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	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at the Creek	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)
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** 16352 35822 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. -The facility did not care plan Resident #49 for oxygen via nasal cannula PRN. - 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. This failure placed resident at risk for not receiving oxygen as needed and decrease in quality of life. Findings: 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). 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. Record review of Resident #49's Physician's Order Summary Report revealed the following order: -Dated 02/09/2022 O2 @ 2-3 LPM via nasal cannula as needed for Sat <90% Record review of Resident #49's MAR for the month of March 2024 reflected that oxygen had not been administered. (continued on next page)

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

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

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	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Observation on 03/27/24 at 8:46AM revealed Resident #49 was resting in bed awake no distress observed . 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 . 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. 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). 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. 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. 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 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. Review of Resident #63's weekly skin assessment dated [DATE] reflected resident was assessed to not have any skin./ head to toe (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. Observation while C.NA BB was cleaning and moving catheter tubing, Resident # 63 said the tubing always irritating when moving it 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. 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 checkeds 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. In an interview on 03/27/2024 at 1:50 PM the DON stated Resident #63 always tooktake 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. 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. 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. 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 .

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centerd care plan, and the reisdents' choices, for 1 of 8 (Resident #57)residents feviewed for care. -The NF failed to date Resident #57 IV tubing. -The Wound Care Nurse failed to clean Resident #57's wounds correctly to the lower left extremity to prevent infecting the wounds. -The Wound Care Nurse failed to store the normal saline bottle on the cart, instead took the saline bottle in and out of Resident #57's room during wound dressing changes. These failures placed residents at risk for infections and decrease in quality of life. Record review of Resident #57 face sheet dated 03/27/2024 revealed a [AGE] year old male admitted to the facility on [DATE] with the diagnoses that included the following: cerebrovascular disease (stroke), local infection of the skin and subcutaneous tissue (deepest layer of the skin), depression, chronic (persisting for a long time) atrial fibrillation (irregular heart beat), atherosclerosis (build-up of fats, cholesterol, and other substances in and on the artery walls) of the arteries of other extremities with ulceration (break on the skin). Record review of Resident #57's annual MDS dated [DATE] revealed that resident had a BIMS score of 7 indicating resident cognition was severely impaired. Record review of Resident #57's Comprehensive Care Plan revealed that resident was being care planned for antibiotic Ertapenem sodium 1gm for infection of left leg wound dated 03/21/2024 and revised 03/22/2024 with an intervention that included to follow standard precautions to prevent cross-contamination and spread of infection. Record review of Resident #57's Physician Order Summary Report included the following orders: -Dated 03/20/2024 Venous wound to LT distal leg: cleanse with wound cleanser pat dry, apply collagen powder and alginate calcium sheet (products used to promote wound healing), cover with ABD pad, secure with kerlix and tape daily every day shift. -Dated 03/22/2024 Ertapenem sodium solution reconstituted 1gm intravenously every 24 hours for wound infection for 10 days. Record review of Resident #57's MAR for the month of March 2024 revealed that the facility was administering medications as ordered by the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/26/24 at 11:20AM revealed wound care on Resident #57 by the wound care nurse . Resident #57 was resting in bed. Resident #57 had a dressing to his left lower extremity. Further observation was made of an IV pole at the resident's bedside. Hanging on the IV pole was an empty 50ml bag that reflected ertapenem 1 gm/vial. The IV tubing was not dated. The wound care nurse disinfected her workspace and began to gather her supplies for the dressing change that included a small bottle of saline. At 11:30 AM the wound care nurse removed old dressing from wound. Resident #57 had several wounds on the inside of his left leg lower extending to his inner ankle area. The wound beds were a pale pink and yellow in color with sloughing (dead tissue). The old dressing had moderate yellow drainage. The wound care nurse did not start at the center of the wound cleaning around the wound moving outward one wipe at time instead, the wound care nurse cleansed the wound beds with moisten normal saline 4 x 4 gauze starting around the edges of the wound cleaning over the wound bed with the same gauze. The wound care nurse proceeded with the same technique as she changed gauzes moving to the next wound bed. After cleaning the resident's wounds, the wound care nurse applied calcium alginate powder to the wound beds followed with alginate. The wound care nurse then applied an ABD dressing over the wounds wrapping resident's left lower leg with kerlix wrap and securing with tape. The wound care nurse washed her hands and gathered all soiled materials inside of red biohazard removing from the room. The wound care nurse also took the normal saline bottle from the room and placed it inside of her treatment cart. Interview on 03/26/2024 at 12:30PM the Wound Care Nurse said she had just started working at the facility a few weeks ago, less than a month. The wound care nurse said prior to working at the NF, she was working at an ALF as the Director . Interview on 03/27/24 at 8:37AM the DON said the wound care nurse had been working at the facility less than a month and use to work at an ALF. The DON said the Infection Control Nurse in-serviced the Wound Care Nurse on wound care . The DON said Resident #57's wounds to his left lower leg were venous wounds (a wound on the leg or ankle caused by abnormal or damaged veins). Interview 03/28/24 at 9:25AM the Wound Care Nurse said her technique in cleaning wound beds, she wanted to ensure the wound was clean. The Wound Care Nurse said she did not want to waste the saline and therefore placed the saline inside of the treatment cart. The Wound Care Nurse said she realized she should not have taken the normal saline bottle to the resident's and returned to the treatment cart because it was cross contamination. Interview on 03/28/24 at 9:35AM the DON said when cleaning a wound bed, the nurse should clean in the middle of the wound bed cleaning around in a circular motion moving outward one wipe at a time. The DON said the technique was used to prevent infections. The DON said the Infection Control Nurse in-serviced the wound care nurse on how to clean a wound bed. Interview on 03/28/24 at 2:32PM the Infection Control Nurse said IV tubing should be dated and changed every 24 hours for infection control. The Infection Control Nurse said he and the DON checked IV tubing as well as respiratory equipment to ensure that the staff were dating and changing equipment. Record review Competency Training revealed that the Wound Care Nurse had received competency training on of wound care signed by the infection control nurse dated 03/04/2024. Record review of the NF policy for Dressing Changes copyright 2017 revealed in part: (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Don gloves, utilizing aseptic (clean) technique moisten gauze pad with wound cleanser or normal saline. Clean wound using circular motion starting from the center towards the outside .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review the facility failed to ensure a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and promote healing, prevent infection or deterioration of pressure ulcer, for 1 of 8 (Resident #7) residents reviewed for pressure ulcers. -The Wound Care Nurse failed to clean Resident #7's wound correctly to the sacrum to prevent infecting the wound. -The Wound Care Nurse failed to store the normal saline bottle on the cart, instead took the saline bottle in and out of resident #7's room during wound dressing change. This failure placed resident at risk for infections and decrease in quality of life. Findings: Record review of Resident #7 face sheet dated 03/28/2024 revealed an [AGE] year old male admitted to the NF on 11/22/2023 with diagnoses that included the following: hematuria (blood in urine), cardiac pacemaker (device used to treat irregular heart beat), heart disease, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (disrupted blood flow to the brain), gout (form of arthritis that cause severe pain, swelling, redness, and tenderness in the joints). Record review of Resident #7's MDS dated [DATE] revealed the resident had a BIMS score of a 3 which indicated the resident's cognition was severely impaired. Further review revealed that resident had 1 pressure ulcer. Record review of Resident #7's Comprehensive Care Pan dated 02/10/2024 and revised 03/27/2204 revealed that resident was being care planned for pressure ulcer to the sacrum (large flat bone in the lower part of the spine) with interventions that included the following: perform treatments per order. Record review of Resident #7's Physician's Orders revealed the following order: -Dated 03/15/2024 stage 3 pressure wound: Cleanse sacral wound with wound cleanser pat dry, apply alginate calcium with silver, cover with gauze every day shift for wound care. Record review of Resident #7's TAR for the month of March 2024 revealed that the NF was following physician's orders for wound care. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/28/24 at 9:20AM revealed wound care for Resident #7 by the Wound Care Nurse with the assistance of CNA's V and CNA W. Both CNA's assisted the resident from the w/c to the bed. The Wound Care Nurse washed her hands, sanitized her workspace, sanitized her hands, and began to gather her wound dressing supplies that included a bottle of normal saline and took the supplies int the resident's room. Resident #7's dressing to the sacral region reflected 03/27/24. Observation of the resident's wound bed to the sacrum was small (less than the size of a coined penny) with no drainage, pink in color. The Wound Care Nurse began to clean the wound bed by wiping over the wound more than once with the same saline gauze before changing gauze. After cleaning the wound bed, the Wound Care Nurse applied to the wound bed silver calcium alginate covering the wound with border dressing. When the Wound Care Nurse had completed the task, she removed the normal saline bottle from the room and placed it inside of the treatment cart. Interview on 03/26/2024 at 12:30PM the Wound Care Nurse said she had just started working at the facility a few weeks ago, less than a month. The wound care nurse said prior to working at the NF, she was working at an ALF as the Director . Interview on 03/27/24 at 8:37AM the DON said the facility had 1 in house pressure wound who was Resident #7 that had a stage III sacral wound that was almost healed. The DON said the wound care nurse had been working at the facility less than a month and use to work at an ALF. The DON said the Infection Control Nurse in-serviced the Wound Care Nurse on wound care. Interview 03/28/24 at 9:25AM the Wound Care Nurse said her technique in cleaning wound beds, she wanted to ensure the wound was clean. The Wound Care Nurse said she did not want to waste the saline and therefore placed the saline inside of the treatment cart. The Wound Care Nurse said she realized she should not have taken the normal saline bottle to the resident's and returned to the treatment cart because it was cross contamination. Interview on 03/28/24 at 9:35AM the DON said when cleaning a wound bed, the nurse should clean in the middle of the wound bed cleaning around in a circular motion moving outward one wipe at a time. The DON said the technique was used to prevent infections. The DON said the Infection Control Nurse in-serviced the wound care nurse on how to clean a wound bed. Interview on 03/28/24 at 2:32PM the Infection Control Nurse said IV tubing should be dated and changed every 24 hours for infection control. The Infection Control Nurse said he and the DON checked IV tubing as well as respiratory equipment to ensure that the staff were dating and changing equipment. Record review Competency Training revealed that the Wound Care Nurse had received competency training on of wound care signed by the infection control nurse dated 03/04/2024. Record review of the NF policy for Dressing Changes copyright 2017 revealed in part: .Don gloves, utilizing aseptic (clean) technique moisten gauze pad with wound cleanser or normal saline. Clean wound using circular motion starting from the center towards the outside .

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 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). The facility failed to ensure Resident #63's catheter was secured as ordered by a physician. This failure to secure catheters placed residents with urinary catheters at risk for traumatic removal and catheter acquired infections. Findings included: 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). Record review of Resident #63 progress notes reflected he was readmitted with slit penis on 5/17/23 from the hospital to the facility. 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. 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 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. 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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Resident #63 will not develop 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. 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. Observation while C.NA BB was cleaning and moving catheter tubing, Resident # 63 said the tubing always irritating when moving it 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. In an interview on 03/27/2024 at 4:37 PM C.NA BB stated that Resident #63 always does did things for himself. 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 checkeds 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. 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. 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. Record review of facility policy of indwelling catheter 6/2019, did not address securing indwelling catheter. (continued on next page)

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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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) . 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.

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
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35822 Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 8 (Resident #32) residents' reviewed for respiratory care. -The NF failed to date Resident #32's breathing mask and store inside of bag. -The NF failed to dispose of Resident #49 humidifier bottle that was dated 03/05/24. These failures placed residents at risk for infections and decrease in quality of life. Findings: Resident #32 Record review of Resident #32's face sheet date 03/28/2024 revealed a [AGE] year old male admitted to the facility on [DATE] with the diagnoses that included the following: chronic obstructive pulmonary disease (a group of lung diseases that block airflow making it difficult to breathe), heart failure, and Alzheimer's Disease (disease that destroys memory and other important mental functions). Record review of Resident #32's quarterly MDS dated [DATE] revealed resident had a BIMS score of 6 indicating that resident cognition was severely impaired. Record review of Resident #32's Comprehensive Care Plan dated 11/10/2023 and revised 01/19/2024 revealed that resident was being care planned for COPD with the included intervention to give aerosol or bronchodilators (type of medication that makes breathing easier) as ordered. Record review of Resident #32's Physician's Order Summary Report included the following order: -Dated 11/23/2023 Budesonide (medication that reduces the swelling in the airways) inhalation suspension 0. 5mg/2ml inhale every 8 hours as needed for COPD. Record review of Resident #32's MAR for the month of April 2024 revealed that resident had received the medication budesonide inhalation suspension 0/5mg/ml on 03/20/2024. Resident #49 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). (continued on next page)

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)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #49's quarterly MDS dated [DATE] revealed that residents BIMS score was 3 indicating that resident's cognition was severely impaired. Further review revealed for special treatments that resident was not coded for oxygen therapy intermittent . Record review of Resident #49's Comprehensive Care Plan revised 03/25/2024 did not reflect the resident was being care planned for O2 via nasal cannula. Record review of Resident #49's Physician's Order Summary Report revealed the following order: -Dated 02/09/2022 O2 @ 2-3 LPM via nasal cannula as needed for Sat <90 %. Observation on 03/26/24 at 8:56AM revealed Resident #49 not in room. Further observation of resident having an oxygen machine in the room with a humidifier bottle connected to the machine. The humidifier bottle was dated 03/05/24 . Observation on 03/26/24 at 9:15AM revealed Resident # 32 was sitting up in w/c at the bedside, dressed in street clothing with the call light in reach. Further observation revealed a breathing mask connected to tubing hanging off resident's nightstand drawer. The breathing mask and tubing was not dated. Interview on 03/27/24 at 2:18PM LVN Z said all respiratory equipment including tubing, mask, and oxygen humidifier bottle had to be changed out once a week on Sundays on the night shift for infection control. LVN A said when the respiratory equipment mask was not in use, it had to be inside of a bag. LVN Z said the mask should be dated. Interview on 03/27/24 at 2:32PM the DON said all respiratory equipment when being used should be changed weekly and dated for infection control. The DON said the respiratory equipment should also be stored inside of a bag when not in use. The DON said it was her herself and the Infection Control Nurse that ensured the practices were being carried out. The DON said IV tubing should be changed daily and dated to prevent being used outside of the parameters. The DON was asked for a policy on storage of respiratory equipment. The DON said she did not think the NF had a policy on maintaining respiratory equipment. Interview on 03/28/24 at 2:32PM the Infection Control Nurse said IV tubing should be dated and changed every 24 hours for infection control. The Infection Control Nurse said he and the DON checked IV tubing as well as respiratory equipment to ensure that the staff were dating and changing equipment.