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	01/21/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, was involved in developing the care plan and making decisions about his or her care for 1 (Resident #1) of 12 resident reviewed for person centered care plans. The facility failed to revise Resident #1's care plan to address ongoing refusals of medication, ADLs, meals, and wound care. This failure could place residents at risk for not receiving individualized responsive care and a decline in wellbeing. Findings included:Record review of Resident #1's face sheet, reviewed 1/9/26, revealed a [AGE] year-old male, admitted on [DATE]. His admitting diagnoses included metabolic encephalopathy (brain dysfunction caused by an underlying condition), cerebral infarction (stroke), Type 2 Diabetes (body is insulin resistant), viral pneumonia, end stage renal disease (final stage of chronic kidney disease), cognitive communication deficit, need for assistance with personal care, dependance on renal care, and acquired absence of left leg below knee. He was discharged on 1/8/26. Record review of Resident #1's MDS dated [DATE], documented a BIMS of 6 indicating severe cognitive impairment. Section GG- Functional Abilities documented that he was dependent on staff to complete shower/bathing himself, upper body dressing, lower body dressing, sitting to stand, toilet transfer, chair to bed transfer, and toileting hygiene. Resident #1 required the maximal assistance for oral hygiene, personal hygiene, and was moderate assistance for eating. Section H- Bowel and Bladder documented that he was always incontinent. Record review of Resident #1's care plan, reviewed 1/9/26, dated 1/1/26, documented the following pressure injuries: wound to right hip, stage 3 to right heel, stage 3 to sacral wound, unstageable to left BKA. No additional information besides wound care was included in Resident #1's care plan. Record review of Resident #1's weight and vitals reviewed 1/9/26, revealed he weighed 185.5 lbs on 12/23/25. No additional weights were documented. Record review of Resident #1's progress notes, dated 12/22/25- 1/9/26, revealed the following medication refusals and were documented in the progress notes as followed:1/8/26: refused Insulin.1/8/26 at 6:21 a.m.: refused B/S check despite the education provided.1/7/26 at 3:11 p.m.: Insulin refused.1/7/26 at 2:23 p.m.: refused1/7/26 at 5:48 a.m.: refused1/6/26 at 8:00 p.m.: refused1/6/26 at 5:41 a.m.: refused1/5/26 at 4:19 p.m.: Pain Relief External Patch 4 %: refused nurse informed.1/5/26 at 8:48 a.m.: refused1/4/26 at 8:53 p.m.: refused all meds nurse informed1/4/26 at 4:44 p.m.: Patient refused B/S check x3 despite all the education given, patient still refused.1/4/26 at 9:36 a.m.: refused1/3/26 at 9:31 p.m.: refused all medications, nurse informed.1/3/26 at 4:09 p.m.: Patient refused.1/3/26 at 2:11 p.m.: Resident refused Medications, accuchecks (glucose monitoring product), and both meals this shift. Resident refused x several attempts. MD notified. Will continue to monitor.1/3/26 at 9:43 a.m.: (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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refused1/2/26 at 11:15 p.m.: levofloxacin Oral Tablet 750 MG; Give one tablet by mouth one time only related to acute upper respiratory infection. Resident refused the one-time dose, was educated on the reason why the antibiotic was prescribed but still he remained adamant.1/2/26 at 2:39 p.m.: refused1/2/26 at 10:46 a.m.: refused1/1/26 at 3:07 p.m.: refused1/1/26 at 10:00 a.m.: refused12/31/26 at 5:42 p.m.: refused. Nurse informed.12/30/25 at 8:59 a.m.: refused12/30/25 at 11:00 a.m.: refused12/29/25 at 10:49 a.m.: refused12/28/25 at 9:51 p.m. refused, nurse informed.12/27/25 at 3:47 p.m.: refused12/26/25 at 12:13 p.m.: refused12/26/25 at 8:51 a.m.: refused12/25/25 at 1:01 p.m.: refused B/S check x 312/24/25 at 9:14 p.m.: refused, nurse informed12/24/25 at 12:57 a.m.: refused12/23/25 at 8:23 p.m.: refused12/23/25 at 4:22 p.m.: refused Record review of Resident #1's progress notes, dated 1/5/26 at 2:36 p.m., the WCN, documented: During wound rounds with the WCD, resident allowed for wound care team to assess wounds and obtain measurements. Resident then requested that staff return to apply dressings because he was tired. Upon re-entering his room, resident stated his wound care had already been done. After attempting to re-orient resident and explaining that treatments have not been completed, resident continued to refuse treatments today. Attempted to notify resident's FM, but no answer on either telephone number listed. Record review of Resident #1's POC, dated 12/22/25- 1/9/26, revealed Task for Eating - (The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident) documented:12/24/25- refused12/22/25, 12/23/25, 12/25/25, 12/26/25, 12/27/25, 1/5/26, 1/8/26, 1/9/26- Not applicable- not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Record review of Resident #1's POC, dated 12/22/25-1/9/26, Task Nutrition - (what percentage of the meal was eaten) documented:12/28/25, 12/31/25, 1/1/26, 1/2/26, 1/4/26: consumed 0-25% of a meal.12/27/25, 12/31/25, 1/1/26, 1/4/26, 1/6/26, 1/7/26, 1/8/26: consumed 26-50% of a meal.12/23/25, 12/24/25, 12/26/25, 12/28/25, 12/29/25, 1/2/26, 1/3/26, 1/4/26 1/5/26, 1/6/26: response not required (did not occur). During an interview on 1/9/26 at 12:50 p.m., CMA C stated that she had worked at the facility for 11 years. She recalled that Resident #1 seemed to be very depressed and would always say not right now whenever she attempted to give his medications. She stated when he refused, she would usually try 2-3 times and then inform the nurse. She stated in efforts for Resident #1 to take his medicine, she purchased pudding and soda from the store. She stated she also tried ice-cream and soup from the kitchen to serves with his medications, but he refused. She stated she did the best she could. During an interview on 1/9/26 at 1:09 p.m., the WCN stated she worked at the facility for two years and was familiar with Resident #1. She stated he had a stomp (lower extremity was amputated) with wounds under his stomp, on the right heel, right hip, sacrum (a triangular bone in the lower back formed from fused vertebrae and situated between the two hipbones of the pelvis), redness, and an opening in the groin area that went back to the gluteal folds (the horizontal skin crease located directly below the buttocks, marking the boundary where they meet the upper thigh). The WCN stated he refused a lot of care and she reached out to the FM so they could encourage him. The WCN stated the FM would be on the phone during wound care so that she could provide treatment. The WCN stated she saw a decline with his wounds and that was more so redness and irritation on the left gluteal folds. She stated when she went in to do wound care, he told staff it was already done. She stated most days she was able to provide wound care, but when he had a very adamant no, she would have to reach out to his FM. In an interview on 1/9/26 at 3:07 p.m., the DON stated Resident #1 was admitted for therapy but he refused medications, showers, or anything patient care related. The DON stated for assistance, staff called his FM and they assisted by talking with him over the phone and encouraging his cooperation. She stated Resident #1 stated he was tired of wound care and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refused care. The DON stated Resident #1 also refused meals and his FM brought him home cooked meals. The DON stated the NP was very aware that Resident #1 refused care and the NP rounded at the facility daily between the hours of 9:00 a.m. - 11:00 a.m. During an interview on 1/9/26 at 4:20 p.m., the ADM stated she was informed that Resident #1's care plan was not updated and the only area of care mentioned in the care plan was for wound care. The ADM was asked for the contact information for the NP, who was currently on leave. During a follow up interview on 1/20/26 at 11:30 a.m., the ADM stated she had spoken with the FM of Resident #1 in the past and let her know that Resident #1 was a failure to thrive. Resident #1 did not care to do dialysis, eat when fed, nor participated in therapy. The ADM said she went into Resident #1's room a couple of times and told him that he needed to be changed and explained to him that because he had a sacral wound, he was at risk of deterioration or infection. ADM informed the surveyor that the NP was no longer with the medical group that oversaw the residents at the facility, but there was a new NP working in her place. She was asked to provide an additional contact number and stated she would ask the DON if she had one. No additional number was found. During a follow up interview on 1/20/26 at 11:49 a.m., the DON stated she started working at the facility in October 2025. She could not say why none of Resident #1's refusals were documented inside of the care plan. The DON stated the MDS nurse resigned during Resident 1's admission and the MDS nurse had to take time off. She explained that the MDS nurse was responsible for updating the care plans and she would gather information by going to speak with different residents and sitting in at clinical meetings. Wound care was responsible for updating their part in the care plan but for the nursing and activities department, the MDS nurse was responsible for making any updates. DON stated that when the MDS nurse was not in the building, she would update acute changes in the care plan, but for the most part, the responsibility fell on the MDS nurse. When the MDS Nurse informed administration she would be absent, a representative from the facilities corporate office would assist. The DON stated that care plans that were not updated could affect how the aids provided care, but they received daily communication from the nurses. The POC inside the Kardex filtered directly from the care plan and would reflect any information documented. During an interview on 1/20/26 at 12:17 p.m., the DSS stated she began working in the facility on 11/3/25. The DSS stated her job responsibilities were handling all discharges, services such as dental, vision, podiatry, hearing, various assessments, grievances/concerns, and completing her portion of the MDS. She stated she had 72 hours to complete her portion of the MDS upon admission and the nurses would do their own care plan, but staff were to complete update care plans whenever they were needed. The DSS stated she did not remember completing Resident #1's care plan, but his initial social services assessment was completed 12/23/25. She stated that she was educated by the ADM (after 1/9/25) because she was not aware that she had to complete the care plan or how to do them. She explained that she initially held care plan meetings with the family and did not inform department heads to attend because she didn't want to bother them. The ADM stated all department heads should be present during care plan meetings and they should be scheduled right after their morning meeting. During an interview on 1/20/26 at 12:56 p.m., LVN A stated she was a charge nurse and had worked at the facility for 17 months. She stated Resident #1 was non-compliant and she felt he had a failure to thrive. Resident #1 did not want to eat and he shook his head no when staff brought him food. The FM was concerned that he refused meals and wanted staff to call during every meal, but LVN A let her know that it was not feasible while assisting other residents with meals. When meals came, LVM A stated she encouraged Resident #1 by waking him up, arousing him, and setting up his tray. She stated that staff had also tried to feed him, but he refused to be fed. LVN A stated she tried to encourage Resident #1 to eat, but she did not do anything (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with care plans. In an interview on 1/20/26 at 2:16 p.m. with the DM, she stated that she had worked at the facility for four years and was not made aware that Resident #1 refused meals. During an interview on 1/20/26 at 2:28 p.m. CNA B stated she began working at the facility in October 2025. She stated at the beginning of each shift, she received a report from the nurse and CNA on the previous shift and they would walk from room to room to give her updates. She stated she was told Resident #1 was total care. She could not remember his appetite or how much food he ate during meals. She stated she also never witnessed him refusing to eat and he never spoke to her. During an attempted telephone interview on 1/20/26 at 2:43 p.m., the previous MDS Nurse did not answer and the voicemail was not set up; however, a text message requesting a call back was sent. During an attempted telephone interview on 1/20/26 at 2:52 p.m., with the NP, the call went to voicemail and a message was left requesting a return call back. During an attempted telephone interview on 1/20/26 at 2:56 p.m., the Dietician did not answer and a voicemail was left requesting a call back. During an attempted telephone interview on 1/21/26 at 10:11 a.m., 10:12 a.m., and 1:16 p.m., the previous MDS Nurse did not answer and the voicemail was not set up; however, a text message requesting a call back was sent. In an interview on 1/21/26 at 12:43 p.m. with the RA, she stated that as soon as a resident was admitted , she would weigh them and weigh them weekly for 4 weeks and then collect their weights monthly. She stated Resident #1 allowed her to capture his weight upon admission but refused the following weeks. During an interview on 1/21/26 at 1:29 p.m. the ADM stated completing the care plans was a shared responsibility between nurse management and the MDS nurse. She explained that if there was a consistent behavior, the MDS nurse would capture it and update the care plan. All members of the IDT have their own section, and once completed, they signed and locked it in the system. ADM stated in the absence of the MDS nurse, the facility had a corporate representative that could assist with completing the care plans. Record review of the facility's policy, revised June 2024, titled, Care plan meeting documented that care plan meetings were to be held upon admission, quarterly/annually, after a significant change, and as needed. Record review of the facility's policy, revised May 2022, titled, Care Plan Revisions documented: 1. The comprehensive care plan will be reviewed and revised every quarter, when a resident experiences a status change and as deemed necessary. 2. 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.d. Staff involved in the care of the resident will report resident response to 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. 3. The MDS Coordinator will determine whether a Significant Change in Status Assessment is warranted. If so, the assessment will be completed according to established procedures