STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455699	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at the Creek	1405 Valhalla Dr Wharton, TX 77488

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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 Note: The nursing home is disputing this citation.	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** Based on interview and review the facility failed to report alleged violations of abuse, neglect, exploitation of mistreatment, including injuries of unknown source. Immediately but no later than two hours if the events that cause the allegation involve abuse or result in serios bodily injury for 1 out of 1 incident (Resident # 1) sampled for abuse and neglect.The facility failed to report an unwitnessed fall of Resident # 1 that resulted in a fracture of clavicle.This failure places residents at risk of not receiving complete or accurate investigation of incidents that resulted in emergency services implementing interventions.Findings includedRecord review of Resident # 1 face sheet revealed an [AGE] year-old male with readmission date of 5/24/2026. Diagnoses include pain, age-related osteoporosis (a condition where bones become weak, brittle, and porous due to a decrease in bone mass and density), cellulitis (a common, potentially serious bacterial skin infection) of the lower right limb, acute hematogenous osteomyelitis (a bone infection caused by bacteria that travel to the bone through the bloodstream), osteoarthritis (the most common form of arthritis. It is a degenerative joint disease where the protective cartilage cushioning the ends of the bones gradually wears away), muscle wasting and atrophy (the loss or thinning of muscle tissue, leading to weakness and reduced mass), lack of coordination, adult failure to thrive,Record review of Resident # 1 Care Plan dated 4/22/2026 indicated a risk for spontaneous fracture due to diagnoses of Osteoporosis. Interventions revealed to provide reducing and positioning devices as needed. Goal dated 4/22/2026 indicated Resident # 1 will not experience any spontaneous fractures over the next 90 days. Record review of Resident # 1 progress note dated 5/2/2026 created by LVN C read in part Heard thump and looked up to find Resident # 1 lying on left side of his body on the floor. Rolled Resident # 1 slowly to his back. No bleeding skin tears noted. Reports pain to his left shoulder and head. Alert able to verbally respond to questions appropriately. Resident assisted to wheelchair per 3 persons and returned to bed. NP notified and orders received to send out for CT scan. 911 called for transport. DON notified and POA notified.Record review of x-ray exam dated 5/2/2026 read in part left shoulder: Nondisplaced fracture involving the distal portion of the clavicle without extension to the acromioclavicular joint.Record review of facility Incident by Incident Type list date range 4/15/2026 - 6/15/2026 did not indicate Resident # 1 had an incident. Attempted interview on 6/16/2026 at 3:49 with LVN C left voicemail for call backInterview on 6/16/2026 at 4:00 with RN said she did not see how Resident # 1 fell and was not the nurse monitoring Resident # 1 at that time. Interview on 6/16/2026 at 7:40 pm with DON said Resident # 1 was at the nurses station and RN saw him begin to lean forward and couldn't catch him as she was clocking out. Resident # 1 did not have any devices in place but was going to get a device of cushion to be placed in wheelchair. Fall was witnessed, which was why it was not reported to HHSC. DON said the nurses knew to put pillows in place every time Resident # 1 was in wheelchair or would use a blanket as Resident # 1 did not have good trunk control and would slouch in the chair. DON was not aware of other staff present monitoring Resident # 1 other than RN. Interview on 6/16/2026 at 7:40pm with Administrator said the facility did not need to report Resident # 1 fall because the fall was not a cause of abuse or neglect and was witnessed. Administrator said there (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	were staff around Resident # 1 at the nurses station in his wheelchair. Administrator stated, I have no problem reporting incidents but yall (HHSC) said this was not reportable because we (facility) know Resident # 1 fell from his wheelchair, no one pushed him it was not abuse. Resident # 1 was found on the floor after RN looked up from the nurses station. Record review of facility policy Risk Management- Incidents & Accidents dated 1/2024 read in part The facility will conduct thorough investigations as indicated to determine underlying causes and contributing factors to incidents and accidents; and will put interventions in place from the investigative findings and IDT input. Facility leadership will review reporting requirements and report incidents to the state agency as indicated. The Facility Administrator should determine incidents/accidents that require thorough investigations and ensure completion. Incident logs, history, and trends will be reviewed by the IDT team in QAPI, and Performance Improvement Plans will be implemented as indicated. The facility should follow the policies and procedures referencing the nature of the incident/accident (example: Fall Policy and Procedure or Elopement Policy and Procedure).Record review of facility policy Abuse Neglect and Exploitation dated 4/2024 read in part reporting and Response Type of Incident: Abuse with or without bodily injury, Neglect, Exploitation, or Mistreatment, Injuries of unknown source that result in serious bodily injury

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity for 1 out of 4 (Resident #1) residents reviewed for resident assessmentsThe facility failed to revise Resident # 1 MDS to address cellulites (a common, potentially serious bacterial skin infection)of right lateral foot and right ankle and the intervention of antibiotics. This failure causes a risk to residents not receiving current or updated treatment and monitoring of infections based on MDS triggered Care Plans Area.Findings includeRecord review of Resident # 1 face sheet dated 6/16/2026 revealed an [AGE] year-old male with an original admission date of 8/27/2021readmission date of 5/24/2026. Diagnoses included pain, age-related osteoporosis (a condition where bones become weak, brittle, and porous due to a decrease in bone mass and density), cellulitis (a common, potentially serious bacterial skin infection) of the lower right limb, acute hematogenous osteomyelitis (a bone infection caused by bacteria that travel to the bone through the bloodstream), osteoarthritis (the most common form of arthritis. It is a degenerative joint disease where the protective cartilage cushioning the ends of the bones gradually wears away), muscle wasting and atrophy (the loss or thinning of muscle tissue, leading to weakness and reduced mass). Record review of Resident # 1's hospitalization on 5/14/2026, chief complaint of cellulitis and ulcer on right ankleRecord review of Resident # 1's mobile wound care dated 3/10/2026 - 3/24/2026 indicated not healed cellulitis of right lateral foot and not healed trauma wound of right ankle. Record review of Resident # 1's mobile wound care dated 3/31/2026 - 5/5/2026 indicated not healed trauma wound of right ankleRecord review of Resident # 1's medication order dated 4/3/2026 indicated Doxycycline (antibiotic used to treat bacterial infections) for cellulitis of the right foot for 10 daysRecord review of Resident # 1's MDS dated [DATE] and 5/12/2026 Section M. Skin Conditions, indicated Resident #1 did not have an unhealed pressure ulcer or injury in the last 7 days.Record review of Resident # 1 facility reviewed and completed Care Plan dated 4/22/2026 did not indicate pressure wounds or that Resident # 1 was at risk for further skin breakdown, infections, and worsening of existing pressure wounds. Care Plan indicated resolved cellulitis of lower right limb and antibiotic use dated 2/27/2026. Focus area did not indicate recent diagnosis of cellulites of right lateral foot or trauma wound of right ankle according to physician order date of 3/10/2026 - 3/24/2026 or focus area of antibiotics start date of 4/3/2026. Interventions also did not indicate antibiotic use state date of 4/3/2026.In an interview on 6/15/2026 at 2:16pm, CNA A said Resident # 1 has two wounds on his heel and said wounds on foot have been there since he arrived last year. CNA A said she was not aware of Resident # 1 having any infections and would assume the nurse would tell her that he has an infection that was being treated.In an interview on 6/15/2026 at 4:20 pm, LVN B said Resident # 1 had cellulitis on his foot which was there for months and on his ankle. LVN B said Resident # 1 was on antibiotics for that infection. LVN B said Resident # 1 wound on the foot was no longer infected and pictures were sent to the wound care doctor.In an interview on 6/16/2026 at 1:09 pm, the NP said the wound on Resident # 1's foot was resolved. The NP said cellulitis indicates a red, hot and swollen area that may need antibiotics. The NP said if she wrote an order for antibiotics, it was for the foot. The NP said either the ankle and/or the lateral foot would be addressed with the antibiotic order. The NP said Resident # 1's wound on the foot was to be resolved and the medication order was for the foot either the ankle or lateral foot even if the order read cellulitis of right foot.In an interview on 6/16/2026 at 2:59 pm, the MDS Coordinator said she completed residents care plans by entering information in the MDS assessment and that information would trigger Care Areas focus and interventions. The MDS Coordinator stated information from the morning meetings, progress notes, and physician orders were used to update care areas and MDS assessments when due or a change in condition happens. The MDS Coordinator stated she was not aware Resident # 1 had cellulitis or an infection and was ordered antibiotics in the (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	timeframe of the quarterly MDS. The MDS Coordinator said Resident # 1 had resolved cellulitis care areas in their care plan and previous orders of antibiotics. The MDS Coordinator stated Resident # 1's MDS was coded incorrectly in Section M regarding pressure ulcers or not healing wounds.Record review of the facility policy Nursing Policies and Procedures Subject: Minimum Data Set dated 6/2019 read in part It is the policy of this facility that a registered nurse will conduct or coordinate each assessment with the interdisciplinary team. An MDS, which is a comprehensive, accurate, standardized reproducible assessment will be completed for each resident. Quarterly and Significant Change assessments are completed as required. The facility is responsible for addressing all needs and strengths of each resident. Each staff 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 responses.significant change is a major decline or improvement in a resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions and the decline is not considered self-limiting. Impacts more than one area of the resident's health status. Requires interdisciplinary review and/or revision of the care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview and record review the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 6 residents (CR #1) reviewed for comprehensive care plans. The facility failed to develop a care plan area for CR #1's hyperammonemia. The facility failed to implement CR #1's care plan interventions related to medication management and behaviors by not administering prescribed routine dosage of lactulose from 5/4/2026 - 5/23/2026 resulting in approximately 57 missed doses. These failures could place residents at risk for unmanaged medical conditions, worsening mental status and behaviors, and a decline in physical and psychosocial well-being. Findings included: Record review of CR #1's facesheet revealed a [AGE] year-old male admitted on [DATE] and discharged to the hospital on 5/23/2026. His diagnoses included: Alzheimer's Disease (progressive, irreversible brain disorder that slowly destroys memory and thinking skills), Major Depressive Disorder (mental health condition that affects a person's mood, thoughts, and ability to participate in normal activities), and Disorder of Urea Cycle Metabolism (condition in which the body cannot properly remove waste ammonia from the blood). Record review of CR #1's admission MDS dated [DATE] revealed a BIMS score of 6 out of 15 indicating severe cognitive impairment. Further review of the MDS revealed behaviors were assessed 0 (not exhibited) in the Behaviors Section. Record review of CR #1's care plan, initiated 3/5/2026, revealed a care area for behaviors: Resident had episodes of behaviors and was at risk for further increased episodes and injury as evidenced by:3/22/26: altercation with another resident, received physical aggression from another resident. Interventions included: Staff intervened immediately, resident removed from situation. Assessed for injuries, skin issues or pain. Provide psych consult as ordered4/24/26: became combative during peri care and kicked a CNA in the foot. Interventions included: Resident redirected and encouraged to allow staff to complete perineal care (the gentle cleaning of the genital and anal area to prevent infection, manage irritation, and promote healing).5/23/26: resident altercation, punched another male resident in the mouth and scratched his hand. Interventions included: Residents separated. Encouraged resident to not get physical, no visible injuries noted to resident. Resident transferred to psychiatric hospital per NP orders.Encourage to attend social activities of preference.Explain procedures using terms/gestures the resident can understand.Give medications as ordered - monitor labs - report results to MD.Monitor and chart behaviors as they occur and report progress/declines to MDObserve for early warning signs of behavior - approach in a calm manner, call by name, remove from unwanted stimuli. Record review of CR #1's care plan, initiated on 3/5/2026 and cancelled on 6/15/2026, revealed no care area addressing risk or development of hyperammonemia (metabolic condition characterized by toxic levels of ammonia in the blood). Record review of CR #1's physician order started on 3/5/2026 and discontinued on 4/29/2026 revealed an order for Lactulose (a synthetic sugar used to lower blood ammonia levels) give 30 ml by mouth three times a day. Record review of CR #1's March 2026 and April 2026 MAR revealed order for lactulose 30ml by mouth three times a day was administered from 3/5/2026- 4/29/2026. Record review of CR #1's progress note by NP A dated 3/24/2026 revealed Staff reports patient had a confrontational behavior with another patient including physical altercation Record review of CR #1's Progress Note by NP B dated 4/27/2026 revealed 12:17 pm PMHNP received a call from DON who states that resident kicked staff twice today. DON states that resident has been displaying verbal/physical aggression towards others for several days now. PMHNP ordered Depakote (prescription medication primarily used to treat epilepsy, prevent migraine headaches, and manage the manic phase of bipolar disorder) 125mg 1 tablet po BID for Mood Disorder, Ammonia and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	them to increase lactulose for 3 days and continue the previous dose of lactulose after the increased dose was completed. NP A said she was not aware CR #1 was not receiving lactulose at all from 5/4/2026 - 5/23/2026. She said she did not know the risk associated of him not receiving lactulose or at what point not receiving lactulose would affect him. She was not sure how long it would take for ammonia to build up because he had just received the very high dose. NP A said high ammonia levels could affect CR #1's behaviors. NP A stated there was not a follow-up ammonia lab ordered before CR #1 was discharged to the psych hospital on 5/23/2026. Interview on 6/16/2026 at 4:20 pm, Corporate Nurse said they were addressing CR #1's increased behaviors by target behavior monitoring every shift, side effect monitoring on all the medications, psychotherapy by Psych Services, and metabolic management. The Corporate Nurse stated CR #1 was receiving Lactulose for metabolic management for his ammonia levels. She said high level of ammonia could cause increased behaviors which was why they increased his lactulose for 3 day when lab results showed elevated ammonia levels. The Corporate Nurse was not aware lactulose was not continued after the 3 day increase and said she would have to go check with the staff. Interview on 6/16/2026 at 4:54 pm, MDS Nurse said she created and edits all resident care plans. She said she makes the resident's MDS and it triggers the care areas for the care plan. During morning IDT/staff meetings the team discuss items that may need to be added to care plan. She was not aware of CR #1's urea cycle metabolism diagnosis or that he had increased ammonia levels. She said if she heard about his high ammonia levels she would not necessarily put high lab values on the care plan. She stated the risk of not putting urea cycle metabolism diagnosis in the care plan is that interventions like labs and medications may not be monitored. Interview on 6/16/2026 at 5:59 pm, LVN A said she did not know why she did not hold previous lactulose order and discontinued it. She said she knew the procedure for when a temporary order was given they should place the routine order on hold until the temporary order was finished and then have it set to resume. LVN A said she thought the order to increase lactulose for CR #1 was given over the phone and remembered NP A saying, go ahead and increase the order for 3 days. She said the risk of CR #1 not receiving lactulose was an increase in ammonia levels and possibly in aggressive behaviors. Interview on 6/16/2026 at 6:44 pm, DON said she talked to LVN A, the lactulose 45ml was done for 3 days and his regular dose of 30ml was not resumed after completion of temporary order. DON said if the order the NP gave did not specify to resume regular maintenance dose of lactulose the nurse should clarify the order. DON was not sure why CR #1 was taking lactulose without looking at his records but stated it was probably for encephalopathy. DON said the risk of CR #1 not getting lactulose was his ammonia being high and could affect his behaviors. DON said her expectation is that Care Plans are updated when issues arise or something changes with the residents. DON stated to her knowledge CR #1 was still at the psych hospital and she was not sure of his current condition but stated no adverse effects regarding ammonia levels had been reported back to the facility. Record review of CR #1's discharge summary from the psych hospital dated 6/18/2026 revealed resident had a history of hyperammonemia and noted order for lactulose 20ml by mouth three times and to hold if greater than three bowel movement in 24 hours. Further review of discharge record revealed CR #1 was discharged to a different nursing facility on 6/18/2026 and had no mention of ammonia labs or levels. The discharge noted improvement in CR #1's behavior and becoming stable by the time of discharge after medication adjustments were made. Record review of facility Care Planning policy revised 6/2019 revealed It is the policy of this facility that interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 6 residents (CR #1) reviewed for medication errors. The facility failed to provide CR #1 with lactulose 30mg three times a day to manage ammonia levels from 5/4/2026 - 5/23/2026 resulting in approximately 57 missed doses. This failure placed residents at risk for elevated ammonia levels which could seriously impair him or cause increased behaviors. Findings include: Record review of CR #1's face sheet revealed a [AGE] year-old male admitted on [DATE] and discharged to the hospital on 5/23/2026. His diagnoses included: Alzheimer's Disease (progressive, irreversible brain disorder that slowly destroys memory and thinking skills), Major Depressive Disorder (mental health condition that affects a person's mood, thoughts, and ability to participate in normal activities), and Disorder of Urea Cycle Metabolism (condition in which the body cannot properly remove waste ammonia from the blood). Record review of CR #1's admission MDS dated [DATE] revealed a BIMS score of 6 out of 15 indicating severe cognitive impairment. Further review of the MDS revealed behaviors were assessed 0 (not exhibited) in the Behaviors Section. Record review of CR #1's care plan, initiated on 3/5/2026, revealed a care area for behaviors: Resident had episodes of behaviors and was at risk for further increased episodes and injury as evidenced by:3/22/26: altercation with another resident, received physical aggression from another resident. Interventions included: Staff intervened immediately, resident removed from situation. Assessed for injuries, skin issues or pain. Provide psych consult as ordered4/24/26: became combative during peri care and kicked a CNA in the foot. Interventions included: Resident redirected and encouraged to allow staff to complete perineal care (the gentle cleaning of the genital and anal area to prevent infection, manage irritation, and promote healing).5/23/26: resident altercation, punched another male resident in the mouth and scratched his hand. Interventions included: Residents separated. Encouraged resident to not get physical, no visible injuries noted to resident. Resident transferred to psychiatric hospital per NP orders.Encourage to attend social activities of preference.Explain procedures using terms/gestures the resident can understand.Give medications as ordered - monitor labs - report results to MD.Monitor and chart behaviors as they occur and report progress/declines to MDObserve for early warning signs of behavior - approach in a calm manner, call by name, remove from unwanted stimuli. Record review of CR #1's physician order started on 3/5/2026 and discontinued on 4/29/2026 revealed an order for Lactulose (a synthetic sugar used to lower blood ammonia levels) give 30 ml by mouth three times a day. Record review of CR #1's March 2026 and April 2026 MAR revealed order for lactulose 30ml by mouth three times a day was administered from 3/5/2026- 4/29/2026. Record review of CR #1's progress note by NP A dated 3/24/2026 revealed Staff reports patient had a confrontational behavior with another patient including physical altercation Record review of CR #1's Progress Note by NP B dated 4/27/2026 revealed 12:17 pm PMHNP received a call from DON who states that resident kicked staff twice today. DON states that resident has been displaying verbal/physical aggression towards others for several days now. PMHNP ordered Depakote (prescription medication primarily used to treat epilepsy, prevent migraine headaches, and manage the manic phase of bipolar disorder) 125mg 1 tablet po BID for Mood Disorder, Ammonia and Valproic Acid level (labs testing levels of Ammonia and Valproic Acid in the blood, Valproic Acid can elevate blood ammonia levels) in the AM and every 6 months (October/April) thereafter. Record review of CR #1's Behavioral Health Solution Diagnostic Assessment by LP dated 4/27/2026 revealed Patient is a 68-yr-old Caucasian male who presents with symptoms of depression and withdrawal. Patient also appears to have some moderate memory loss and confusion and his chart indicates a history of being combative with staff when providing care or refusing ADL's. He was referred following an altercation with another resident, Record review of CR #1's ammonia lab results collected on 4/28/2026 at 9:35 AM and resulted on 4/28/2026 at 11:41 am revealed a high Ammonia (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455699	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at the Creek	1405 Valhalla Dr Wharton, TX 77488

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	level of 51.0 with reference range of 10.0-47.0 ug/dL. Record review of CR #1's progress note by NP A dated 4/28/2026 revealed, F/U status of chronic conditions including, Behaviors, elevated ammonia. Staff reports patient has elevated ammonia and he will receive increased lactulose, he had combative behavior with altercation with a staff member, usually patient is calm and cooperative, guardian reports patient has not had behaviors at the other facility, another patient had an altercation with him Further review of progress note revealed Urea cycle metabolism disorder/hyperammonemia - Chronic illness poses a threat to bodily function-start increase lactulose x 3 days then continue lactulose previous dosage. Record review of CR #1's progress noted dated 4/29/2026 at 5:06 pm by LVN A revealed, received new order to increase lactulose for 3 days due to elevated ammonia level and to collect urinalysis due to increased behaviors Record review of CR #1's physician order by NP A started on 4/29/2026, revealed an order for lactulose 45ml by mouth three times a day for 3 days. Record review of CR #1's April 2026 and May 2026 MAR revealed order for lactulose 45ml by mouth three times a day for 3 days was administered from 4/30/2026 - 5/3/2026. Further review of May 2026 MAR revealed no lactulose was administered from 5/4/2026 - 5/23/2026. Record review of CR #1's Chronic Care Management (CCM) note by NP A dated 4/30/2026 revealed, CCM Activity Log 4/1/2026 Coordination of Care with Community Provider - Notes: patient .also has issues with elevated ammonia currently treated with lactulose. Record review of CR #1's progress note by NP A dated 5/21/2006 revealed History - F/U status of chronic conditions including elevated Ammonia, agitation and confrontational behavior, Staff reports patient was transferred from another facility due to his behaviors, he is at high risk for increased agitation and confrontational behavior with staff and patients, he is calm and cooperative, he had a slightly elevated ammonia level and he was given lactulose. Further review of Progress Note revealed Assessment & Plan - Urea cycle metabolism disorder/hyperammonemia- Chronic illness poses threat to bodily function- continue lactulose. Record review of CR #1's progress note dated 5/23/2026 at 9:36 am by LVN A revealed, Med Aid called for nurse stating overheard resident cursing at male resident and by the time cma was able to get to residents, resident was physical with male resident, cma had redirected resident to dining room at this time, both residents separated. resident unable to state what happened and denied getting physical. encouraged resident to not get with physical, no visible injuries noted to resident, resident in dining room at this time. don and administrator aware, np made aware, called guardian and left message to call back Record review of CR #1's progress note dated 5/23/2026 at 9:45 am by LVN A revealed, resident placed with one-on-one monitoring Record review of CR #1's Chronic Care Management(CCM) note by NP A dated 5/23/2026 revealed, CCM Activity log 5/7/2026 -discussed patient's worsening behavior, he is confrontational, he has anger management issues, he may need to be transferred to another facility,. his ammonia level was elevated and his lactulose was increased. Record review of CR #1's progress note dated 5/23/2026 at 3:38 pm by LVN A revealed, city ambulance transport in facility to transport resident to psych hospital for aggressive behavior. Interview with the NP A on 6/16/2026 at 12:44pm revealed she gave verbal orders to increase CR #1's lactulose for 3 days in response to high ammonia lab and to then continue with his regular dose after of 30mg three times a day. The NP was not aware that he had not been getting the lactulose prior to him being transferred to the psych hospital. The NP stated she was not sure of the risk of CR #1 going without his lactulose for that long. She stated he just had the increased dose of lactulose so it would maybe take a while for ammonia levels to build up and she could not say for certain the impact of not getting the medication would have on him. The NP said some side effects of increased ammonia levels could be increased behaviors or disorientation. Interview with Corporate Nurse 6/15/2026 at 4:40 pm revealed, metabolic management was one of the many interventions being used to address CR #1's behaviors and they were doing this by monitoring his ammonia labs and giving lactulose to control ammonia levels since increased ammonia levels could possibly cause increased behaviors. The Corporate Nurse was not sure why the medication was not being given after he finished the increased dose. Interview with LVN A on 6/16/2026 at 5:59 pm revealed, she received (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the order to increase CR #1 lactulose for 3 days and said she was aware that he needed to continue his regular dose after. She would typically place the regular order on hold until the temporary order is finished. She could not say why she discontinued CR #1 routine lactulose order and said it was done in accident. She stated she had already been in-serviced by the corporate nurse and DON about the situation and how she needs to enter temporary orders. Interview with the DON on 6/16/2026 at 6:44 pm revealed, LVN A should have entered the temporary increase order for the lactulose and placed his routine dose on hold. The DON said LVN A made an error when she entered to the order into the system. The DON said going forward they will start to review new orders every morning and ensure they have been entered accurately and are being followed. The DON said she was not sure why CR #1 was getting lactulose but stated a side effect of increased ammonia levels could be increased behaviors. Record review of CR #1's Psychiatric Hospital Discharge summary dated [DATE] revealed resident had a history of hyperammonemia and noted order for lactulose 20ml by mouth three times and to hold if greater than three bowel movement in 24 hours. Further review of discharge record revealed CR #1 was discharged to a different nursing facility on 6/18/2026 and had no mention of ammonia labs or levels. The discharge noted improvement in CR #1's behavior and becoming stable by the time of discharge after medication adjustments were made. Record review of the facility Physician Orders policy revised 12/2024 revealed in part, .If an order is received verbally or via telephone: A licensed nurse or authorized staff member must document the order in the medical record immediately. The order must include: Resident's name, Date and time of the order, Specific details of the order, The name and title of the prescribing practitioner. The facility staff must transcribe and verify the order accurately into the medical record. Facility staff are responsible for: Reviewing the order promptly, Ensuring that all orders are correctly implemented within the timeframe specified, Communicating any barriers to implementation to the prescribing practitioner. If clarification is required, the staff member must: Contact the prescribing practitioner for clarification, Document the clarification conversation and any modifications in the medical record.