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	08/12/2025

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. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 2 of 5 residents (Resident #1 and Resident #2) reviewed for comprehensive care plans. The facility failed to ensure Resident #1 and Resident #2's comprehensive care plans included all care areas triggered on their assessments. This failure could place residents at risk of not receiving care and services specific to their needs. Findings include: 1. Record review of Resident #1's admission face sheet, dated 08/12/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included respiratory failure (occurs when the lungs can't properly exchanges), cerebral infarction (in a pathological process that results in an area of necrotic tissue in the brain), sepsis (immune response triggered by an infection), metabolic encephalopathy (a change in brain function), acute respiratory failure with hypoxia (a medical condition where the lungs cannot adequately oxygenate the blood), Diabetes Mellitus (high blood sugar), hypertension (high blood pressure) narcolepsy (chronic sleep disorder), chronic congestive heart failure (a condition where the heart doesn't pump blood as well as it should), right AKA amputation (above the knee amputation). Record review of Resident #1's admission MDS, dated [DATE], revealed Resident #1 was coded as severely impaired for cognition skills for decision making, dependent on staff for ADL care, has a Foley catheter and frequently incontinent of bowel. Resident #1 was triggered for cognition, incontinence, pressure sore, activities, dehydration, feeding tube, psychosocial well-being, communication, nutrition and return to the community. Record review of the care plan, initiated 6/06/2025, revealed the care plan did not addressed cognition, activities, communication and returning to the community. 2. Record review of Resident #2's admission face sheet, dated 08/12/2025, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included anemia (not having sufficient health red cells), neurogenic bladder (lack of bladder control), aphasia (a language disorder that affect communication), Parkinson (disorder of the central nervous system that control movements), dehydration (loss of body fluid cause by illness), hypokalemia (a blood level that is below normal in potassium), malnutrition (when the body lacks nutrients), dysphagia (difficulty swallowing foods or liquids), fracture (a break in bone), urinary tract infection (infection of the bladder), cognitive deficit (a brain function deficit that impact a person's ability to think learn and remember), lack of coordination (impaired balance), muscle weakness (decreased strength in the muscles), schizophrenia (disorder that affects a person's ability to think, feel and behave clearly) and falls. Record review of Resident #2's admission MDS, dated [DATE], revealed Resident #2 had a BIMS score of 03, which indicated she was severely impaired for cognition skills for decision making, dependent on staff for ADL care, has a Foley catheter and always incontinent bowel. Resident #2 was triggered for cognition, incontinence, pressure sore, activities, dehydration, falls, psychosocial well-being, communication and nutrition. Record review of Resident #2's care plan, initiated 6/06/2025, revealed the care plan did not address cognition, activities and nutrition. In an interview on 8/12/2025 at 2:18 PM, the DON said they did not have a MDS Coordinator. She said the corporate nurse was helping them and was doing a 100% audit to ensure all triggered areas on the MDS were captured on the care plan. She said they were going to try and ensure all triggered areas on the MDS were captured on the care plans to ensure residents care needs were addressed. Record review of the policy and procedures, dated March 2022, Care Plans, Comprehensive Person-Centered read in part .Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 5 (CR#1) residents reviewed for accidents and supervision. 1. The facility failed to ensure CR#1 received adequate supervision and assistance devices to prevent accidents resulting in CR#1 sliding out of bed to the floor sustaining a cut to the right eye and left thalamic bleed (a type of intracerebral hemorrhage) without intraventricular (inside the brain's ventricles) involvement. 2. CNA A failed to ensure two-person assistance was used to provide care to CR #1, who required total assistance with all ADLs, and resulted in CR#1 sliding out of bed to the floor. The noncompliance was identified as PNC. The IJ began on 08/11/2025 and ended on 08/12/2025. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of experiencing serious injury, pain, hospitalization and death. Findings include: Record review of CR#1's face sheet, dated 08/08/2025, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. He was diagnosed with type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), dysphagia (difficulty swallowing), respiratory failure (when the lungs cant properly exchange gases causing abnormal level of carbon dioxide or oxygen in the blood), cerebral infarction (brain tissue dies due to lack of blood supply), unspecified hypoxia (low oxygen in the blood), and hypertension (high blood pressure), Constipation (difficultly passing stool) vitamin deficiency (too little of one or more of the essential vitamins in the body), gastroesophageal reflux disease (a digestive disease in which the stomach acid or bile irritates the food pipe lining), feeding tube (a device that delivers liquid nutrition directly to the stomach or small intestine through a tube), anticoagulant therapy (treatment that prevents or reduces blood clotting), tracheostomy (a surgical procedure that creates an opening in the wind pipe to help with breathing) and need assistance with personal care. Record review of CR#1's baseline care plan, dated 8/5/2024, revealed he was assessed as dependent on staff for all areas of ADL's. Record review of CR#1's revised care plan, dated 8/5/2025, revealed the following areas of concern: Focus: ADL Self Care Deficits: CR#1's has ADL selfcare deficits and is at risk for further decline in ADL functioning and injury AEB decline physical function.Goal: CR#1 will be well dressed, groomed, clean, dignity will be maintained and will have no further decline in ADL functioning or injury the next 90 daysIntervention: Anticipate needs - provide prompt assistance. Encourage independent function as able Encourage resident to ask for assistance for ADL care as neededEnsure call light is within reach and answer in a timely mannerKeep daily preferred routine unchangedProvide (Total) assistance of (2 of support persons) for transfersProvide (Total) assistance of (1 of support persons) for bathingProvide (Total) assistance of (1 of support persons) for bed mobilityProvide (Total) assistance of (1 of support persons) for eating via peg tubeProvide (Total) assistance of (1 of support persons) for personal hygiene/groomingProvide (Total) assistance of (1 of support persons) for toileting/incontinent careProvide (Total) assistance of (1 of support persons) for upper/lower body dressingFocus: Bowel Incontinence: CR#1 has bowel incontinence related to:Goal: CR#1 will have no alterations in skin integrity related to incontinence or brief use through the review dateIntervention: Monitor for signs of discomfort or agitation that may indicate the need for toiletingPerform routine rounding to include incontinence care and brief changes. Record review of CR#1's nurses notes, dated 8/6/2025, revealed CR#1 had a change in condition: - Fall 8/06/2025 at 5:00 AMLocation of the Fall: Resident's room classification of the Fall: witnessed with Head Injury:What was the resident doing prior to the Fall:Resident AAOx1, nonverbal. Vital Signs Post Fall Event: Blood Pressure-122/68, Pulse-72.Resident was sent to the hospital. Record review of CR#1's, undated, hospital records revealed he was admitted to a local hospital on [DATE] with a cut to the right eye, swollen shoulder and was later diagnosed with left thalamic bleed without intraventricular involvement. Observation on 8/08/2025 at 12:00 PM of CR#1 at the hospital revealed CR#1 was in bed. He appeared to be asleep, he did not respond when his name was called. He was clean and without odor, he was observed with a raise to the right-side front of his head, he had swelling to the right shoulder. There were no other visible injuries. In an interview on 8/8/2025 at 12:05 PM, the hospital RN said the resident was admitted to the facility on [DATE] from the nursing home due to a fall. She said he had swelling to the right shoulder, a cut to the right eye and a raise to the right front of the head but she did not know if the raise to the front of the head was because of the fall or an old injury. She said the family mentioned an injury to the left hand, but she did not see any injury to the left hand on her assessment. In an