STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675344	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at Sweeny	109 N McKinney Sweeny, TX 77480

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45581 Based on interviews and records reviews, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care for 1 (Resident #60) of 18 residents reviewed for base-line care plans. The facility failed to ensure (Resident #60) had a baseline care plan developed within 48-hours after admission with goals and interventions. The failure could place newly admitted residents at risks of not receiving the care and continuity of services. Findings included: Record review of Resident #60's Face Sheet (undated) revealed, a [AGE] year-old male who admitted to the facility on [DATE] and with diagnoses which included: cerebral infarction (also known as a stroke) refers to damage to tissues in the brain due to a loss of oxygen to the area.) due to embolism (embolism) of right middle cerebral artery, muscle wasting and atrophy (waste away, especially as a result of the degeneration of cells), not elsewhere classified, multiple sites. Record review of Resident #60's Medicare 5-Day MDS assessment dated [DATE] revealed a BIMS score of 12 indicating moderately impaired cognitively. He required substantial/maximal assistance with toileting/hygiene, Shower/bathe self, Lower body dressing, and putting on/taking off footwear. He required Partial/moderate assistance with oral hygiene and upper body dressing. Record review of CR #1's Resident #60's Baseline Care Plan dated 10/23/2024 was completed 72 hours after admission. Interview on 03/21/2024 at 1:18 PM with the MDS Coordinator/LVN. She said it was team effort when writing a care plan. She said the RN, the DON were responsible for writing the Base Line Care Plan. She said she reviewed the Base Line Care Plan. She said the Baseline Care Plan due in 72 hours unless it was the weekend and then it was done that day. She said the DON wrote the Baseline Care Plan the day of admittance or the next business day if it was on a weekend. She said if a resident was admitted on a weekend the Baseline Care Plan was written that next Monday. She said the current DON had been at the facility for three months. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/21/2024 at 1:24 PM the DON stated the ADON was responsible for writing the Base Line Care Plans and the ADON just left the facility in March 2024. She said anyone can complete it, but the assessment needed to be reviewed and accepted/approved by an RN. She said the Base Line Care Plan were due within 72 hours. She said if a resident were admitted on the weekend or late Friday then a weekend nurse would write the Base Line Care Plan. She said she last had training on Base Line Care Plans a couple of months ago. She said she was responsible for ensuring staff followed policy regarding writing the Base Line Care Plans. She said they worked as a team. She said the risk to a resident if policy was followed was the resident may not get the care they needed. She said the worst thing that can happen to the resident when proper protocols are not practiced was improper care for the resident. Interview on 03/21/2024 at 1:33 PM the Administrator said the Base Line Care Plans were the responsibility of the nurse management, ADON and DON. She said the Base Line Care Plans were due upon admission. She said she last training on Base Line Care Plans during 2021, end of 2022. She said she was responsible for ensuring staff followed policy regarding the Base Line Care Plans. She said the risk to residents if policy was followed was something may be missed. She said the worst thing that can happen to the resident when proper protocols were not practiced was if a resident needed a specific medication and they could not get it timely, and that resident suffered from the side effects. Record review of the Policies and Procedures Care Planning - Baseline Care plan dated 12/2021 read in part . Policy: Each resident will have a baseline care plan developed within 48 hours of admission to the center that addresses identified risk areas and resident's initial individual needs .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48863 Based on observation, record review and interview, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment for 3 of 10 residents (Residents #52, #220, and #15) reviewed for care plans. The facility failed to update Resident #52's care plan to indicate the use of a foley catheter had been discontinued. The facility failed to update Resident #220's care plan to indicate the resident's diet, ADLs, and the use of an antipsychotic medication. as noted on the MDS The facility failed to revise Resident #15's care plan to indicate the presence of a newly acquired pressure wound. These failures could affect residents by not addressing their physical, mental, and psychosocial needs for each to attain or maintain their highest practicable physical, mental, and psychosocial outcome. Findings included: 1. A record review of an updated face sheet revealed Resident #52 was a [AGE] year-old-male that was admitted on [DATE] with diagnoses of Down Syndrome (a genetic disorder associated with physical growth delays ad mild to moderate developmental and intellectual disability), Esophageal Obstruction (narrowing or blocking of the esophageal), Urinary Incontinence(uncontrolled leak of urine), and Full incontinence of feces ((uncontrolled leak of feces). Record review of Resident #52's Minimum Data Set (MDS) assessment, dated 02/27/24, revealed this BIM score (Brief Interview for Mental Status) was not noted on the most recent MDS. The MDS indicated that Resident #52 had a urinary catheter and was incontinent to stool. He was also shown to have a weight loss of 10% or more in the last 6 months. During observation on 03/20/2024 at 11:37 a.m., it was revealed resident #52 no longer had a Foley Catheter, and the resident was wearing a brief for incontinence for both stool and urine. A record review of a care plan with a revision date of 02/26/24 revealed care plan for Resident #52's titled Foley catheter indicating that the resident had a catheter and was at risk for increased UTI's and skin breakdown. There was no updated or revised care plan for bladder incontinence without the use of the foley catheter. Record review of the care plan titled Therapeutic Diet was last updated 05/23/23 and revealed only a puree diet for nutritional support. The care plan was not updated to include the current weight loss and the weekly weights ordered by the physician starting 03/08/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of resident's face sheet dated 05/17/2022 indicated Resident #220 was a [AGE] year-old female that was admitted on [DATE] with diagnoses of Dementia(loss of cognitive functioning that interferes with daily life and activities), Severe Intellectual Disabilities, Chronic Kidney Disease (long-term condition where the kidneys gradually lose their ability to properly filter waste and excess fluids), and Hypertension (It is when the pressure in your blood vessels is too high). Record review of the MDS dated [DATE] indicated Resident #220 had a BIM score of 05 (severe cognitive impairment). Record review of the care plan for Resident #220 last revised on 02/27/24 revealed only four focus categories were addressed to include, Full Code status, New to Nursing Facility, Cognitive Impairment, and Behavior Problems. During record review of the care plan for Resident #220, there was no care plan to identify all existing and potential needs for bowel and bladder, ADLs, or use of Psychotropic Medications, as indicated on the 3/08/24 MDS. MDS assessement revealed that the resident required assitance with ADLs, occassional incontinent to bowl and bladder, and was on receiving psychotropic medications Record review of the face sheet indicated Resident #15 was a [AGE] year-old female that was admitted to the facility on [DATE] with the diagnoses that included Unspecific Psychosis), Displaced Intertrochanteric Fracture of left femur (hip fracture), urinary tract infection(an infection in the organs in your urinary tract, which includes the bladder and kidneys), and Diabetes Mellitus (A metabolic disorder in which the body has high sugar levels for prolonged periods of time). A record review of Resident # 15's MDS dated [DATE], indicated Resident #15 had a BIMS (Brief Interview of Mental Status) score of 00 which indicated severe cognitive impairment. A record review of a care plan for Resident #15 with the last revision date of 02/23/24 revealed no care plan for Resident #15's Left heel wound. During an interview on 03/21/24 at 1:42 pm the Administrator stated it was the responsibility of the MDS nurse to revise the care plan. She said, We do weekly QOC meetings (Quality of care meetings) where new medication and changes are reviewed. The nurse MDS nurse will revise the care plans after the meeting due to change of condition or because it is time for the resident's quarterly assessment. She said, the risk of not having an accurate care plan can place the of risk of missing something that could be detrimental to care and safety of the resident.: During an interview on 03/21/24 at 1:52 pm with the MDS Coordinator, who has been working at the facility since April 2023, stated that she does the care plan revisions. She said, These car plan revisions are done normally with the quarterly MDS but can be done, before, or after it. She stated that revisions should also be done with a change of condition, which she learns about during the weekly Quality of Care meeting. She said, the risk of not completing or revising a comprehensive care plan can be a problem because they wouldn't know how to take care of the resident. Record review of facility's Policy and Procedure titled Care plan Revisions revealed The comprehensive care plan will be reviewed and revised every quarter, when a resident experiences a status change and as deemed necessary.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48863 Based on observation, interview and record review, the facility failed to provide pharmaceutical services, (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 (Resident #170) of 1 resident reviewed for pharmacy services. LVN B failed to dissolve Resident #170's Dexamethasone 4 mg tablet, Famotidine 20 mg tablet, and Midodrine 15mg tablet in water prior to administering it through the g-tube. This failure could place residents with G-tubes (Gastrostomy tube) at risk of tube clogging/obstruction, tube replacement, medical complications, or a decline in health due to inappropriate G-tube care, management, and not following appropriate procedures. Findings Include: [AGE] year-old male resident admitted on [DATE] with a history of Hemiplegia (one-sided paralysis), Bacteremia (bacteria in the blood.), and Malignant Neoplasm of Brain (tumor that occurs in the brain due to an abnormal growth or division of cells, or neoplasia). During an observation on 3/20/2024 at 4:03 pm, LVN B crushed Resident #52's medications in preparation for G-tube administration. LVN B did not dissolve the medications in water. Upon entering the room, LVN B disconnected the feeding pump, checked placement, and began to flush the tube with 30 milliliters (ml) of water; LVN B proceeded to administer the crushed medications directly into the G-tube. Before administering the second medication, LVN B flushed the tube with 5-10 ml of water and then proceeded to pour the third crushed medication into the G-tube dry (not dissolved in water), followed by an additional 30 ml of water. In an interview on 03/21/24 at 8:43 a.m. with LVN B, who stated that she normally administers crushed G-tube medications without dissolving it in water before administration via the syringe. She denied being aware that this was the procedure for G-tube medication administration per the facility's policy. She stated the risk of not adding water and dissolving the medication prior to adding it to the syringe was that the resident may not get all the medication he needs, or the g-tube can get clogged if it's not crushed all the way. During an interview on 03/21/24 at approximately 10:15 a.m. the DON stated that LVN B had already informed her of the errors made during G-tube administration and stated that G-tube medications should be dissolved in water prior to administration. She stated that the process should be to wash hands, set up each medication cup with each individual crush medication, add 10-15 mls of water to each crush medication, check placement, and flush before, in between each medication, and after medication administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy entitled, Medication Administered through and Management revised 06/2019 revealed: .Procedure 13c. Prepare medication(s) 1. Liquid form is recommended and should be used whenever possible. 2. Elixir and suspensions are recommended over syrups to reduce risk of occlusion 3. If liquid is unavailable, crush tablet to a fine powder and mix thoroughly with 10-15 ml warm water in medicine cup and rinse the cup to get all medication. 6h. Fill a syringe with liquid or crushed diluted medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45581 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen observed for kitchen sanitation. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety reviewed for food and nutrition services. Several food items in the refrigerator had use by dates that were expired but were still observed in refrigerator during initial kitchen observation. This failure could have the potential to affect residents who ate food from the facility's kitchen placing them at risk of foodborne illness. The facility failed to ensure hairnets and beard guards were worn while in the kitchen. This failure could place residents at risk for food contamination and foodborne illness. Findings included: Observation of the kitchen with the Dietary Manager on [DATE] at 8:13 a.m. revealed in the following: a. Nine cans of [NAME] Mild Fire Roasted Dice Green Chiles with used by date of [DATE]. b. One bag of Cornflakes opened in storage room without an opening date noted on bag. c. Fruit punch labeled [DATE] with an expiration date of [DATE] In an interview on [DATE] at 8:19 a.m. with the Dietary Manager, who started at the facility three weeks ago, stated that the cans of the Green chiles and the fruit punch that have exceeded the dates noted on the cans and container should be discarded. He stated that the fruit punch was mislabeled because a new batch of fruit punch was made yesterday. He also stated that the open bag of corn flakes should also be discarded because it was not labeled, and we do not know when it was opened. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on [DATE] at 11:08 AM with the Dietary Manager was observed in the kitchen preparing a cake while not wearing a hairnet or beard guard over his beard and mustache. He said this was his third week at the facility. He said he was supposed to wear a beard guard to prevent hair getting onto the resident's food. He said he did not have a beard guard on because he had been in and out of the kitchen and forgot to put one on when he went back into the kitchen. He said he had not been trained on hairnets/beard guards at this facility. The Dietary Manager put on a beard guard, but only over his beard and not over his mustache. He said he was trained that it needed to cover the beard and not the mustache. He said he was responsible for ensuring staff followed policy regarding hairnets/beard guards. He said the risk residents if policy for hairnets/beard guards was not followed was cross contamination and the worst thing that could happen to residents if policy were not followed was residents could get sick. Interview on [DATE] at 1:33 PM with the Administrator. She said the policy for hairnets and beard guards was hair nets, guards must always be worn while in the kitchen even if no hair/bald or wearing a cap like a baseball cap. She said she was responsible for ensuring policy was followed. She said she last had training within the last two months because a staff was not wearing his beard guard. She said risk to res could have cross contamination from hair follicles, and the worst thing could be infection control issues. In an interview with the Administrator on [DATE] at 1:45 p.m., she stated that the Dietary Manager was a new employee. She stated that she was aware of the expired food items in the kitchen's storage room, and that she accompanied the Dietary Manager, and the Dietitian on [DATE] to review all food items in the storage and in the refrigerator. She stated the risk of having expired food items in the kitchen can place the residents at risk for food poisoning that can ultimately lead to death. The Administrator stated a Labeling and Dating Inservice was performed by the Registered Dietitian on [DATE]. Record review of the facility's Food Storage Policy & Procedure dated [DATE] and revised [DATE] revealed that all food will be stored according to the state, federal and US Food codes and HACCP guidelines. The policy read in part that; a. All containers must be label and dated. b. Refrigerated leftover items is to be used within 72 hours and discard items that are over 72 hours old. Record review of Nutrition Services Policies and Procedures Dress Code dated ,d+[DATE] read in part . The Nutrition/Culinary Services Department employees will adhere to a facility dress code that facilitates safe, sanitary meal production and service, and will present a professional appearance. Culinary staff involved in food production adheres to the department dress code that includes: 6. Appropriate hair restraints (such as hats, hair covers or nets, beard restraints) while involved in food production activities .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27846 Based on observations, interviews, and record reviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 residents (Resident #60) observed for infection control. LVN A failed to perform any hand hygiene (hand washing or hand sanitizing) with glove changes during wound care for Resident #60. This failure could place residents at risk of exposure to communicable diseases and infections. Findings included: Record review of Resident # 60's admission face sheet undated revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that non-pressure chronic ulcer of left heel and mid left foot (common ulcer with arterial disease). Record review of Resident #60's care plan date Initiated 11/13/2023 date revised 02/17/2024 revealed: Focus: Resident #60 had pressure ulcers to his left heel, left ankle, left mid lateral foot. Resident #60 was at risk for further skin breakdown, infection, worsening of existing pressure wounds, new pressure wound formation. Goal: Resident #60's skin would remain clean, dry and wounds would heal without further complications. Interventions: Perform treatments per order Record review of Resident #60's quarterly MDS dated [DATE] revealed Resident's BIMS was 12 out of 15 which indicted moderate cognitive impairment. Section I Active Diagnoses was marked for medically complex conditions. Section M Skin Conditions had pressure ulcers present on admission. Dressings were applied to his feet. Record review of physician's order summary dated as of 03/21/2024 revealed: *Cleanse wound to sacrum (located at the base of the lumbar vertebrae) with normal saline, pat dry apply alginate and cover with dressing daily. *Cleanse left great toe with normal saline; pat dry apply betadine. *Cleanse left first metatarsal (bone at the great toe) with normal saline; pat dry apply betadine. *Cleanse left medial foot (area on the foot directly under the metatarsal) with normal saline, pat dry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of wound care on 03/20/2023 at 9:42AM by LVN A LVN A washed her hands and gloved. LVN A removed Resident #60's sacral wound dressing. Resident #60's sacral wound dressing was dated 03/19/2024. The dressing was slightly soiled with serosanguineous drainage (common type of wound drainage due to tissue damage appears pale red or pink due to the presence of blood). LVN A changed her gloves. LVN A did not perform any hand hygiene. LVN A cleaned the resident's sacral wound with normal saline. LVN A changed her gloves. LVN A did not perform any hand hygiene, LVN A applied alginate (wound medication to promote wound healing) and dry dressing to Resident #60's sacral wound. LVN A changed her gloves. LVN A did not perform any hand hygiene. LVN A applied nystatin powder (treats fungal or yeast infection of the skin) to Resident #60's buttock area around the sacral dressing. LVN A changed her gloves. LVN A did not perform any hand hygiene. LVN A cleaned the dry necrotic (dead tissue) area to Resident #60's left toe and metatarsal area. The area was left open to the air as ordered. LVN A removed her gloves. LVN A washed her hands then left the room. During an interview on 03/21/2024 at 10:41 AM LVN A stated she has worked in the facility about eight months as the unit manager. LVN A stated she did not sanitize her hands between each glove change during the wound care on Resident #60. LVN A stated she should have done some hand hygiene when she changed her gloves. LVN A stated she had been in serviced on infection control, glove changes and wound care. LVN A stated she did not remember when she completed the last in-service on hand hygiene. LVN A stated the risk to the resident could be causing or worsening an infection, cross contamination of wounds. LVN A stated the facility policy was to sanitize hands with each glove change to keep the resident infection free. As the interview continued, she stated the DON was responsible for monitoring infection control and wound care. During an interview on 03/21/2024 at 10:51 AM the DON stated her expectations was for staff to wash or sanitize hands to prevent infections. The DON stated she was responsible for monitoring infection control wound care and PPE (gloves, mask, gowns) use. The DON stated she monitored the staff and trained on infection control and hand hygiene monthly. The DON stated the facility policy was to follow standard precautions such as hand hygiene between glove changes. The DON stated the risk to the resident was increased risk of infection, worsening of infection, hospitalization and death. During an interview on 03/21/2024 at 11:10 AM the Administrator stated her expectations were the staff sanitized their hands between glove changes. The Administrator stated to prevent this in the future in services along with one-on-one observations of wound care at the resident's bedside would be conducted. Record review of the facility policy titled Nursing Policies and Procedures revised dated 02/2022 read in part: Subject: Infection Control Program. Policy: Evidence-based policies and procedures are the foundations of a facility's infection control and prevention program. Goals: The goals of the infection control program are to maintain compliance with the state and federal regulations relating to infection prevention and control. To provide a healthy living environment with respect for the health and well-being of each resident, staff and visitor . Record review of the facility policy titled Nursing Policies and Procedures undated read in part: Subject: Performing A Dressing Change. Policy: A dressing change will follow specific manufacture's guidelines and general infection control principles. Procedures: NOTE: (Wash hands before and after donning glove) .