STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455714	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm Northwest	17600 Cali Dr Houston, TX 77090

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to revise the comprehensive care plan for 2 (Resident #1 and CR #2) of 5 residents reviewed for care plan timing and revision. -The facility failed to revise Resident #1's care plan for a suprapubic catheter (tube inserted into bladder through incision in abdomen) after 3/26/25. -The facility failed to revise CR #2's care plan for severe contractures (shortening/hardening of muscles, tendons, and other tissue) after 5/19/25. This failure could place residents at risk of not receiving the appropriate care and services to maintain the highest practical well-being. The findings included: Record review of Resident #1's undated face sheet revealed an [AGE] year-old female who was originally admitted to the facility on [DATE], with the most recent admission of 3/14/25. Her diagnoses included respiratory failure (not enough oxygen in the blood), COPD (long-term lung disease), hypertension (high blood pressure), neuromuscular dysfunction of the bladder (nerves controlling bladder function are damaged), functional quadriplegia (unable to move arms and legs due to disability and not a spinal cord injury), TIA (mini stroke), dysphagia (trouble swallowing), tracheostomy (opening in neck for access to the windpipe), gastrostomy (opening into stomach from abdomen), dependence on ventilator (dependence on a machine to breathe), and heart failure (heart does not pump efficiently). Record review of Resident #1's admission MDS Assessment, dated 03/18/25, revealed a BIMS score of 14 which indicated normal cognition. The MDS revealed she had an indwelling catheter. Record review of Resident #1's Care Plan dated 2/25/25, revealed the resident was care planned for having urinary incontinence but not having a suprapubic catheter. Record review of Resident #1's physician orders revealed an order for a urethral indwelling catheter dated 3/26/25 by MD S. Record review of Resident #1's progress notes, dated 05/13/25 at 6:14 p.m., revealed the resident had a suprapubic catheter and the foley catheter was draining clear yellow urine. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 6/12/25 at 2:30 p.m., Resident #1 was lying on her back in bed. She said she had a suprapubic catheter. The foley bag was observed hanging on the side of her bed. Record review of CR #2's undated face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE], with the most recent admission being 6/3/25. His diagnoses included osteomyelitis (bone infection), anoxic brain injury (brain infection due to loss of oxygen), dysphagia (trouble swallowing), sepsis (infection throughout body), pneumonia (lung infection), type 2 diabetes (body does not produce insulin or resists it), endocarditis (infection of the heart), epilepsy (seizures), dependence on ventilator (requires a machine to breathe), persistent vegetative state (awake but shows no signs of awareness or consciousness), respiratory failure (not enough oxygen in the blood), tracheostomy status (opening in neck for access to the windpipe), and gastrostomy status (opening into stomach from abdomen). Record review of CR #2's admission MDS Assessment, dated 5/12/25, revealed a BIMS score was not performed due to his medical condition. His cognitive skills for daily decision making were severely impaired. CR #2 was dependent on staff for all of his ADLs. He had an impairment in both extremities, on the top and bottom. Record review of Resident #2's Care Plan dated 9/27/24, revealed the resident was not care planned for his contractures. Record review of CR #2's progress notes, dated 5/19/25 from MD S, revealed the resident had contractures. Record review of CR #2's previous hospital records dated 5/25/25 from MD A, revealed he had contracted extremities. During a telephone interview on 6/12/25 at 12:16 p.m., CNA E said CR #2's right leg was contracted up to his chest and his left leg was contracted behind his back. During a telephone interview on 6/12/25 at 12:30 p.m., CNA B said CR #2's legs were contracted so that his right leg was crossed over his left leg, like he was sitting crisscrossed. During a telephone interview on 6/12/25 at 12:45 p.m., LVN D said CR #2's legs were really contracted, crisscrossed and turned to the right, while his chest turned towards the left. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/12/25 at 4:19 p.m., the MDS nurse said she was the one who created and updated the care plans for residents. She said she went through the admissions and updated as situations arose. She said she was the one who updated catheters and contractures on the resident's care plans. She said Resident #1's care plan was taken care of by a third party who handled all the Managed Care residents, and she did not know why the catheter was not on the care plan. She said she was going to do a 100% audit of all the residents with catheters to ensure they were on their care plans. The MDS nurse said she saw CR #2's contractures were not on his care plan that morning (6/12/25) and added it. She said the contractures should have been on the care plan before and she was going to do a 100% audit on all of the residents with contractures to make sure they were on their care plans. She said she did not think those two focuses (catheters and contractures) not being on the care plan would affect the residents or care because there was an order in the system, and it was on the MAR for the catheter and catheter care. Record review of the facility's policy and procedure on Careplan Revisions (Revised 5/2022) read in part: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents within the facility. The comprehensive care plan will be reviewed and revised every quarter, when a resident experiences a status change and as deemed necessary. Procedure for reviewing and revising the care plan is as follows: a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. c. The care plan will be updated with the new or modified interventions e. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. f. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs .