CNAs came and assisted CR #1 to the floor. She said while the other nurse got the crash cart, the aides assisted CR #1 to the floor. She said they had to get keys for the crash cart because they did not have keys with them. She said someone had to run and get the key. She said the key was now located on the back of the crash cart (the keys located on the back of the crash cart did not open the crash cart). She said on the day of CR #1's incident, the keys were in a drawer at the nurse's station. She said the nurses knew where the keys were located, but she did not know if the CNAs knew because a CNA was running for the crash cart keys and she had to ask where they were. She said a nurse had to help the CNA find them. She said maybe ,d+[DATE] minutes passed from when she initially saw CR #1 and when they started CPR. She said a nurse was back in less than a minute with the keys to the crash cart. She said when she and the other nurse walked in, the aides were just standing there. She said when a resident was unresponsive, you have to immediately get them to the floor. She said in this situation, CR #1 was immediately placed on the floor. She said two aides helped her place CR #1 on the floor. She said she had CR #1's two legs and the aides had his trunk on each side. LVN B said she checked CR #1's radial and carotid pulses and he had a faint pulse. She said they had an AED, and they were waiting on that. She said while the AED was being applied, RN Weekend Supervisor started chest compressions. She said they did not normally do CPR on a person with a pulse, but by the time they reassessed CR #1 on the floor, his pulse was gone. She said she looked for a carotid and radial pulse and there was none at all. She said normally, a code was called but everybody except for a few people were already in the room. She stated she was trained on CPR and codes. She said once the EMS arrived, they took over and got an Ambu bag (bag valve mask which is used to provide respiratory support) out. She said she held the mask while the EMS worked. She said the incident started after lunch around 1:15 p.m. or 1:30 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In a follow-up interview with LVN B on [DATE] at 3:00 p.m., she stated on [DATE], she, RN Weekend Supervisor, and LVN C were at the nurse's station when the housekeeper (Laundry Aide D) came out and said they needed a nurse in the unit. She said when they were almost at the locked unit, the housekeeper said it was CR #1, and then she said it was an emergency when they were almost to the dining room where CR #1 was. She said it was not very long before the nurses got up from the nurse's station after the housekeeper told them they needed a nurse. She said they did not walk very fast because the housekeeper did not say it was an emergency. She said she thought CR #1 fell because he fell a lot. She said RN Weekend Supervisor was still sitting at the nurse's station and did not go inside the unit at that time. She said when they approached CR #1, they saw him sitting in his wheelchair with his head back and his mouth and eyes were open. She said if the housekeeper would have said CR #1 was unresponsive, they would have gone in with the crash cart, and they knew where the key was. She said instead, the aides were running around because they did not know what to do or how to handle the situation. She said LVN C ran and made the call to 911 and all the other staff left her in the dining room alone. She said she kept yelling that she needed oxygen for CR #1. She said CR #1's pulse was a little strong but got fainter. She said maybe , d+[DATE] minutes maximum passed before the other staff returned to the unit. She said she did not want to dump CR #1 on the floor, and she could not leave him alone. She said when the aides came back in, they helped her lower CR #1 to the floor. She said they waited for the crash cart, but the key was not with it once it arrived. She said CNA G came back and said she could not find the key, so she told her where it was. She said CNA G came back with the key within 30 seconds. She said if there was a faint pulse, she would do CPR, but if it were a deeper pulse, she would not. She said at first, CR #1 had a pulse, so she would not do CPR, but by the time they lowered him to the floor, and she reassessed him, the pulse was faint, and it was time to do CPR. She said she needed the AED and the oxygen tubing from inside the crash cart. She said the oxygen was administered to CR #1 before they got the key to the crash cart because they found tubing somewhere else. She said they started chest compressions before they got the crash cart key. She said LVN C started chest compressions and after a couple of rounds, RN Weekend Supervisor took over for , d+[DATE] rounds, then she (LVN B) took over. She said maybe ,d+[DATE] minutes passed between the time CR #1 was placed on the floor and when the AED came. She said as soon as they had access, they placed oxygen on CR #1. She said once EMS arrived, they tried to intubate twice, but were unsuccessful. She said EMS only suctioned saliva from CR #1's mouth. She said CR #1's mouth was already stiff, and his color changed while they did CPR. She said CNA A did not tell her she started CPR compressions. She said the nursing staff did everything correct and were not slow to respond.</p> <p>In a telephone interview with Housekeeper E on [DATE] at 1:51 p.m., she stated on Saturday, [DATE], she was in the dining room of the locked unit after lunch, and she had just started to clean it. She said the CNA back there (CNA A) looked at the residents, then she walked out to the hall to get trays from other residents. She said not two minutes later, she looked up and saw CR #1 leaned back in his chair with his mouth and eyes open. She said he was unresponsive and other residents were trying to wake him up. She said she went and told the aide and the aide looked at him and told Laundry Aide D to go get a nurse. She said she helped to get the other residents out of the dining room. She said it took the nurses more than 3 minutes to get to the unit. She said one of the nurses had her phone. She said once the nurses got back there, it was not good because none of them brought the crash cart and then they could not find the key. She said the nurses sent a CNA out to look for the key who did not know where they were. She said there was a visitor inside the dining room who said she did not understand what was going on because of all the confusion. She said CR #1 was still in his wheelchair and was not placed on the floor for more than 5 minutes after the nurses were told about CR #1. She said she heard LVN B say to leave CR #1 in his wheelchair because he had a pulse and was breathing, but his chest was not going up and down. She said two aides placed CR #1 on the floor.</p> <p>(continued on next page)</p>		

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  05/28/2024
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.			
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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with Laundry Aide D on [DATE] at 2:15 p.m., she stated on Saturday, [DATE], she was delivering clothes in the locked unit. She said she heard something was wrong with CR #1 and the CNA ran back there to the dining room. She said the CNA asked for someone to grab a nurse and she was closer to the door. She said she asked both nurses who were at the nurse's station if someone could come back because CR #1 needed assistance and the aide needed help. She said she could not say exactly how many minutes it took the nurses to go to the unit, but they were behind her. She said she was already back down the hall and in the dining room by the time the nurses came. She said she saw CR #1 laying back in his wheelchair with his mouth open. She said they tried to make sure all the residents were out of the dining room and by that time, the more mobile residents started coming back out of their rooms. She said she closed the door to the dining room so the residents could not see inside. She said she recalled seeing CNAs from every hall run down the hall to help each other get CR #1 of his chair and they laid him flat on the floor. She said RN Weekend Supervisor from C hall heard the commotion and she ran down there to assist. She said she had been trained that if there was an emergency, she was supposed to get help. She said she did not recall being trained to call any codes in an emergency.</p> <p>In an interview with the Administrator and DON on [DATE] at 3:00 p.m., the Administrator said on [DATE], he was at a store across the street from the facility, and he received a call from RN Weekend Supervisor who said CR #1 coded. The Administrator said when he arrived at the facility, EMS had just brought CR #1 out and they were still working on him. The Administrator said the EMS told him they could not give a status report on CR #1 because they were still working on him, but they had not pronounced him dead at that time. The Administrator said he spoke to staff, including CNA A and RN Weekend Supervisor. The Administrator said the staff told him they started CPR immediately. The Administrator said LVN C told him the same story as the other staff, that the laundry aide said they needed a nurse to the unit and the nurses went in there and called 911 on the way in. He said the staff told him CNA A was doing CPR and RN Weekend Supervisor grabbed the crash cart and took it the to unit. The Administrator said that is what he got from the staff who were there. The Administrator said nobody told him CR #1 was in his wheelchair when they started CPR. The DON said it was not appropriate to do CPR while a resident was in a wheelchair. The DON said staff should call a code blue to get assistance when a resident was unresponsive. The DON said staff should check for a pulse, check vital signs, get assistance, and place the resident on the floor. The DON said the first person to respond to the unresponsive resident would check vitals and pulse. The DON said the resident should not be left alone and the staff should document the incident later. The DON said anybody could initiate CPR if they were trained. The Administrator said he did not know what time he was called regarding CR #1 but RN Weekend Supervisor called him. The Administrator said he had a lot going on with his phone, so he could not look through his call log to see what time staff called him. The DON said RN Weekend Supervisor called her on [DATE] regarding CR #1's incident, but she could not look through her phone to provide the time she was called. The DON said the crash cart was usually locked because residents had a tendency to go into it. The DON said the key to the crash cart was at the nurse's station. And all staff knew where key was because they had an in-service regarding the crash cart on [DATE]. The DON said none of the staff told them they had trouble finding the key to the crash cart on [DATE].</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Paradigm at the Creek		STREET ADDRESS, CITY, STATE, ZIP CODE  1405 Valhalla Dr Wharton, TX 77488	
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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with LVN C on [DATE] at 10:00 a.m., she stated she normally worked the 6:00 a.m. - 6:00 p. m. shift. She said she worked on A hall and half of B hall, but she never cared for CR #1 because he was on the opposite side of B hall. She said on Saturday, [DATE], a housekeeper inside the unit opened the door when she and the other nurse were sitting at the nurse's station. She said the housekeeper said they needed a nurse for CR #1 inside the unit, but she did not say what was wrong. She said she and LVN B both went because the housekeeper had an urgent look on her face. She said they went inside and saw right away that CR #1 was in distress. LVN C said she called 911 before she knew if CR #1 was full code or DNR so EMS could be on the way. She said she then ran to the nurse's station to check CR #1's code status. She said it took her and LVN B about 30 seconds to get to the unit and she observed CR #1 sitting in his wheelchair with his head leaned back. She said CR #1 looked unresponsive and LVN B assessed him while she was on the phone with 911. She said LVN B tried to see if CR #1 had a pulse, and she tried to arouse him, but he looked unresponsive. LVN C said she did not stick around because she wanted to see if CR #1 was full code. She said once she saw CR #1 was full code, she ran back and yelled it out down the hall, but CR #1 was already on the floor out of his wheelchair. She said she told the staff he was full code, then they started CPR. She said someone had already gotten oxygen before that. She said there were a lot of staff back there, including aides from another hall. She said she got the crash cart after she told staff CR #1 was full code. She said she brought the crash cart into the unit, but it was locked. She said the crash cart should be locked because residents could get into it. She said that was her first time having to get the crash cart. She said once the cart was inside the unit, she thought the key was hanging on a keyring on the back of the cart, but they did not need it because they had everything t [TRUNCATED]</p>		