STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455812	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at First Colony	4710 Lexington Blvd Missouri City, TX 77459

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48923 Based on observation, interview, and record review, the facility failed to ensure the resident's right to respect and dignity for 3 (Resident #78, Resident #70, and Resident #73) of 8 residents reviewed for respect and dignity, in that: 1. CNA M and MA J laughed while redirecting Resident #73 away from Resident #78 and #70. 2. CNA M and MA J called Resident #73 crazy while redirecting him away from Resident #78 and #70. This deficient practice could lead to psychosocial harm due to feelings of low self-esteem and/or embarrassment. The findings were: Record review revealed of Resident #78's Facesheet dated 10/14/2024 revealed she was an [AGE] year-old female who admitted to the facility on [DATE]. Her medical diagnoses included but not limited to cognitive communication deficit, diabetes mellitus (body's inability to regulate blood sugar) due to underlying condition with diabetic neuropathy (blood flow damage), muscle weakness, encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg above knee, pain, other lack of coordination, and difficulty in walking. Record review of Resident #78 Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS, with 15 being the highest cognitive function) score of 15 which reflected intact cognition. Record review of Resident #78's undated Care Plan revealed: MOOD/BEHAVIOR: Resident had a history of alteration in mood or exhibition of behavioral symptoms of crying withdrawal r/t depression. Record review of Resident #70's Facesheet dated 10/14/2024 revealed Resident #70 was a [AGE] year-old female who admitted to the facility on readmitted on [DATE] and initially admitted on [DATE]. Resident's medical diagnoses included but were not limited to metabolic encephalopathy (brain disorder causing imbalanced functions), benign neoplasm (brain cancer) of cerebral meninges (benign tumor), repeated falls, Alzheimer's disease with early onset, and major depressive disorder, recurrent. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #70's Comprehensive MDS dated [DATE] revealed a BIMS, (with 15 being the highest cognitive function) score of 13 which reflected intact cognition. Record review of Resident #70's Care Plan revised 09/09/2024 revealed resident MOOD/BEHAVIOR: Resident had a behavior or exhibition of behavioral symptoms, crying and increased confusion r/t: Depression. 07/15/2024 Crying in her room, offered r/t, stated she was fine. Date Initiated: 04/05/2023 Revision on: 07/16/2024. COGNITIVE IMPAIRMENT: Resident had impaired cognition and was at risk for further decline and injury as evidence by (AEB), diagnosis (Dx) ALZ/Dementia Date Initiated: 09/18/2023 Revision on: 09/18/2023. Record review of Resident #73's Facesheet dated 10/05/2024 revealed Resident #73 was a [AGE] year-old male who admitted to the facility on [DATE] and initially admitted on [DATE]. Resident's medical diagnoses included but were not limited to altered mental status, bipolar disorder, dementia, unspecified severity, with other behavioral disturbance, and insomnia. Record review of Resident 73's Quarterly Minimum Data Set (MDS) dated [DATE] revealed a BIMS (with 15 being the highest cognitive function) score of 09 which reflected moderate impairment. Record review of Resident #73's Care Plan revised 09/12/2024 revealed Care Plan revised 09/09/2024 revealed resident had difficulty being engaged throughout the day. INSOMNIA: Resident had a potential for fluctuations in sleep patterns and injuries AEB, Dx insomnia Date Initiated: 09/09/2024. Resident had a Dx of Dementia and was at risk for increased confusion and decline in Activities of Daily Living (ADL)'s as the diseases progresses Date Initiated: 09/09/2024 Revision on: 09/09/2024. During an observation/interview on 10/05/2024 at 01:28 PM, Resident #78 stated that on 10/03/2024 Resident #73 came into her room in his wheelchair. She stated that she was lying down in her bed and jumped up into her wheelchair. She stated Resident #73 came towards her and began pulling her hair and t-shirt. She stated she began screaming and was able to wheel into the hallway screaming for help until staff whose names and descriptions she could not provide came to remove Resident #73 from her room. She stated the staff who came to remove resident #78 kept laughing, saying, What can we do he is crazy. She stated that was their only answer and response to Resident #73's actions and she does not feel they understood the emotional impact of fear and lack of peace and security it had brought to her. She could not understand why the staff thought it was funny to laugh when she was so upset. She stated that she does not feel like staff had taken the situation serious and it made her feel bad. She stated that this was the second time that Resident #73 had come into her room where staff had to remove him. She stated that she had only one leg and it hinders her ability to get around. She asked why she should not have to cope with Resident #73 coming into her room making her feel unsafe and fearful when her mobility was already affected. She stated that she wanted to live in peace not to be hurt and not to be hit by Resident #73. She stated the incident had affected her nerves negatively. She stated that the facility was a madhouse and not a decent place to live peacefully. She stated that the resident belonged in another area of the facility where he does not bother resident who need and receive normal care. She stated she wanted to get out of this facility so she could live a quiet life. She does not want to be afraid. Resident #78 provided her interview while visibly upset and tearful. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/05/2024 at 01:37 PM, Resident #70 stated that on 10/03/2025 she was in her bed when Resident #73 entered into her and her roommate #78's room. She stated Resident #70 wheeled himself over to Resident #78's side of the room, but because of the privacy curtain she could not see. She stated then she began hearing Resident #78 screaming and crying and Resident #78 wheeled past her out of the room into the hall screaming and crying. She stated then Resident #73 then wheeling behind the curtain in front of Resident #78's bed, but his wheels had gotten stuck near the foot of Resident #78's bed and he could not move. She stated from her bed she continued to see and hear Resident #78 continued screams and yells. She stated that 2 or 3 staff came to assist Resident #73 out of their room. She stated that the staff were laughing saying Resident #73 was crazy and what could they do. She stated that she felt so bad for Resident #78 who was crying and very upset. She stated the staff's laughter had made her feel bad and she felt bad for Resident #78 when she heard the staff laughing about what had happened. She stated she had not seen Resident #73 pull Resident #78's hair or t-shirt maybe because that had happened when the privacy curtain blocked her line of sight. Resident #70 stated that she feels safe at the facility, but she does not appreciate how the staff laugh and called Resident #73 crazy. During the interview Resident #70 was observed confidently recalling the events of the incident. When the resident was specifically asked what she witnessed of the staff, Resident #70 shrunk down in her bed and began to speak softly. Resident #70 stated it had made her feel bad when the staff had laughed and called Resident #78 crazy for what he had done to Resident #78. She stated that she does not believe that was the professional response to the incident. During an observation and interview on 10/05/2024 at 01:41 PM, revealed Resident #73 lying in his bed under a blanket, alert. Resident #73 repeated everything asked of him. He was only able to respond that he was Resident #73. During an interview on 10/05/2024 at 01:42 PM, CNA O stated she worked PRN and had begun working with facility on 10/03/2024. CNA O was observed sitting in a chair at the foot of Resident #73's bed. She stated she had been assigned to provide one-on-one (1:1) care for the resident. She stated that she had been sitting with the resident since 6:00 AM and had fed him breakfast, lunch and changed his briefs throughout her shift with Resident #73. She stated she was not aware why but was told the resident was required 1:1 care 24-hours a day. She stated that she would sit with the resident until 2:00 PM when her shift ends and then another staff member would sit with the resident. She stated she was unaware when the 1:1 began but was told that someone had sat with the resident overnight. She stated that he had not gotten up out of the bed today but had spoken with her throughout the day making jokes and laughing. She stated 10/05/2024 was her first 1st time working with Resident #73. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/07/2024 at 12:41 PM, CNA M stated that on 10/03/2024 she was in another resident's room when she heard Resident #78 screaming. She came out to find Resident #78 screaming into her phone's interpreter app which translated that Resident #73 came into her room and hurt her. She stated that CM J told her that she had not seen Resident #73 in Resident #78's room, only at the resident's room door. She stated that MA J redirected Resident #73 back to his room. She stated that Resident #73 was hungry and may have entered Resident #78's room because she has food on her table. She stated that Resident #73 wanders and staff redirected him to his room by giving him snacks. She stated Resident #73 had usually went to the dining room to get snacks from the kitchen, but since remodeling he has not been able. She stated she had in-services on abuse and residents with behaviors. She stated that she cannot be everywhere and stated she was sorry the incident happened. She stated that MA J reported the incident to the RN F. She stated that Resident #78 does not have behaviors such as yelling or screaming, and never asked staff for assistance. She stated staff only attend to Resident #78's roommate Resident #70. She stated she had not laughed nor was aware if MA J laughed when redirecting the residents. During an interview on 10/07/2024 at 01:36 PM, RN F stated that MA J reported to her that Resident #78 was upset that Resident #73 entered her room. She stated she was unaware if MA J witnessed Resident #73 enter Resident #78's room. She stated she witnessed Resident #78 speaking in her language and speaking to MA J. She stated that she had not witnessed any staff laughing when redirecting the residents. She stated if she had witnessed inappropriate laughing or resident abuse or neglect, would report the incidents to the ADM who was the abuse coordinator. During an interview on 10/07/2024 at 01:39 PM, MA J stated she was on break when she heard a commotion. She stated she came into the hall but had not seen Resident #73 go into Resident #78's room. She stated she had not heard any laughter nor heard anyone call the residents crazy. She stated she does not know who removed Resident #73 from Resident #78's room. During an interview on 10/07/2024 at 01:41 PM, ADM A stated that she interviewed staff, and all denied laughing when redirecting residents. She stated Resident #73 was receiving 1:1 supervision until psych services and the DON could determine if he would be appropriate placed in the secure unit. She stated that Resident #73 has a BIMS of 09 which reflected he was moderate impairment, but had ended up rummagin through resident's items. She stated that they had begun educating staff on resident rights. She stated the SW met with Resident #78 on 10/03/2024 and reported that she does not want Resident #73 in her room. She stated that Resident #70 had not mentioned any staff laughing when Resident #73 was in their room. During an interview on 10/07/2024, 01:41 PM, the DON stated that Resident #73 was evaluated by psych service to determine if he should be appropriately placed in the secure unit after incidents of rummaging. She stated they were waiting on the outcome of the assessment. Record review of Resident #78's Progress Note dated 10/04/2024 at 06:32 PM reveled Social Services Note Note Text: PSYCHO SOCIAL ASSESSMENT: SW met with resident in her room, resident appeared calm and relaxed. Resident was on her phone watching a video. SW spoke with resident regarding incident that occurred yesterday with the aid of an interpreter. When asked if she was ok, resident replied that she is fine. When asked if she felt safe, she said yes. When asked if she would like to see the psychologist or psychiatrist, resident declined. Resident does not appear to have any adverse effects from said incident. SW will continue to follow up with resident. Author, SW. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #78's Progress Note dated 10/04/2024 at 06:32 PM reveled Social Services Note Note Text: PSYCHO SOCIAL ASSESSMENT: SW met with resident in her room, resident appeared calm and relaxed. Resident was on her phone watching a video. SW spoke with resident regarding incident that occurred yesterday with the aid of an interpreter. When asked if she was ok, resident replied that she is fine. When asked if she felt safe, she said yes. When asked if she would like to see the psychologist or psychiatrist, resident declined. Resident does not appear to have any adverse effects from said incident. SW will continue to follow up with resident. Author, SW. Record review of Resident #78's Progress Note dated 10/04/2024 at 06:39 PM revealed Social Services Note Note Text: SW informed psychologist of incident that occurred yesterday. Author, SW. Record review of Resident #73's Progress Note dated 10/03/2024 at 06:01 PM revealed Summary Narrative: resident alert to self with needs anticipated by staff. Resident to be on 1:1 until further notice due to potential for wandering into other resident's room. Author, DON. Record review of Resident #73's Progress Note dated 10/03/2024 at 06:42 PM revealed Social Services Note Late Entry: Note Text: SW informed psych service's NP, SW r/t resident's aggressive behavior towards another resident. Social Services. Record review of Resident #73's Progress Note dated 10/03/2024 at 08:47 PM revealed, Nursing Note: Resident has been receiving one on one care until further notice, no behavior issue noted on shift. Will continue with the plan of care. Author, LVN OO Record review of Resident #73's Progress Note dated 10/03/2024 at 11:30 PM revealed, No Type Specified. Note Text: NP and responsible party (RP) notified about incident involving a second resident. No concerns presented at this time. Author, ADM A. Record review of the facility policy Resident Rights last revised June 2019, revealed the facility provides the resident with an environment that preserves dignity, privacy and contributes to a positive self-image . 13. The facility must provide a safe, functional . and comfortable environment for residents, staff and the public.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on observation, interview, and record review the facility failed to ensure all alleged violations involving abuse are reported immediately to the Administrator of the facility for 1 resident (Resident #91) reviewed for abuse. LVN M failed to immediately report her suspicions of abuse when notified Resident #91 was slapped. The deficient practices could affect any resident and contribute to further abuse or neglect. Findings included: These failures could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. Findings included: Record review of Resident #91's Facesheet dated 10/01/2024 revealed Resident #91 was an [AGE] year-old female who admitted to the facility on [DATE]. Her medical diagnoses included but not limited to chronic obstructive pulmonary disease (lung disease making it difficult to breath), dementia (cognitive loss), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, atherosclerotic heart disease of native coronary artery (plaque builds up in the coronary arteries) without angina pectoris (heart muscle not receiving enough oxygen), schizophrenia, anxiety disorder, depression, difficulty in walking, adult failure to thrive, and Alzheimer's disease. Record review of Resident #91's Quarterly MDS dated [DATE] revealed a BIMS, (a measure of cognitive function, with 15 being the highest cognitive function) score of 07 which indicated severe cognitive impairment. Record review of Resident #91's Care Plan revised 09/12/2024 revealed resident was care-planned for the following: Focus: increased pain, limited ambulation, Focus: Resident resides in the memory care unit, impaired cognition secondary to dx: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, schizophrenia, unspecified and need for reduced stimuli. date initiated: 04/24/2024 revision on: 04/24/2024 due to memory loss, she forgets and needs frequent reminders date initiated: 03/22/2024 revision on: 06/03/2024. Record review of Resident #91's Progress Notes dated 07/13/2024 at 02:12 PM entered by LVN M revealed Family #1 reported that Resident #91 told her that an unknown CNA had slapped her 3 or 4-days ago. Resident #91 could not remember the person and she had not told any staff. LVN M reported to the manager on duty the complaint. The manager on duty spoke with Family #1. Resident #91 stable, awake alert to her baseline. No distress or any discomfort noted at this time. Denied any spitting of blood or pain at this time. Plan of care continue on this shift. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #91's Progress Notes dated 07/22/2024 at 11:54 AM entered by LVN M revealed resident awake and alert to her baseline. Resident reported CNA/someone slapped her and when LVN M went with the CNA (unknown), resident stated nobody slapped her or had done anything to hurt her. During an observation and interview on 10/01/2024 at 02:57 PM Resident #91 stated that she could not remember reporting someone slapped her, but it was possible. She stated that staff rough her, and that Family #1 would know about happened. She was unable to provide any staff names, descriptions, or dates of incidents. During an interview on 10/02/2024 at 01:12 PM, Family #1 stated that Resident #91 reported to her that she was being assaulted by CNAs. She stated that Resident #91 was incontinence, frequently used the bathroom, and had issues with her holding down food and often removed her brief when staff would not timely. She stated that this frustrated staff who would then as reported by Resident #91 would rough her up, particularly a young Indian lady. She stated she reported the allegations to a manager on duty and the DON. During an interview on 10/02/2024 at 02:57 PM, the DON stated that she had not been informed of any abuse allegations reported regarding resident #91. She stated that ADM B was the abuse coordinator and responsible for reporting abuse allegations to the State Survey Agency and initiated and complete the abuse investigations. During an interview on 10/03/2024 at 10:30 AM, the ADM A stated that she could not find that the Resident #91's abuse allegations were reported to HHSC. She stated she reported the allegations to the HHSC on 10/03/2024 and treating it as a brand-new reportable allegation. During an interview on 10/04/2024 at 01:05 PM, LVN M stated that Family #1 had visiting on the weekends and reported that someone had slapped Resident #91. She stated called the manager on duty, or maybe the therapy manager but could not recall who either of those individuals were. During an interview on 10/14/2024 at 03:11 PM, ADM B stated she never received any communication from LVN M or any other staff or individual that Resident #91 was slapped by a staff. Record review of the facility policy, Abuse, Neglect, and Exploitation, revised April 2024 revealed that the Administrator or designee shall report allegations of abuse to the State Health Department within 24 hours. Record review of HHSC reporting intake website does not reveal any reports/intakes of abuse involving Resident #91. In July 2024 10/03/2024.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44669 Based on interview and record view the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or result in serious bodily injury to the administer of the facility and to other officials including the State Survey Agency in accordance with State law through established procedures for 1 of 6 residents (Residents #91) reviewed for abuse and neglect. The facility failed to report an incident where Resident #91 reported to Family #1 she was slapped by CNA/someone at the facility on 07/13/2024 and 07/22/2024. These failures could place residents at risk for abuse/neglect and could lead to a diminished quality of life and psychosocial harm. Findings included: Record review of Resident #91's Facesheet dated 10/01/2024 revealed Resident #91 was an [AGE] year-old female who admitted to the facility on [DATE]. Her medical diagnoses included but not limited to chronic obstructive pulmonary disease (lung disease making it difficult to breath), dementia (cognitive loss), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, atherosclerotic heart disease of native coronary artery (plaque builds up in the coronary arteries) without angina pectoris (heart muscle not receiving enough oxygen), schizophrenia, anxiety disorder, depression, difficulty in walking, adult failure to thrive, and Alzheimer's disease. Record review of Resident #91's Quarterly MDS dated [DATE] revealed a BIMS, (a measure of cognitive function, with 15 being the highest cognitive function) score of 07 which indicated severe cognitive impairment. Record review of Resident #91's Care Plan revised 09/12/2024 revealed resident was care-planned for the following: Focus: increased pain, limited ambulation, Focus: Resident resides in the memory care unit, impaired cognition secondary to dx: unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, schizophrenia, unspecified and need for reduced stimuli. date initiated: 04/24/2024 revision on: 04/24/2024 due to memory loss, she forgets and needs frequent reminders date initiated: 03/22/2024 revision on: 06/03/2024. Record review of Resident #91's Progress Notes dated 07/13/2024 at 02:12 PM entered by LVN M revealed Family #1 reported that Resident #91 told her that CNA (unknown) slapped her maybe 3 or 4-days ago and she had not remembered the person and she had not told nobody. LVN reported to the manager on duty the complaint. The manager on duty spoke with Family #1. Resident #91 stable, awake alert to her baseline. No distress or any discomfort noted at this time. Denied any spitting of blood or pain at this time. Plan of care continue on this shift. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #91's Progress Notes dated 07/22/2024 at 11:54 AM entered by LVN M revealed resident awake and alert to her baseline. Resident reported CNA/someone slapped her and when LVN M went with the CNA (unknown), resident stated nobody slapped her or had done anything to hurt her. Resident stated that it happens in her dream not in this place. Assessment done no bruise or redness noted on resident face, head, or any part of her body at this time. Plan of care will continue. During an observation and interview on 10/01/2024 at 02:57 PM Resident #91 stated that she could not remember reporting someone slapped her, but it was possible. She stated that staff rough me up. She stated that Family #1 would know about her being roughed up. She stated she had problems with staff all the time but could not neither provide any specifics on being roughed up, nor any staff names, descriptions, or dates of incidents. When asked had she felt safe at the facility resident responded, I guess. and shrugged her shoulders. During an interview on 10/02/2024 at 01:12 PM, Family #1 stated that Resident #91 reported to her that she was being assaulted by CNAs. She stated that Resident #91 was incontinence, frequently used the bathroom, and had issues with her holding down food. She stated that the resident reported to her that CNAs were not coming and change her briefs timely and the resident would become irritated with the soiled briefs and remove them. She stated that the resident told her that when removing the briefs, she would make a mess and staff would become frustrated with the resident because of the mess and roughed her up. She stated that the resident could not provide the name of the CNA but descripted her as a young Indian lady. She stated there were no bruise marks or evidence of resident being roughed up. She stated she never spoke with the CNA. She stated that the resident was moved to another room and that CNA no longer provided the resident care and she had not seen her since. She stated she reported the allegations to management and the nurses. She stated that they listened to her concerns, but they informed her without any names or descriptions there was nothing they could do. She could not recall the names of the management staff only than one of them was filling for the DON. She stated Resident #91 has not spoken about being roughed up in a while and hoped that incidents had stopped. During an interview on 10/02/2024 at 02:57 PM, the DON stated that she had been with the facility since May of 2024. She stated she had not been made aware that Resident #91 made allegations of abuse on 07/13/2024 and 07/22/2024. She stated that ADM B was the abuse coordinator and responsible for reporting abuse allegations to the State Survey Agency and initiated and complete the abuse investigations. The DON stated the potential negative outcome of not following the facility's abuse policy was that someone could be abused, harmed, or not be taken care of at the facility. She said she was familiar with the facility's abuse policy and had been trained on the policy. She stated had she been made aware of an allegation of abuse, she would immediately notify the ADM, ensure that the resident was safe from any further harm, complete a head-to-toe assessment of the resident to ensure no signs of pain or injury were present. She stated the ADM B's last day with the facility was 08/30/2024. During an interview on 10/03/2024 at 10:30 AM, the ADM A stated her first day with the facility was on 09/30/2024. She stated that she could not find that the Resident #91's abuse allegations were reported to HHSC. She stated she reported the allegations to the HHSC on 10/03/2024 and treating it as a brand-new allegation since it cannot be located. She stated that the SW would perform resident safety questionnaires. (continued on next page)

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	455812	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at First Colony	4710 Lexington Blvd Missouri City, TX 77459

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/04/2024 at 01:05 PM, LVN M stated that she was PRN with the facility. She stated her last full-time shift with the facility was in July 2024. She stated she was familiar with Resident #91 and the abuse allegations. She stated Family #1 had visiting on the weekend and reported that someone had slapped Resident #91. She stated she checked on the resident walked the resident around and told her to point at the staff member who slapped her. She stated that the resident was unable to identify a staff member and told her that maybe it happened another day. She stated she performed a physical assessment on resident. The resident said she was slapped in the face, then the back, and then said, No, on the leg. The resident then told her that maybe it had been a dream and happened on another day, and maybe not in that facility. She stated that her physical assessment found no bruising or redness noted to resident's face, head or any part of her body at that time. She stated once the assessment was completed, Family #1 asked was the allegation going to report to ADM B. She told Family #1, yes, but Family member said not to report since there were no marks also stating that maybe the incident does not even happen, as the resident said things that have not happened all the time due to her dementia diagnosis. She stated that she told Family #1 since a slap had been reported, she had to report. She stated called the manager on duty, or maybe the therapy manager who spoke to Family #1. During an interview on 10/14/2024 at 03:11 PM, ADM B stated she was the interim administrator of the facility from approximately 05/23/2024 through 08/28/2024 and was the facility's abuse coordinator. She stated that she submitted several self-reports during her time at the facility, never received any communication from LVN M regarding Resident #91 being slapped by a staff of [NAME] nationality. During an interview on 10/18/2024 at 06:34 PM, ADM A stated on 07/13.2024, the manager on duty was the DOR. She stated on 07/22/2024 ADM B and the DON were on duty. Record review of the facility policy, Abuse, Neglect, and Exploitation, revised April 2024 revealed that the Administrator or designee shall report allegations of abuse to the State Health Department within 24 hours. Record review of HHSC reporting intake website does not reveal any reports/intakes of abuse involving Resident #91. In July 2024 10/03/2024. 48923

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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** 32422 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment describing services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 3 residents (Residents #88 and #43) reviewed for comprehensive care plans. 1. The facility failed to care plan Resident #88's behavior of removing her oxygen cannula off her face and not properly storing the cannula when not in use. 2. The facility failed to care plan Resident #43 for potential skin issues due to being always incontinent with bladder and frequently incontinent with bowel . This failure could lead to residents not having their individual, medical, functional, and psychosocial needs identified and cause a physical or psychosocial decline in health. Findings included: 1. Record review of Resident #88's face sheet dated 09/30/2024 revealed a [AGE] year-old who was admitted to the facility on [DATE] with medical diagnoses including: chronic obstructive pulmonary disease (lung condition that limits airflow in and out of the lungs due to swelling and irritation), dysphagia (difficulty swallowing), Major Depressive Disorder, Post-Traumatic Stress Disorder, hypothyroidism (underactive thyroid gland), and hypertension (high blood pressure). Record review of Resident #88's Quarterly MDS assessment dated [DATE] revealed she had a BIMS (short assessment of mental status) score of 15, indicating high cognitive intactness. Further review revealed Resident #88 used a wheelchair and that she was fully independent in all self-care activities except for showering or bathing, where she required set-up or clean-up assistance . Resident #88's MDS did not reflect that she was on oxygen therapy. Record review of Resident #88's MAR (medication administration administration) for September 2024 revealed she had physician orders started on 10/16/2023 for oxygen at 2-6 liters to keep o2 sats above 92% as needed. Record review of Resident #88's physician notes dated 07/02/2024, the MD wrote under her COPD diagnosis: patient has a history of significant COPD, currently symptoms/COPD well-controlled, patient is sometimes noncompliant with keeping the oxygen on, patient has been advised to keep the supplemental oxygen on, understands risks. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #88's care plan last reviewed 09/10/2024 revealed she had a focus area of shortness of breath and at risk for respiratory distress/failure and increased episodes of SOB (shortness of breath) as evidenced by COPD diagnosis. Resident #88 refused to be sent to the ER for evaluation after complaining of SOB on 04/29/2024. Interventions included: applying O2 per order, check pulse oximetry as ordered, and observe for s/sx of respiratory infection and report any noted to the MD. Resident #88's care plan did not address her behavior of removing oxygen cannula against physician orders. Observation of Resident #88's room on 09/30/2024 at 9:30am, revealed the oxygen cannula was on the bed underneath two sheets and one blanket near the left edge of the bed. Observation and interview with RN G on 09/30/2024 at 9:30am, revealed RN G came into Resident #88's room and took the cannula out and put it in a clean bag. RN G stated a risk of keeping the cannula on the mattress would be it could catch fire and infection control . Interview with Resident #88 on 09/30/2024 at 12:55pm, she stated that her oxygen was working well and she had no issues and that she measured her own oxygen using her personal pulse oximeter because she was a smoker. She had been educated on oxygen use by staff. Interview with the Administrator and RNC on 09/30/024 at 2:16pm, the RNC said Resident #88 tended to lay her cannula on the sheet. The RNC said that the nurses should have cleaned the cannula when Resident #88 laid it on her bed but that it was not an infection control issue because it was unknown if Resident #88 placed the cannula back on for use without it being cleaned first. The RNC said Resident #88 had been at the facility for a few years and was independent and that nurses did not track or monitor the oxygen while she smokes. Interview with the MDS Coordinator A on 10/05/2024 at 1:01pm, she said that Resident #88 has PRN oxygen orders and that there is was documentation Resident #88 was educated on keeping her oxygen equipment clean and taking care of it. MDS Coordinator A said Resident #88 was care-planned for oxygen, but that MDS Coordinator A recently put in the care plan that Resident #88 tended to take off her cannula and leave the room without cleaning it and storing it. MDS Coordinator A said that Resident #88 leaving the cannula out in the open was an infection control risk because it could end up on the floor which is dirty and where people step on it. MDS Coordinator A said that Resident #88 is documented for respiratory issues and that she should know how to turn off her oxygen concentrator, but that staff are responsible for turning it off if they saw her going down the hall away from her room. Another interview with the Administrator on 10/07/2024 at 2:00pm, she said that each patient had individualized care plans which allowed staff to know how to better take care of the patient as an individual. 2. Record review or Resident #43's admission record dated October 3, 2024 revealed a [AGE] year-old male admitted to the facility on [DATE]. Resident #43's diagnoses included cerebrovascular disease (conditions that affect blood flow to your brain) and hemiplegia and hemiparesis following cerebral infarction (both conditions that can occur after a cerebral infarction, or stroke, and are characterized by weakness or paralysis on one side of the body). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #43's admissions MDS dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 out of 15 revealing he was cognitively intact. The MDS assessment revealed that Resident #43 was impaired on one side with upper extremities and limited on both sides with lower extremities with functional range of motions. Resident #43 was coded to be always incontinent of bladder and bladder. Record review of Resident #43's baseline care plan dated of 5/29/2024 revealed that he was always incontinent with bladder and frequently incontinent with bowel. 1. Urinary continence required assistance to total dependence with his ADL's Record review of Resident #43's comprehensive care plan revealed there was no skin/wound care planned though the area was triggered on the Admission CAA (Care Area Assessment summary) dated 6/2/2024. During an interview on 10/3/24 at 1:32pm the DON said that Resident #43 should have a comprehensive care plan to address the potential for skin issues, that Resident #43 was incontinent of bladder and also used the urinal. She added that a potential negative outcome of not having a care plan to address skin issues would be a potential unawareness of required care to provide. She said that the MDS Coordinators would be responsible for creating the care plans and that they facility had one MDS Coordinator on site along with a Regional MDS Nurse. During an interview on 10/4/2024 at 1:00 pm MDS Coordinator A said that Resident #43 should have a comprehensive care plans to address the resident for skin issues and she missed it. She said Resident #43 was in bed quite a bit, he was care planned for using the urinal, but she should have care planned him for skin issues. She said she used the RAI manual for assessments and care plans. She said that a negative outcome for a resident not care planned for skin could be skin irritation, rashes and possible skin break down. She added that there was another staff that also held responsibility for care plans that works off-site, MDS Coordinator B and she believed that Resident #43 admitted under skilled care so MDS Coordinator B would have completed Resident #43's initial care plan. During a telephone interview on 10/4/2024 at 1:15 pm with MDS Coordinator B, she said that Resident #43 should have had a care plan to address skin issues and the potential negative outcome could be skin breakdown, if not care planned. She confirmed using the RAI Manual for care plans. Record review of the facility's Care Planning Nursing Policies and Procedures last revised June 2019, revealed the comprehensive care plan is developed within seven days of the comprehensive assessment for each resident by the interdisciplinary team.

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 48923 Based on observation, interview and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 1 (Resident #37) residents reviewed for intravenous fluids. - The facility failed to ensure Resident #37 had physician orders and care plan in place for monitoring and dressing change of Resident #37's PICC line (Peripherally Inserted Central Catheter, a tube inserted through a vein in the arm which passes to the larger veins near the heart and used to deliver medications, liquid nutrition or other treatments) from when Resident #37 was readmitted from the hospital with a PICC line on 9/09/2024 to 10/2/2024 when the NP put in an order for the PICC line to be discontinued. -The facility failed to ensure Resident #37 's PICC line was removed after completion of IV antibiotics which ended on 09/19/24. -The facility failed to ensure Resident #37 's dry dressing was changed every 5 to 7 days per facility policies and procedures, including orders for monitoring the site. An IJ was identified on 10/04/2024. The IJ template was provided to the facility on [DATE] 12:47pm. While the IJ was removed on 10/06/2024 at 11:47am, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern due to the facility need to evaluate the effectiveness of the corrected system. This deficient practice could place residents at risk of serious harm, injury or death by leaving the PICC line in longer than necessary and exposing residents to infections in the blood stream and serious illness. Findings included: Record review of Resident #37's face sheet dated 10/03/2024 revealed he was a [AGE] year-old male that was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of acute cystitis with hematuria (a bladder infection that may cause blood in the urine), anemia(low red blood cell count), hypotension (abnormally low blood pressure), colostomy (a surgical opening for the colon in the abdomen which provides an alternative channel for feces to leave the body), intestinal obstruction, and schizophrenia (a serious mental health condition which may include hallucinations, delusions and disorganized thinking and behavior) . (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #37's hospital discharge records dated 9/9/24 revealed Resident #37's midline placement (a catheter placed in a vein used to deliver medications and other treatments quickly to the body) date was 09/05/24. Further review revealed Resident #37 was ordered meropenem (MERREM) 500 mg intravenously every 8 hours for 9 days with a start date of 9/10/2024 and a stop date of 9/19/2024. He had a transfer diagnosis of hematuria (blood in urine). Record review of Resident #37's September MAR revealed he received the medication every shift as ordered starting 09/10/2024 at 11:00pm to 09/19/2024 at 3:00pm. Record review of Resident #37's physician's orders last updated 10/03/2024 and care plan last revised 09/11/2024 revealed no documented orders or instructions for maintenance of midline and dry bandage. Record review of Resident #37's physician's progress notes dated 9/11/24 revealed, Patient is being seen today to follow up on hospitalization . Patient is on IV abx (antibiotics) for 9 days for sepsis . Observation on 10/1/24 at 5:10 p.m., revealed Resident #37 lying in bed and , had a PICC line in his left arm, double lumen (a catheter which splits into two tubes, with each tube being used to take or give blood products and the other used for medication or IV fluids) with two tape dressings cover it one on the other. The first dressing was dated 9/5/24 which was when Resident #37 was in the hospital and the second dressing on top was used to secure the first dressing and was not dated. Both dressings and tape were brownish in color. Resident #37 was not interview-able and had a representative at bedside. Interview with the DON on 10/2/2024 at 2:54pm, nurses should ensure residents with PICC line have physician orders for it. PICC line dressings should be changed every 5 to 7 days and that nurses should observe the PICC line site every shift to ensure no redness, drainiage, not be hot to the touch. Interview with the MDS Coordinator A on 10/3/24 at12:28p.m., she was not aware of Resident #37's PICC line. She always assessed a resident with PICC on admission, documenting how the PICC line site is and checking for infection. She said currently the facility had 2 residents with a PICC. Interview with LVN B on 10/03/2024 at 11:52am, she stated that nurses were to follow physician's orders for residents with PICC llines. LVN B stated that dressing changes should be done every 5 to 7 days and as needed and that nurses should inform the doctor when a resident's antibiotic therapy was completed. LVN B said sometimes a PICC Line was not removed immediately after antibiotic therapy completion because the resident's physician ordered more labs before discontinuing the PICC Line, but that she would continue to monitor and flush the PICC line every shift until it is discontinued. She said she never worked with Resident #37. Interview with LVN C on 10/03/2024 at 12:00pm, he stated that when a resident is admitted to the facility with a PICC Line, they should already have physician's orders for it, including dressing changes. LVN C stated that after a resident completes antibiotic therapy, the physician should be notified. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with LVN A on 10/03/2024 at 3:00 pm, LVN A stated when a resident was admitted the nurse was supposed to call the physician do all the paperwork such as verifying and entering medications and treatments into the MAR. Interview with NP A on 10/3/2024 at 4:32pm, she stated that when a resident is admitted from the hospital the NP will review medications that day and review the resident's clinical notes the next on-site visit. NP A stated she did not put any orders for the resident's PICC line to be discontinued nor for dressing changes it, but that it was her fault that the orders were not put in Resident #37's MAR and it was her responsibility to do that when her residents were admitted with a PICC line. She stated that nurses are to update her if there is changes in condition and to questions her orders, but that they did not do so. NP A stated that PICC lines would be discontinued after the treatment is completed and after all labs are done to confirm it can be removed. She stated the facility called her on 10/2/24 to get the PICC line discontinued. NP A said that risks for a resident not having their dressing changed per physician's orders or standard practice is that it could cause infection and sepsis. Interview on 10/3/24 at 5:04pm with the ADON and Administrator, the ADON said that the PICC line and dressing change should be administered according to physician's orders and that nurses were expected to let the doctor know when the antibiotics were completed. The ADON said that when a resident completed their antibiotics, the nurse should call the physician to see if the order should be discontinued, if labs needed to be drawn or if the antibiotics need to be continued. The Administrator said that staff should have followed physician's orders. The ADON said that having the dressing on since 9/5/24 would be an infection control concern and it could pose a risk of bacteria with a dressing on that long without being changed and cleaned. The Administrator said the risk due to leaving the bandage on for that amount of time is related to infection control . An IJ was identified on 10/04/2024. The facility was notified of the IJ on 10/04/2024 at 12:47pm with the Interim Administrator, RNC and DON present. The IJ template was provided to the facility on [DATE] 12:47pm and a POR was requested by email to the Interim Administrator, RNC and DON. The following Plan of Removal was submitted by the facility and accepted on 10/04/2024 at 5:45pm. Allegation F694: [Facility Name] - IJ Plan of Removal F694 10/4/2024 The facility failed to ensure a peripherally inserted central catheter (PICC) (a thin, flexible tube that is inserted into a vein in the upper arm and ends in a large vein near the heart) used to administer parenteral fluids and antibiotics had an order how to cleaned and discontinued consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. On October 2, 2024, Resident #37's PICC line was assessed by the Director of Nursing (DON), with no adverse effects or signs or symptoms of infection noted. A physician's order was obtained for the removal of the PICC line, and PICC line was discontinued without adverse effects. The Physician ordered lab work on 10/3/24 and results were noted with no adverse findings. (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On October 2, 2024, all other residents with central lines were assessed by the Director of Nursing to ensure an up-to-date dressing, active order sets to include monitoring, flushes, dressing changes, orders to obtain central lines after IV therapy is completed, and central line specific care plans. No adverse findings were noted. The Administrator and DON informed the Medical Director of the Immediate Jeopardy situation on October 4, 2024, through an AD Hoc QAPI meeting. The Regional Nurse Consultant provided 1:1 education with the DON on 10/2/24 on providing oversight with residents with central lines and ensuring compliance with central line policies and procedures to include active orders for monitoring central line site, flushing the central line, central line dressing changes, and obtaining orders to remove central lines after IV therapy is completed. The Director of Nursing initiated in-services with licensed nurses on 10/2/24 on and ensuring compliance with central line policies and procedures to include active orders for monitoring central line site, flushing the central line, central line dressing changes, and obtaining orders to remove central lines after IV therapy is completed. Education will be completed on 10/4/24. Licensed Nurses will be educated prior to their next shift: including PRN employees or new hires. After the IJ was called out on 10/4/24, the Director of Nursing conducted 100% rounds on residents with central lines and compliance was noted with policies and procedures. The Administrator reviewed the Central Line Policies and Procedures on 10/4/24 and no changes were required. The charge nurse will input and complete orders for residents who obtain or admit with a central line and will be validated in clinical morning meeting by nurse leadership. The clinical morning meeting will include reviewing high risk residents to include residents with central lines and ensuring compliance with central line policies and procedures (orders and care plans). DON Inservice nurse leadership on 10/4 on the above process; The charge nurse will input and complete orders for residents who obtain or admit with a central line. Completion date 10/4. Record review of Physician Order policy last reviewed January 2024 revealed that all physician orders must be verified by the receiving nurse for accuracy and upon receipt the nurse will enter the order into the electronic health record. Nursing staff will review physician orders and follow up on any discrepancies or unclear orders with the prescribing physician. Record review of the facility's Nurses' Infusion Manual for Long Term Care Facilities last updated 05/16/2022 revealed a dressing changing must be done every 7 days or sooner if compromised adn be monitored for signs and symptoms of compllications from infection like swelling, redness or pain. Record review of the facility's Central Line policy last revised January 2024 revealed that nursing staff are not obtain physician orders to remove the central line once IV therapy is completed. [Signed by Interim Administrator, 10/4/2024] Monitoring the Plan of Removal for Effectiveness as follows: (continued on next page)

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation on 10/05/2024 at 12:45pm of Resident #10 revealed the resident had a left peripheral IVF hep-lock single lumen (a single catheter line placed in a vein on a resident's left side of the body that contains a medication called heparin used to prevent blood clotting), the site was cleaned with no redness, dressing infiltration, odors, or warmth. The dressing on the site was dated 10/03/24. Observations and record review of other residents with a PICC line revealed: Record review of Resident #7's orders revealed nurses were to monitor the PICC line site every shift, midline dressing change every 5 days and as needed, a midline flush 10 millilters of Normal Saline every shift. Observation of the resident on 10/05/2024 revealed Resident #7 was sitting in the dining area eating lunch with their PICC line to their left upper arm intact. Resident #7 had a left upper arm IVF hep-lock double lumen, the site was clean with no redness, dressing infiltration, odors, or warmth. Dressing on the PICC line site was dated 10/02/24. Record review of Resident #155's orders revealed nurses were to monitor the midline every shift, midline dressing changes every 5 days and as needed, a midline flush of 10 milliliters of Normal Saline every shift. Observation of Resident #155 on 10/05/2024 revealed the resident was sitting in the dining area eating lunch with the PICC line to their upper arm intact. Resident #115 had left upper arm IVF hep-lock double lumen line, the site was clean with no redness, dressing infiltration, odors, or warmth. Dressing on the PICC line site was dated 10/02/24. Interview with LVN I on 10/04/2024 at 4:30pm, she said she only took care of Resident #37 when he was admitted . LVN I said she was supposed to document in the TAR that Resident #37 is to have his PICC line inititaed but that she forgot. LVN I said that any nurse, including the nurse on the next shift could have obtained orders and entered them in Resident #37's chart. LVN I said she had not worked at the facility since that day when she admitted Resident #37. Interview with RN G on 10/05/2024 at 1:15pm, she said that she received in-services a few days ago for PICC line. RN G said she was educated on making sure residents with a PICC line had orders from their physician for monitoring, maintaining the dressing, which should be changed every 5-7 days depending on the physician orders , and to notify the physician when the residents get to the facility and when antibiotics were completed so that the nurse could place an order to discontinue the PICC line. Interview with RN A on 10/05/2024 at 1:30 pm, she said that she received in-services a few days ago for PICC line. RN A said she was educated on making sure residents with a PICC line had orders from their physician for monitoring, maintaining dressing which should be changed every 5-7 days depending on the physician orders, and that she should notify the physician when the residents get to the facility and when antibiotics are completed so that the nurse can place an order to discontinue the PICC line. Interview with the DON on 10/05/2024 at 2:00pm, the DON said the nurses were not doing what they should have, which included the documenting residents with PICC line and to check the line every shift and flush the line, ensure the site is clean, and getting Physician Orders for removal of PICC line after antibiotics are completed. The DON said she immediately started in-services on PICC line for the nurses. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455812	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at First Colony	4710 Lexington Blvd Missouri City, TX 77459

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F 0694 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with RN E on 10/05/2024 at 8:30pm, she stated she worked every other weekend as a weekend supervisor. RN E said she had in-services and also conducted in-services for other nurses, which included making sure staff get physician orders for residents with PICC lines including monitoring the line site and maintenance of the line, notifying the physician when antibiotics are completed, contacting the physician with labs and when to discontinue the PICC line. RN E stated that staff are to notify the resident's physician if they do not see PICC line orders. RN E also said that all care provided to a resident for their PICC line should be documented in their MAR. Interview with LVN B on 10/05/2024 at 8:42pm, she said that she received in-services a few days ago for PICC line. LVN E said she was educated on making sure residents with a PICC line have orders from their physician for monitoring and changing the resident's dressing every 5 to 7 days depending on the physician orders, and to notify the physician when the residents get to the facility and when antibiotics are completed so that the nurse can place an order to discontinue the PICC line. Interview with LVN D on 10/05/2024 at 9:47pm, she stated that she had been at the facility for a year and works night shifts. She stated she received educations on PICC and IV lines, making sure residents have orders after having a PICC line placed, calling the physician and verifying that residents have orders for the PICC line, monitoring for signs and symptoms of infection, and dressing changes which are every 5 days. LVN D said she also received education on informing the physician when the antibiotics are completed and make sure that orders are put in for PICC line to be discontinued. LVN D said that after treatment is completed and before being discontinued, nurses should still observe for any changes in the PICC line site and to flush the line every shift and to document anything done for the PICC line in the resident's chart. Interview with RN D on 10/05/20234 at 9:54pm, she stated that she had been with the facility for more than a year and works night shifts. She stated that she received in-services on PICC line on 10/04/2024, which included making sure residents with a PICC line have orders for dressing changes every 5-7 days depending on the physician orders, flushing before and after medication and every shift, monitoring the PICC site for signs of infection and reporting any changes to the physician, and to inform the physician when the resident's antibiotics are completed and to get an order to discontinue the PICC line per physician orders. RN D stated that after a resident is admitted , nurses are to verify PICC line orders with the resident's physician, the nurse then assess the PICC line site to see where and when the line was placed, make sure there are orders for signs of infection, dressing changes, how often to flush the line, checking fluids through the lines, and documenting PICC line care in the resident's MAR. An IJ was identified on 10/04/2024. The IJ template was provided to the facility on [DATE] 12:47pm. While the IJ was removed on 10/06/2024 at 11:47am, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of pattern due to the facility need to evaluate the effectiveness of the corrected system.

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	455812	A. Building B. Wing	10/24/2024

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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 - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16352 48923 Based on observation, interview, and record review, the facility failed to ensure that residents who needs respiratory care, including tracheotomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of two residents reviewed for tracheotomy care (Resident #200). -The facility failed to ensure RN G used sterile technique during tracheotomy care and suctioning for Resident #200. This failure could place residents with a tracheotomy requiring suctioning at risk for respiratory infections, hospitalization s, and a decline in their quality of life. Findings included: Record review of Resident #200's face sheet dated 10/2/2024 revealed a [AGE] year-old male resident was admitted to the facility on [DATE]. Resident #200 had diagnosies of Acute Respiratory Failure with Hypoxia (occurs when the body doesn't have enough oxygen in its tissues) and alcoholic cirrhosis of liver with ascites (ascite being abnormal fluid buildup), abnormal posture, esophageal varices with bleeding (enlarged veins in the esophagus with bleeding), alcohol abuse, and other seizures, metabolic encephalopathy (alteration in consciousness caused by an underlying condition, which can lead to confusion, memory loss and loss of consciousness). Record review of Resident #200's MDS assessment dated [DATE] revealed the BIMS assessment was blank and mental status assessment found he had short-term and long-term memory/recall ability problems and was severely cognitively impaired. Record review of Resident #200's Care Plan reflected Resident #200 had ADL self-care deficits and was at risk for further decline in ADL functioning and injury. It also reflected Resident #200 had a tracheostomy and was care-planned for routine equipment maintenance and changes as indicated, following physician orders related to oxygen administration, medication administration, labs, and encouraging resident to keep head of bed elevated. Record review of Resident #200's Physician Orders reviewed 09/28/2024 revealed the following: -Order date: 09/28/2024 - Tracheostomy Care cuffed flex Shiley 6 with disposable inner cannula) as indicated every 12 hours and PRN. Trach Care: Suctioning,every shift Suction tracheostomy tube as needed to clear airway. Document # of Suctions Performed During Assigned Shift. Notify MD of any abnormalities. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/2/2024 at 11:00 am revealed Resident #200 was in bed with audible moist breath sounds. RN G donned gloves and set up a clean field on top of the bedside table, checked Resident #200's oxygen saturation which was 98%. RN G removed her dirty gloves and picked up a Trach Care Kit. RN R opened the sterile Trach Care Kit, then picked up and donned the sterile gloves in the kit, and suctioned Resident #200 several times. She changed into a new pair of gloves without washing her hands or using hand sanitizer in between. She grabbed the sterile suction catheter kit tray with the inner canula, opened it, then donned sterile gloves again without washing her hands. RN G then removed Resident #200's used inner cannula and replaced it. RN G cleaned the surrounding trach area using the sterile 4x4 inch gauze and dipped the gauze in the normal saline three different times without changing gloves or performing hand hygiene during the cleaning and changing of tracheostomy tubes. In an interview on 10/02/2024 at 1:30 PM, RN G stated she did not wash her hands during trach care or during suctioning. She stated she should have used sterile technique throughout, and she was recently in-serviced on tracheostomy care but could not recall the date of the in service. RN G did not disclose why she failed to use sterile technique. She stated she was working with Resident #200 for the first time during the observed trach care. RN G stated that her observed technique placed the resident at risk for a respiratory infection. In an interview on 10/04/2024 at 5:00 PM, the DON stated that RN G had not been in-serviced on tracheostomy and that RN G started working 3 days ago. The DON stated that RN G should have used sterile techniques during tracheostomy care. The DON stated that using the technique RN G used could have placed the resident at risk for an infection. The DON stated that the facility's scheduled respiratory therapist was usually responsible for providing respiratory care, but the nurses are trained in the event that the respiratory therapy staff is not available. The DON stated that the respiratory therapy department primarily oversaw the trach care, but she would be working with the respiratory therapy to ensure that nursing staff were held accountable as well. Review of the facility's policy titled Tracheostomy Care revised 11/2022, read Aseptic technique must be used: during cleaning and sterilization of reusable tracheostomy tubes; during all dressing changes until the tracheostomy wound has granulated (healed); and during tracheostomy tube changes, either reusable or disposable. Gloves must be used on both hands during any or all manipulation of the tracheostomy. Sterile gloves must be used during aseptic procedures.