STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675321	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at Faith Memorial	811 Garner Rd Pasadena, TX 77502

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	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** 45328 Based on interviews and records reviewed, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 (Resident #1) of 8 residents reviewed for incontinent care. -The facility failed to replace Resident #1's foley catheter's drainage bag after it was removed by the resident. This failure could place residents at risk for urinary tract infections. The findings included: Record review of Resident #1's Admission Record, dated 08/15/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. The resident's diagnoses included retention of urine (inability to completely empty the bladder) and obstructive and reflux uropathy (when urine can't flow (either partially or completely) through ureter, bladder, or urethra due to some type of obstruction. Instead of flowing from kidneys to bladder, urine flows backward, or refluxes, into kidneys). Record review of Resident #1's physician orders revealed a urethral indwelling urinary catheter with catheter care on 08/05/24. Record review of Resident #1's Admission MDS assessment, dated 08/02/24, revealed a BIMS score of 1, indicating severe cognitive impairment. Further review revealed the resident required partial/moderate assistance with toileting. Record review of Resident #1's undated care plan revealed the resident had a need for an indwelling foley catheter and was at risk for increased UTIs and skin breakdown related to obstructive uropathy. Interventions included providing catheter care and perineal hygiene as indicated. (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/15/24 at 12:31 p.m., CNA B said on 08/13/24, she took Resident #1 back to her room after dinner and when they were in the room the resident pulled off her catheter drainage bag. She said she left the resident in the room and notified Nurse A about the catheter bag and as soon as she went back to the resident's room, she found her on the floor. She said she notified Nurse A and they both went to the resident's room. She said Nurse A checked the resident and sent them out to the hospital. She said Nurse A did not put on another catheter bag. She said it took EMS approximately 10 minutes to arrive at the facility. In an interview on 08/15/24 at 1:03 p.m., Nurse A said she was at the nurse's station between 7:00 p.m. and 8:00 p.m. when CNA A came and told her Resident #1 pulled off her catheter drainage bag. She said when she was on her way to check on the resident, another CNA told her the resident was on the floor. She said the catheter bag was on the resident's room floor. She said she assessed the resident, called the DON, and then called 911. She said the catheter bag was not put back on because she would have had to go to the closet located in the middle of the hallway on station 1 to get a new bag. She said the closet was locked and she could not give the key to the CNA because it also opened the medication cart, oxygen storage, and medication room. She said she wanted to make sure the resident was not dizzy or closing her eyes. She said Resident #1's safety was the priority and not her catheter bag. She said at that time there was a CNA in the room with her and the resident. She said she was not sure, but she thinks there were two other nurses on shift with her on the night of 08/13/24. She said she did not ask the CNA to get another nurse so they could get another catheter bag. She said it took EMS approximately 5-8 minutes to arrive at the facility. She said the potential harm that could have resulted from having open tubing and no attached catheter bag was that it was an open portal and could cause a UTI if it touched the floor or cross contamination but said the foley catheter tubing was attached to her leg and the tubing was not touching the floor. She said Resident #1 was wearing pants at that time. In an interview on 08/15/24 at 2:18 p.m., the DON said the resident had a leg strap to help keep the catheter drainage bag in place. She said her understanding was Resident #1 took her catheter bag off and at some point, the bag was on the floor. She said the Nurse A called 911 and they came and got the resident before the nurse was able to get the resident a new bag. She said she did not know for certain how long it took EMS to arrive at the facility, but they usually responded very quickly. She said the nurse was focused on neuros, keeping the resident stable, and was hyper focused on calling 911 since the resident hit her head. She said her expectation would be to get another catheter bag to make sure it was draining and not pulled out of place. She said had Resident #1 not hit her head, she thinks all of this would have taken place. She said there could have been a potential for exposure to pathogens since it was an entry into the body. Record review of the facility's policy titled Competency of Nursing Staff, dated 07/21/21, read in part . licensed nurses and nursing assistants employed (or contracted) by the facility will . and b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care .