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	08/18/2025

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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
	455714	A. Building B. Wing	08/18/2025

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 0580 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 consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 (Resident #1) of 5 residents reviewed for notification of changes. The facility failed to establish contact with the NP after Resident#1 had an unwitnessed fall where he was found lying face down on the floor on 8/13/25 at 11am. LVN A sent the NP a text at 11:40 am but she was not aware until she received a second text notification at 12:44 pm. Resident #1 was transported to the hospital at 1:30 pm, after an induration formed above his left brow. An IJ was identified on 8/15/25 at 6:05 pm. The IJ template was provided to the facility on 8/15/25 at 7:10 pm. While the IJ was removed on 8/16/25, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not IJ, due to the need for the facility to evaluate the effectiveness of the corrective action. This failure could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition and/or additional injury, paralysis or death. Finding included:Record review of Resident#1's face sheet revealed a fifty-six-year-old man who was admitted to the skilled nursing facility on [DATE]. His admitting diagnoses were hemiplegia and hemiparesis following cerebral infraction affecting the right dominant side (paralysis and weakness on one side of the body), paraplegia, cerebral aneurysm (blood vessel in the brain), a cerebral infraction (stroke), and the use of a tracheostomy. Record review of Resident #1's care plan disclosed that he utilized a feeding tube for meals and required supplemental oxygen. Record review of Resident #1's progress note dated 8/13/25 at 1:30 pm by LVN A documented unwitnessed fall, resident on floor next to bed in prone position with head turned to the left side. Bilateral arms straight and bilateral legs straight. Small swelling to left upper temporal noted upon assessment. Resident assisted back to bed x4. Vital signs obtained BP: 123/87 pulse: 89 respiratory: 20 temperature: 96.8. Neurological checks initiated per protocol. Physician and family notified. Resident mother stated resident tends to move a lot and he will try to get out of bed and this is not a new action for him. Precautions have been put in place. Two bedside mats or placed next to resident bed. Bed will continue to be lowered to ground call light within reach. In an interview with LVN A on 08/14/25 at 3:38 pm, she stated that Resident #1's mother alerted her that he was on the floor around 11am. She stated that she found him laying with his arms to his side and he did not have any signs of pain. The NP was notified, and she began neuro checks. After a few checks, she noticed a raised area forming above his brow and she alerted the NP who was also in the building at that time. The NP ordered Resident #1 to be sent out for further evaluation. LVN A explained that no fall protocols were put into place because he had not moved much since his admission, and they were not aware that he was able to move on his own. In an interview with Resident #1's family member on 08/15/25 at 10:50 am, she stated that when she entered his room at 11am, he was laying on the floor facedown with his trach still connected to his throat. LVN A was immediately alerted, and staff came inside the room and began assessments. She stated that she informed that staff amongst admission that Resident #1 could move and prior to him coming to the facility, he had done physical therapy at other facilities. EMS was called and he was transported to the hospital at 1:30 pm due to swelling above his left eyebrow. In an interview with CNA A on 8/15/25 at 11:53 am, she explained that she had worked with Resident #1 on 8/13/25 around 9:30 am to shower him. She stated that day, he was moving a lot. He would constantly move his legs up and down and he moved his head a lot. Resident #1 slept on an air mattress and before she left his room after his shower, she lowered his bed to the lowest position. She recalled that there was not a fall mat next to his bed because he was a new admit and she guessed nursing staff did not see a need for it at the time. In an interview with the Unit Manager on 8/15/25 at 12:16 pm, she stated that Resident #1 was nonverbal, but he could follow people with his eyes. She explained that he was able to move his arms and legs and described them as jerk like reactions. She stated that since Resident #1 was admitted , he had begun to move a lot more and his mother had also noticed his increase in movement. On that day of the fall, she was called to his room (time unknown) by LVN A and noticed that he was face down on the ground. There was no blood, and he was able to move his head. Initially there was no swelling, but after a few hours swelling began to appear on his left side. The Unit Manager recalled that the NP was in the building, but she could not recall if she assessed him immediately after the fall. The Unit Manager stated that the protocol after an unwitnessed depended on if it

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	08/18/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	08/18/2025

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 0684 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 based on the comprehensive assessment of a resident, that resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 (Resident #1) of 5 residents reviewed for quality of care. The facility failed to contact 911 after Resident#1 was found laying face down on the floor after an unwitnessed fall on 8/13/25 at 11am. Resident was transported to hospital at 1:30pm, after an induration began to form above his left brow. An IJ was identified on 8/15/25 at 6:05 pm. The IJ template was provided to the facility on 8/15/25 at 7:10 pm. While the IJ was removed on 8/16/25, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not IJ, due to the need for the facility to evaluate the effectiveness of the corrective action. This failure could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition and/or additional injury, paralysis or death. Findings included:Record review of Resident#1's face sheet revealed a fifty-six-year-old man who was admitted to the skilled nursing facility on [DATE]. His admitting diagnoses were hemiplegia and hemiparesis following cerebral infraction affecting the right dominant side (paralysis and weakness on one side of the body), paraplegia, cerebral aneurysm (blood vessel in the brain), a cerebral infraction (stroke), and the use of a tracheostomy. Record review of Resident #1's care plan disclosed that he utilized a feeding tube for meals and required supplemental oxygen. Record review of progress note dated 8/13/25 at 1:30 pm by LVN A documented unwitnessed fall, resident on floor next to bed in prone position with head turned to the left side. Bilateral arms straight and bilateral legs straight. Small swelling to left upper temporal noted upon assessment. Resident assisted back to bed x4. Vital signs obtained BP:123/87 pulse:89 res:20 temp:96.8. Neurological checks initiated per protocol. Physician and family notified. Resident mother stated resident tends to move a lot and he will try to get out of bed and this is not a new action for him. Precautions have been put in place. Two bedside mats or placed next to resident bed. Bed will continue to be lowered to ground call light within reach. In an interview with LVN A on 08/14/25 at 3:38 pm, she stated that Resident #1's mother alerted her that he was on the floor around 11am. She stated that she found him laying with his arms to his side and he did not have any signs of pain. The NP was notified and she began neuro checks. After a few checks, she noticed a raised area forming above his brow and she alerted the NP who was also in the building at that time. The NP ordered Resident #1 to be sent out for further evaluation. LVN A explained that no fall protocols were put into place because he had not moved much since his admission, and they were not aware that he was able to move on his own. In an interview with Resident #1's family member on 08/15/25 at 10:50 am, she stated that when she entered his room at 11am, he was laying on the floor facedown with his trach still connected to his throat. LVN A was immediately alerted and staff came inside the room and began assessments. She stated that she informed that staff amongst admission that Resident #1 could move and prior to him coming to the facility, he had done physical therapy at other facilities. EMS was called and he was transported to the hospital at 1:30 pm due to swelling above his left eyebrow. In an interview with CNA A on 8/15/25 at 11:53 am, she explained that she had worked with Resident #1 on 8/13/25 around 9:30 am to shower him. She stated that day, he was moving a lot. He would constantly move his legs up and down and he moved his head a lot. Resident #1 slept on an air mattress and before she left his room after his shower, she lowered his bed to the lowest position. She recalled that there was not a fall mat next to his bed because he was a new admit and she guessed nursing staff did not see a need for it at the time. In an interview with the Unit Manager on 8/15/25 at 12:16 pm, she stated that Resident #1 was nonverbal but he could follow people with his eyes. She explained that he was able to move his arms and legs and described them as jerk like reactions. She stated that since Resident #1 was admitted , he had begun to move a lot more and his mother had also noticed his increase in movement. On that day of the fall, she was called to his room (time unknown) by LVN A and noticed that he was face down on the ground. There was no blood and he was able to move his head. Initially there was no swelling, but after a few hours swelling began to appear on his left side. The Unit Manager recalled that the NP was in the building, but she could not recall if she assessed him immediately after the fall. The Unit Manager stated that the protocol after an unwitnessed depended on if it was a fall with an injury; then they would be sent out immediately. If there was an unwitnessed fall without injury, the facility's fall protocol was to notify the