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	12/11/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 1 of 21 residents (Resident #10) reviewed for advance directives. The facility failed to ensure Resident #10's Out of Hospital Do Not Resuscitate (OOH-DNR) form was signed and dated by two witnesses and failed to ensure all persons who signed the form acknowledged that the document was properly completed. This failure could place residents at risk for not having their end of life wishes honored and having incomplete records. Findings included: Record review of Resident #10's admission Record generated on [DATE] revealed she was admitted to the facility on [DATE] and had diagnoses of bipolar disorder (a mental health condition causing extreme mood swings, from emotional highs to lows, affecting energy, judgment, and behavior), major depressive disorder (a serious mood disorder causing persistent sadness, hopelessness, and loss of interest in activities), type 2 diabetes (a common condition where the body either doesn't produce enough insulin or can't use insulin effectively, leading to high blood sugar levels because sugar can't get into cells for energy) and morbid obesity (a severe form of obesity defined by a Body Mass Index (BMI) of 40 or higher). She was [AGE] years of age. The section for Advance Directive revealed she requested do-not-resuscitate, or DNR (a medical instruction telling healthcare providers not to perform cardiopulmonary resuscitation if a patient's breathing or heart stops). Record review of Resident #10's care plan dated [DATE] revealed she requested a code status of DNR. Interventions included, inform MD and staff of DNR status. Maintain copy of code status on chart. Make sure code status is signed and placed in clinical record. Monitor for any decline or change in condition and withhold (cardiopulmonary resuscitation) per residents' wishes. Record review of Resident #10's OOH-DNR dated [DATE] revealed it was signed by Resident #10 on [DATE] and MD S on [DATE]. MD S's signature was at the bottom of the form under a statement that stated, all persons who have signed above must sign below, acknowledging that this document has been properly completed. The document was not signed by two witnesses. In an interview on [DATE] at 12:25pm, the Social Worker said she recently started working at the facility. She said she had completed 3 to 4 advance directives since she started. She said she made sure all parties sign the OOH-DNR document, including the resident, physician and notary or two witnesses. She said if an OOH-DNR document was filled out incorrectly, it could be invalid and a resident would be considered full code (when a patient has requested all possible life-saving measures like CPR if their heart stops or they stop breathing). She said she was not working here when Resident #10 signed an OOH-DNR. In an interview on [DATE] at 12:33pm, ADON A said the facility's social worker was responsible for ensuring the OOH-DNR was completed. She said when the form was complete, the ADONs update the resident's code status in the electronic medical record. She said advanced directives were important because it depicted whether they were full code She acknowledged Resident #10's OOH-DNR form was incomplete. Record review of the Instructions for Issuing an OOH-DNR Order dated [DATE] provided by the Texas Department of State Health Services revealed the OOH-DNR must be signed and dated by two competent adult witnesses who have witnessed the competent adult person making his/her (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	12/11/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signature. Record review of the facility's policy regarding Advanced Directives dated 6/2019 revealed, It is the policy of this facility to:.ensure the resident's choice about advance directives is respected. ensure compliance with state law respecting advance directives. Pursuant to state laws, any person may make a formal declaration specifically authorizing the withholding or withdrawal of resuscitative measures if they stop breathing and their hearts stop beating.Once a DNR is signed by resident or legal representative, it needs to be witnessed by an individual who is not a staff member.

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	12/11/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to refer all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for 1 (Resident #3) of 5 residents reviewed for PASRR.- The facility failed to perform a new PASRR level 1 assessment on Resident #3 due to diagnoses of Schizoaffective Disorder and Bipolar Disorder.This failure could place residents at risk of not receiving needed services and support for mental illness and a decrease in quality of life. Findings Included:Record review of Resident #3's undated face sheet revealed he was a [AGE] year old male admitted to the facility on [DATE], with the most recent admission date of 10/29/25. He had diagnoses of tracheostomy status (tube in throat for breathing), quadriplegia (paralysis of upper and lower extremities), anxiety disorder, bipolar disorder (brain disorder causing extreme shifts in mood, energy, activity levels, and concentration), and Schizoaffective disorder (symptoms of schizophrenia (hallucinations, delusions, disorganized thinking) with those of a mood disorder).Record review of Resident #3's admission MDS assessment dated [DATE] revealed the resident was not considered by the state level II PASRR process to have had a serious mental illness and/or intellectual disability. The assessment revealed a BIMS was unable to be completed due to his medical condition. Resident #3 had moderately impaired (decisions poor; cues/supervision required) cognitive skills for daily decision making. The MDS assessment had anxiety disorder and Bipolar disorder checked off as diagnoses under active diagnoses. The assessment also revealed Resident #3 was taking antianxiety medicationRecord review of Resident #3's Care Plan with the last care plan review completed on 11/18/25, revealed a Focus: Resident has impaired cognition and is at risk for further decline AEB resident is diagnosed with bipolar disorder, and anxiety disorder (Initiated: 6/6/24). The goal was to have the resident's needs met over the next 90 days (Initiated 6/6/24, Revised: 4/24/25). The interventions included repeating information as needed and using terms the resident understands. Focus: The resident has a history of alteration in mood r/t anxiety (Initiated: 8/5/24, Revised: 6/9/25). The goal was to preserve the resident's dignity and quality of life through the review date. Interventions included administering medications as ordered and referring to counseling. Focus: Resident has been identified as having PASRR positive status (having a serious mental illness or an intellectual disability) related to severe mental illness AEB bipolar disorder (Initiated: 8/8/24, Revised: 1/4/25). The goal was for the resident to maintain his highest level of practicable wellbeing over the next 90 days. Interventions included coordinating services with LMHA or MHMR.Record review of Resident #3's previous hospital records dated 4/19/24 revealed a medical history of Bipolar/Manic/schizophrenia/Depression/Anxiety/PTSD and he was taking Depakote and Buspar (medications for mental illness).Record review of Resident #3's PASRR Level 1 Screening dated 5/13/24 reflected he did not have any evidence of mental illness.Record review of Resident #3's May 2024 MAR-TAR revealed he received Methylphenidate HCl (medication for ADHD) Tablet 5mg, Give 0.5 tablet PO QD for ADHD related to Bipolar Disorder. Ordered 5/14/24 and discontinued 5/29/24. He also received Buspirone HCl (Buspar) tablet 15mg, Give 1 tablet via G-tube (tube into stomach for nutrition) BID related to anxiety disorder. Ordered 5/14/24 and discontinued 5/29/24.Record review of Resident #3's Physician Progress Notes dated 5/16/24 from NP A revealed the resident had Bipolar 1 disorder and was taking Methylphenidate HCl Tablet 5mg.Record review of Resident #3's hospital records dated 5/28/24 revealed medical history of bipolar disorder.Record review of Resident #3's hospital records dated 6/19/24 revealed medical history of paranoid schizophrenia (severe mental illness characterized by intense paranoia, hallucinations [especially voices], and delusions [false beliefs, often of persecution]).Record review of Resident #3's Psychiatric Initial assessment dated [DATE] from NP L, revealed hospital records noted paranoid schizophrenia. NP L prescribed Buspar 1 (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	12/11/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablet 15mg BID for anxiety.Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed a BIMS could not be performed due to his medical condition. Resident #3 had severely impaired (never/rarely made decisions) cognitive skills for daily decision making. The assessment had anxiety disorder and bipolar marked as active diagnoses and revealed the resident was taking an antianxiety medication.Record review of Resident #3's Psychiatric assessment dated [DATE] from NP L, revealed he was being treated for Bipolar disorder and anxiety disorder.Record review of Resident #3's hospital records dated 11/21/24 revealed medical history of anxiety and bipolar disorder.Record review of Resident #3's hospital records dated 6/29/25 revealed medical history of bipolar disorder and schizophrenia.Record review of Resident #3's Psychiatric assessment dated [DATE] from NP L revealed Spoke with [family member] regarding pt's psychiatric history. [Family member] reports pt was dx with Paranoid Schizophrenia in his teenage years as well as hx of Bipolar disorder. Pt has hx of mood lability (goes up and down), delusions, auditory and visual hallucinations (hearing/seeing things not there), hx of SI (wanting to kill oneself) and HI (wanting to kill others). Pt was admitted to [hospital] for Delusions approximately 3.5 years ago. She reports a hx of tx with Geodon and Depakote (medications for psychiatric illness), as well as other psychiatric medications. She reports medications were stopped after MVA. [Family member] also reports pt has been observed with multiple personalities and states I have met 4 of them.Record review of Resident #3's Psychiatric assessment dated [DATE] from NP L, revealed the resident met criteria for Schizoaffective Disorder.Record review of Resident #3's Physician Progress Note dated 10/8/25 from NP A revealed medical history of anxiety, paranoid schizophrenia, and schizoaffective disorder, bipolar type.Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed a BIMS could not be performed due to his medical condition. Resident #3 had severely impaired (never/rarely made decisions) cognitive skills for daily decision making. The assessment had anxiety disorder, bipolar disorder, and schizophrenia marked as active diagnoses and revealed the resident was taking an antianxiety and an antidepressant.Record review of Resident #3's Physician Orders revealed the following orders from MD J:- Observation: Behaviors, Target Behaviors (anxiety), every shift. Ordered on 10/30/25.- Observation: Antianxiety Medication (side effects). Document Y if free from side effects and N if side effects are present, every shift. Ordered on 10/30/25.- Sertraline HCl (medication for anxiety) Oral Tablet 25mg, Give 1 tablet via G-tube QD for other specified anxiety disorders. Ordered on 11/11/25.- Buspirone HCl Oral Tablet 10mg, Give 1 tablet via G-tube BID for other specified anxiety disorders. Ordered on 11/11/25.Record review of Resident #3's Mental Illness/Dementia (severe cognitive decline (memory, thinking, reasoning) that impairs daily life) Resident Review dated 12/10/25 from the MDS Coordinator revealed the resident's PASRR Level 1 assessment was completed on 5/13/24. The resident did not have dementia and was diagnosed with schizoaffective disorder on 7/23/25. A new positive PASRR Level 1 was submitted on 12/10/25.In an interview on 12/11/25 at 11:29am, the MDS Coordinator said she was unsure of why Resident #3's care plan said he was PASRR positive and was receiving services because when she went to the PASRR website, it did not show a Level 2 (process to determine if resident would qualify for services) was ever completed for him. She said when the Investigator asked for the Level 2 yesterday (12/10/25) for the resident, she and the Corporate Nurse performed an audit and realized a new PASRR 1 was never filed for Resident #3, so they filed one. She said the initial PASRR should have said yes for mental illness since he had a history of it. The MDS Coordinator did not feel the resident missed out on anything because he was still getting medication, psychiatric services, activities, and there were no services he was missing.In an interview on 12/11/25 at 11:44am, the DON said PASRR was for residents to receive extra services if they were positive (had diagnosed mental illness or intellectual disabilities). She said if a resident was marked negative (no diagnosed mental illness or intellectual disabilities) when they should have been positive, or if a new PASRR Level 1 was not completed after a new diagnosis, the resident would be without potential resources they could have had.Record review of the facility's policies and procedures on PASRR (revised (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	12/11/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/2025) read in part: This policy ensures compliance with federal and Texas Health and Human Services Commission (HHSC) regulations regarding the Preadmission Screening and Resident Review (PASRR) process. The goal is to identify individuals with Mental Illness (MI), Intellectual Disability (ID), or Developmental Disability/Related Conditions (DD/RC) and ensure appropriate placement and specialized services.The PASRR Level I (PL1) Screening Form is designed to identify individuals who are suspected of having mental illness (MI), intellectual disability (ID), or a developmental disability (DD). The referring entity (RE).or nursing facility (NF) will screen the individual and fill out all fields of the PL1 Screening Form and enter the PL1 Screening Form into the LTC Online Portal. If documentation entered on the PL1 Screening Form indicates a suspicion of MI/ID/DD, a PASRR Evaluation (PE) must be completed. PASRR Evaluation (PE) Conducted by: The LA (LIDDA, LMHA, or LBHA). Negative PE: No PASRR specialized services required. Positive PE: Determines specialized service needs and appropriate placement options. Specialized Services: Nursing Facility Specialized Services (NFSS) - Services provided by the nursing facility (e.g., durable medical equipment, habilitative therapies). LA Specialized Services - Services provided by the LA (e.g., independent living skills, day habilitation). Authorization: NFSS requests are submitted via the LTC Online Portal. Monitoring: Regular review of specialized service effectiveness during care plan meetings.

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	12/11/2025

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, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a residents' medical, nursing and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 21 Residents (Resident #10) reviewed for care plans. The facility failed to ensure Resident #10 had a plan of care to address a diagnosis and symptoms of major depressive disorder, including tearfulness and sadness. These failures could place residents at risk of not having their needs met or a decline in psychological health. Findings include: Record review of Resident #10's admission Record generated on 12/11/25 revealed she was admitted to the facility on [DATE] and had diagnoses of bipolar disorder, major depressive disorder, type 2 diabetes and morbid obesity. She was [AGE] years of age. Record review of Resident #10's Default Progress Note dated 7/7/25 revealed Resident #10 had a diagnosis of depressive disorder, single episode, severe without psychotic features. Presently, she admits to severe depression. This episode of depression has been present for the last several years.The symptoms are constant and overwhelming. Record review of Resident #10's care plan dated 9/15/25 revealed she was receiving psychotropic medication (drugs that alter brain activity to treat mental health conditions like depression, anxiety, ADHD, and schizophrenia by adjusting brain chemical messengers such as serotonin, dopamine, and norepinephrine) and was at risk of adverse reactions and episodes of driven behavior. Interventions included, give medication as ordered. monitor for adverse reactions. monitor for episodes of depressive driven behaviors such as spontaneous crying, sad mood effect, self imposed isolation, mood not easily altered, etc. Record review of Resident #10's admission MDS assessment dated [DATE] revealed her BIMS was 15, indicating she had no cognitive impairment. She did not report feeling down, depressed, or hopeless. Record review of Resident #10's Psychological Services Progress Note dated 12/7/25 revealed she had a diagnosis of major depressive disorder. The summary and plan revealed Resident #10 was stuck in past pain and holds on to regret, which continues to impact her mood and emotional functioning.She described ongoing guilt and unresolved memories that weigh heavily on her. In an observation and interview on 12/9/25 at 11:10am, Resident #10 was tearful and crying. She shared information about her past, stating that it made her feel sad and full of regret and she thought about it constantly. She said she had been feeling sad for a long time. In an interview on 12/11/25 at 2:07pm, the DON said if a resident had symptoms of depression, then they should be addressed in the resident's care plan. In an interview on 12/11/25 at 2:47pm, the MDS Coordinator said she was responsible for completing a resident's care plan. She said she would write a care plan if a resident was admitted to the facility with a diagnosis of depression. She said she reviewed resident's treatment record and progress notes in the morning meetings to look for any changes that could indicate a resident's care plan needed to be updated. When asked if tearfulness or sadness should be care planned, she said yes. She said she could not remember if Resident #10 had problems with her mood. She said Resident #10 shared information with her about her former family member that made her upset and she hurt about what happened in her past. In an interview on 12/11/25 at 3:30pm, the MDS Coordinator said Resident #10's care plan for psychotropic medication use dated 9/15/25 should be sufficient for the resident when care planning for depressive symptoms. Record review of the facility policy regarding Care plan Revisions dated 5/2022 revealed the comprehensive care plan would be reviewed and revised every quarter, when a resident experiences a status change and as deemed necessary. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician and the resident representative. the MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options.

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	12/11/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this was not possible or resident preferences indicate otherwise for 2 of 21 residents (Residents #3, #9) reviewed for nutritional status.The facility failed to ensure Resident #9's enteral feeding (a form of nutrition that was delivered into the digestive system as a liquid form via the feeding tube) was administered as ordered by the physician on 12/9/25 and 12/10/25.The facility failed to ensure Resident #3's enteral feeding was administered as ordered by the physician on 12/10/25.This failure could place residents at risk for malnourishment, illness, skin breakdown, and decreased quality of life.Findings included:Resident #9Record review of Resident #9's care plan dated 8/16/25 revealed she was readmitted to the facility on [DATE] with diagnoses of hypothyroidism (happens when your thyroid gland does not make enough thyroid hormones to meet your body's needs), dementia, muscle wasting and atrophy and severe protein-calorie malnutrition. She was [AGE] years old. Further review of the care plan revealed she required the use of a feeding tube for nutrition and was at risk for unplanned weight loss, dehydration and nutritional complications. Interventions included, Follow Physician's orders for feedings and water flushes.monitor weight every month/(as needed), notify the physician of any adverse findings/changes.Record review of Resident #9's Nutrition Assessment from the acute care hospital dated 8/14/25 revealed the acute care dietician stated Resident #9 received a g-tube and would start enteral nutrition on 8/14/25. The acute care dietician revealed an order for enteral nutrition which included Jevity 1.2 cal at 80 mL/hour.Record review of Resident #9's physician order dated 8/15/25 revealed an enteral feeding order written by NP A for Jevity 1.5 cal at a rate of 45 mL/hour via g-tube continuously for 22 hours. The order was discontinued on 10/27/25.Record review of Resident #9's physician order dated 10/28/25 revealed an enteral feeding order written by MD J for Jevity 1.5 cal at a rate of 50 mL/hour via g-tube continuously for 22 hours.In an observation on 12/9/25 at 10:00am, Resident #9 received Jevity 1.5 cal formula at a rate of 44 mL/hour by enteral feeding.In an observation on 12/10/25 at 9:15am, Resident #9 had a 1-liter bottle of Jevity 1.5 cal formula hanging near her bed on a pole. The bottle contained approximately 775 mL of liquid. There was a handwritten note on the bottle stating it was placed on 12/9/25 at 8:00pm with a rate of 45 mL/hour. The pump was beeping and the display stated, pump inactive. Pump has been idle for 10 minutes, press continue.In an interview on 12/10/25 at 9:22am, LVN R said Resident #9's enteral feeding pump was most likely paused by the CNA so they could change her brief. She said a CNA can pause the pump and the nurse would start it again. She said the CNAs were usually good about notifying her when the pump needed to be turned back on. She said she had not been notified this morning of the pump being idle.In an interview on 12/10/25 at 10:52am, CNA U said he was assigned to care for Resident #9. He said when he needed to pause the enteral feeding pump, he notified the nurse. He said he did not push any of the buttons or pause the feeding. He said about an hour ago, LVN R turned off Resident #9's pump so that he could provide incontinent care. He said he only changed her once since arriving at 6am. He said when he arrived, he believed Resident #9's enteral feed pump was on, and LVN R did not indicate anything was wrong with it.In an observation and interview on 12/10/25 at 11:55am, LVN R said they should follow physician's orders for enteral feedings. She said Resident #9's formula bottles usually lasted about 24 hours. She said the bottle was placed at 8:00pm on 12/9/25. She said the feeding was interrupted for water flushes and they could take a while. She said Resident #9's physician order stated the formula rate should be set at 50 mL/hour. LVN R walked to Resident #9's room. She increased the feeding rate from 45 mL/hour to 50 mL/hour. She said when she monitored residents with enteral feedings, she checked for residuals (involves aspirating stomach contents through a g-tube to assess gastric emptying and feeding (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	12/11/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tolerance), abdominal distress, body positioning, site of g-tube insertion and rate. She said at times, the pump will pause because the tube was blocked and she had to fix it. She said residents who do not receive nutrition as ordered by the physician were at risk of weight loss, malnutrition and skin integrity problems.In an interview on 12/10/25 at 1:20pm, when asked about Resident #9's enteral feeding order, NP E said she had not visited the facility since before 10/1/25 and no longer worked at the facility. She said she could not remember and did not have access to Resident #9's medical records.In an interview on 12/10/25 at 2:01pm, MD J said he started working at the facility about 2 months ago. He said the dietician made recommendations for formula rate and he reviewed and either agreed or disagreed. He said Resident #9 had some unavoidable weight loss due to thyroid levels. When informed of the amount of formula in the formula bottle this morning at 9:15am, he said she received a little less than usual. He said it would be hard to generalize and state that the issue could cause weight loss.In an interview on 12/10/25 at 4:50pm, LVN T said when Resident #9 was readmitted from the hospital with a new g-tube, NP A wrote the order for the enteral feeding. She said NP E wanted her to start at 45 mL/hour and wanted it to be gradually increased to 60 mL/hour. She said she worked the 2pm-10pm shift and she changed Resident #9's formula during her shift, usually around 8pm-8:30pm. She said she made a mistake and was setting Resident #9's enteral feed rate at 45 mL/hour instead of 50 ml/hour as ordered. She said 45mL/hour was her previous order. She said sometimes, the CNAs paused the enteral feed pump and forgot to tell the nurse so they could turn it back on.In an interview on 12/11/25 at 3:07pm, CNA I said she never touched a resident's enteral feeding pump. When asked about Resident #9's enteral feeding pump on the night of 12/9/25, she said she did not notice anything out of the ordinary. She said if there was something wrong with it or if it was beeping, she would have notified the nurse. Resident #3Record review of Resident #3's undated face sheet revealed he was a [AGE] year old male admitted to the facility on [DATE], with the most recent admission date of 10/29/25. He had diagnoses of tracheostomy status (tube in throat for breathing), quadriplegia (paralysis of upper and lower extremities), stage 4 pressure ulcer of sacral region (pressure ulcer to the tailbone exposing muscle or bone), stage 3 pressure ulcer to right ankle (pressure ulcer exposing fat), gastrostomy status (tube into stomach for nutrition), dysphagia (trouble swallowing), and muscle wasting and atrophy (muscles are decreasing).Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed a BIMS could not be performed due to the resident's medical condition. The assessment revealed the resident was severely impaired (never/rarely made decisions) with decisions regarding tasks of daily life. Resident #3 was dependent (helper does all of the effort) for all ADLs. The assessment revealed the resident was on a feeding tube and was receiving 51% or more total calories and 501 cc/day or more of his fluid intake through it. There was no indication of weight loss noted. According to the assessment, the resident had 2 stage 3 pressure ulcers, 1 stage 4 pressure ulcer, 2 unstageable pressure ulcers (unable to see how deep it is due to dead tissue), and 1 deep tissue injury (deep bruise that can develop into a pressure ulcer).Record review of Resident #3's Care Plan with the last care plan review completed on 11/18/25, revealed a Focus: Resident is at risk for aspiration, unplanned weight loss, dehydration, and nutritional complications AEB receiving total nutrition/hydration via feeding tube. The goal was for the feeding tube to remain patent (unclogged) and for the resident to be adequately nourished over the next 90 days. Interventions included following physician orders for feedings and water flushes and monitoring weight every month/PRN and reporting any loss or gain of 5% to MD/RP.Record review of Resident #3 Physician Orders revealed an order from MD J for: Enteral Feeding- Jevity 1.5 @ 70/hr with 60/hr free water flush via G-Tube continuously x 22 hours. 22 hours accounts for ADL care. Ordered on 11/21/25 at 2:02pm.Record review of Resident #3's December 2025 MAR-TAR revealed daily nurse initials at 7am and 7pm from 12/1/25 through 12/11/25, indicating the nurse signed off that the resident was receiving the Jevity 1.5 @ 70/hr with 60/hr free water flush.In an observation on 12/10/25 at 11:40am, Resident #3's feeding pump was beeping when the Investigator went in the room, and the feeding was not running. It is unknown how long the machine was beeping or not (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	12/11/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	running. There was a 1500ml bottle of Jevity 1.5 hanging on the pole next to his bed, that indicated it had been hung at 4:00am. The Jevity bottle had 1300ml left in it at 11:40am. The pump was set at 70ml/hr and should have been running for about 7.5hr at that time. Therefore, Resident #3 should have received 525ml of feeding by 11:40am, but only 200ml was missing from the bottle.In an interview on 12/10/25 at 2:30pm, Dietician B said that she was covering for the primary dietician, Dietician A, while she was on leave. She said Dietician A assessed Resident #9 on 12/8/25 and consulted MD J regarding malabsorption. She said malabsorption affected a resident's ability to absorb nutrition they take in. She said Resident #9's formula requirements were calculated based on her ideal body weight rather than her current weight. She said if a resident did not receive nutrients based on the physician's orders, the risk to the resident would depend on a lot of factors, stating that is why they overestimated Resident #9's needs. She said if she received a little less, then it would not have too much effect. She said if the resident had malabsorption, she could not absorb any more nutrients to support or gain weight. In an interview on 12/11/25, the DON said CNAs could pause an enteral feeding pump to provide care then the nurses could start it again. She said if it was paused for too long, it would start to alarm. When informed surveyors observations of Resident #9's enteral feeding that was not consistent with physician's orders, she said those were calories she was not receiving. She said she was unsure if Resident #9 had a clinical condition that caused weight loss.Record review of the facility policy regarding Enteral Feedings dated 9/2023 revealed, The facility will provide adequate care for residents with enteral feeding tubes to prevent complications. Facility will obtain physician orders for enteral feeding (formula and flush orders). Facility will follow physician orders and document feedings on (electronic medication administration record).

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	12/11/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 16%, based on 4 errors out of 25 opportunities, which involved 1 (Resident #71) of 8 residents reviewed for medication errors. -LVN W administered Escitalopram 5 mg to Resident #71 instead of Escitalopram 10 mg and administered Multivitamin with minerals instead of Multivitamins without minerals according to Physician orders on 12/10/25. (Escitalopram is used to treat depression and generalized anxiety disorder). -LVN W crushed and administered Lansoprazole delayed release ODT and Potassium micro extended release via g-tube to Resident #71 on 12/10/25 when it should not have been crushed according to the pharmacy label.These failures could place residents at risk of inadequate therapeutic outcomes. Findings included:Record review of Resident #71's face sheet dated 12/11/25 revealed a [AGE] year-old female who admitted on [DATE]. Her diagnoses included mood disorder with manic features (manic features refer to symptoms associated with mania, characterized by elevated mood, increased energy, and impulsive behavior, often seen in conditions like bipolar disorder), adjustment disorder with mixed anxiety and depressed mood (adjustment disorder is a mental health condition characterized by an excessive emotional or behavioral response to a significant stressor, leading to distress and functional impairment), gastro-esophageal reflux disease (a condition in which stomach acid repeatedly flows back up into to the tube connecting the mouth and stomach), vitamin deficiency, and hypokalemia (low potassium levels in the blood).Record review of Resident #71's admission MDS assessment dated [DATE] revealed her cognitive skills for daily decision making were severely impaired. She was dependent on staff for ADL care, and she had a feeding tube.Record review of Resident #71's care plan dated 11/13/25 revealed she had a history of depression. Interventions were to give medications per order.Record review of Resident #71's Order Summary Report for December 2025 revealed active orders for:Escitalopram 10 mg give 1 tablet via g-tube one time a day related to adjustment disorder with mixed anxiety and depressed mood, order date 12/2/25,Lansoprazole DR ODT 30 mg 1 tablet via g-tube one time a day related to GERD, order date 10/22/25,Multiple vitamin (Multivitamin) give 1 tablet via g-tube one time a day related to vitamin deficiency, order date 10/22/25,Potassium chloride Crys ER 20 mEQ give 1 tablet via g-tube one time a day related to hypokalemia, order date 12/2/25.In an observation on 12/10/25 at 8:53 a.m. LVN W prepared Resident #71's medication for g-tube administration. She prepared Escitalopram 5 mg, Multivitamin with minerals, Lansoprazole DR ODT 30 mg, Potassium micro 20 mEQ ER, Diltiazem, Thiamine, Chlorhexidine, and Clonidine. The pharmacy label for Lansoprazole DR ODT read to dissolve in apple juice if given via g-tube. The pharmacy label for Potassium ER read do not crush, dissolve in water for g-tube. LVN W crushed each pill, placed them into separate medication cups, and dissolved them in water. She then administered the pills to Resident #71 via g-tube.In an interview on 12/10/25 at 10:11 a.m. LVN W said she administered one Escitalopram 5 mg tablet to Resident #71 but should have administered two. She said she administered multivitamins with minerals instead of multiple vitamins (multivitamin) which she said was not correct because of the minerals. She said she did not realize at the time of preparation that she administered the incorrect medication and said she needed to verify the correct medication name, resident, dose, route, and time. She said she crushed the potassium and the pharmacy label read do not crush, dissolve in water. She said Potassium should not be crushed because it was a lethal, dangerous drug. She said she crushed the Lansoprazole and the pharmacy label read do not crush, dissolve in apple juice. She said she was rushing, and the residents were new to her. She said she should review the pharmacy labels when administering medications so she would know what to do.In an interview on 12/10/25 at 4:59 p.m. the Administrator said the facility tried not to have any medication errors. She said she expected staff to follow the MD orders, crush/do not crush instructions and pharmacy labels.In an interview on 12/11/25 at 2:12 p.m. the DON said she (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	12/11/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected nursing staff to check the rights of medication administration which included the right patient, medication, dose, and documentation. She said staff should check the pharmacy labels because it would inform if the medication was crushable or not. She said crushing a delayed or extended-release medication would release all the medication at one time and it would not be distributed like it should. She said there were no negative effects to the resident. She said the risk of Resident #71 receiving Escitalopram 5 mg instead of 10 mg was not getting the full treatment. She said the resident received an extra vitamin when she was administered Multivitamin with minerals instead of multiple vitamins (Multivitamin). Record review of the facility's policy Medication Administration and Management dated 6/2019 read in part, .It is the policy of this facility that the facility will implement a Medication Management Program that incorporates systems with established goals to meet each resident's needs as well as regulatory requirements.M. Authorized licensed or certified/permitted medication aide or by state regulatory guidelines staff must understand: A. Indications/Reasons for therapy. B. Effectiveness of the therapeutic goal. C. Drug actions. D. The 8 Rights for administering medication: 1) The Right Patient/Resident 2) The Right Drug 3) The Right Dose 4) The Right Time 5) The Right Route 6) The Right Charting 7) The Right Results 8) The Right Reason.D. Always follows pharmacy and/or manufacturer's specifications. E. Crushes medication according to physician order using proper device: Medications which cannot be crushed: 1) Enteric-coated tablets 2) Sustained or extended-release tablets 3) Effervescent tablets 4) Sublingual or buccal tablets 5) Capsules.

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	12/11/2025

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 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** 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 out of 5 resident rooms (Resident #5) reviewed for infection control. - CNA D failed to wear appropriate PPE during incontinence care with Resident #5, when she was on Enhanced Barrier Precautions.- CNA D threw Resident #5's dirty brief on the floor instead of in the trash can.These failures could place residents and staff at risk of cross contamination and risk for infection.The findings included:Record review of Resident #5's undated face sheet revealed she was a [AGE] year old female who admitted to the facility on [DATE], with the most recent admission being 8/7/25. She had diagnoses of sepsis (infection throughout body), acute and chronic respiratory failure (not enough oxygen), type 2 diabetes (body does not produce insulin or body resists it), stage 3 pressure ulcer of right buttocks (fat exposed with no bone or muscle showing), and heart failure (heart does not pump effectively).Record review of Resident #5's Care Plan dated 4/13/24 revealed a Focus: Resident #5 has a tracheostomy (tube in throat to assist with breathing) and is at risk for increased secretions, congestion, and infection (Initiated: 4/13/24, Revised: 7/24/24). The goal was to have the secretions/congestion relieved with suctioning/medication and have no infection over the next 90 days (Initiated: 4/13/24, Revised: 4/22/24). Interventions included providing oxygen, tracheostomy care, and tubing change per orders. Focus: Resident #5 requires enhanced barrier precautions AEB indwelling medical device (Initiated: 4/12/24, Revised: 8/10/25). The goal was to have no adverse effects related to the requirements of enhanced barrier precautions through the review date (Initiated: 4/12/24, Revised: 4/22/24). Interventions included PPE: gown and gloves during high-contact resident care activities (dressing, bathing/showering, transferring, providing hygiene, changing briefs, assisting with toileting, device care, wound care). Focus: Resident #5 has a pressure injury to right rear thigh (Initiated: 8/22/25, Revised: 9/23/25). The goal was to show signs and symptoms of improvement through the review date. Interventions included monitoring site for s/s of infection, presence of dressing if indicated, or onset of pain, consult Wound MD, and assist with turning/re-positioning.Record review of Resident #5's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, which indicated normal cognition. The resident was dependent (helper does all of the effort and resident does none of the effort) for toileting, shower/baths, lower body dressing, and putting on/taking off footwear. The resident was frequently incontinent of bladder and always incontinent of bowel. The MDS revealed the resident was on oxygen, non-invasive mechanical ventilator (delivers air/oxygen to lungs using mask or other device without endotracheal tube), IV medications, and received tracheostomy care and suctioning.Record review of Resident #5's Physician Progress Note dated 10/10/25 from NP H revealed she had a tracheostomy and a stage 3 pressure ulcer to her right buttocks. SKIN- skin breakdown on buttocks.RESPIRATORY- tracheostomy 6XLT secured and intact, on ATC (artificial tracheostomy collar) [strap that holds trach in place] with 6L oxygen, PMV (speaking valve for tracheostomy patients) used intermittently during the day. Assessment and Plan: Chronic respiratory failure with hypercapnia [too much carbon dioxide in blood] *: Patient has a tracheostomy and is currently on ATC 6L oxygen with PMV. Patient consistently refusing BiPAP therapy [breathing therapy using machine and mask to deliver two pressure levels]. No acute respiratory distress noted today. Continuing DuoNeb [nebulizer] via trach four times daily and scopolamine patch every 72 hours for respiratory management.Pressure ulcer of right buttock, stage 3 *: Patient has stage 3 pressure ulcer to right buttock which has been improving per previous evaluation. Daily wound care is provided. Continue Vitamin C 500mg daily to support wound healing. Staff will continue to monitor and provide wound care. Patient is currently unable to get out of bed due to non-functioning wheelchair, which may impact wound healing.Record review of (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	12/11/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5's Wound Care Note dated 10/13/25 from NP S revealed a wound to her right thigh with orders for daily and PRN wound care.Record review of Resident #5's Pulmonary Progress Note dated 11/12/25 from NP B revealed she was being seen for tracheostomy management. Physical Examination Neck: Tracheostomy XLT #6 with PMW (Permanent Mechanical Windpipe).Continue monitoring tracheostomy site for appropriate healing. Continue nocturnal [nighttime] ventilator [machine] support as needed.Monitor trach site for bleeding.Record review of Resident #5's Physician Progress Note dated 11/18/25 from MD J revealed Chronic Respiratory Failure, Unspecified.Maintain airway support, suction trach as needed, and monitor respiratory effort and oxygen saturation. Continue Albuterol nebulizer four times daily to support airway clearance and improve airflow.Record review of Resident #5's Skin Observation dated 12/2/25 revealed she had maceration (skin breakdown due to moisture) to the right rear thigh that was being treated with barrier cream with each incontinence episode.Record review of Resident #5's Respiratory Progress Note dated 12/9/25 from RT N revealed Resident was received on room air with PMV attached, wearing Shiley #6XL T, BL 02 via ATC Trach intact and secured. No respiratory distress noted. E-kit at bedside. Will continue to monitor.Record review of Resident #5's Physician Orders from 12/9/25 revealed the following orders:- Trach Care: Disposable Inner Cannula, every day. Change Shiley 6XLT Inner Cannula Daily and PRN. Ordered by MD G on 8/7/25.- Change Vent Circuit (tubing for the vent) Q30 days and PRN, every 30 days. Ordered by MD G on 8/8/25.- Enhanced Barrier Precautions - PPE: Gloves/Gown during high-contact resident care activities, every shift. Ordered by NP A on 8/11/25.- Trach Care: Trach Site - Cleanse with NS, pat dry, apply fenestrated dressing, every shift and PRN. Ordered by NP A on 8/11/25.- Trach Care: O2 via trach collar continuously. Titrate to keep O2 >90%, every shift. Ordered by MD V on 8/11/25.- Ascorbic Acid Tablet 500mg, 1 PO QD for Wound Healing. Ordered by MD J on 10/1/25.- License nurse to monitor: R Thigh (Rear) for any abnormalities or changes to surrounding skin for s/s of infection, pain associated with site, and for presence of dressing Q shift. Ordered by MD J on 10/15/25.Record review of Resident #5's December 2025 MAR-TAR revealed the order for Enhanced Barrier Precautions was checked off by staff for each shift, from 12/1/25-12/9/25.In an observation on 12/9/25 at 9:57am Resident #5 had an EBP sign on the door to her room and a cart that had PPE in it, outside her room. She was lying on her back in bed, on an air mattress, and had a tracheostomy. Resident #5 was receiving incontinence care by CNA D who was wearing gloves, but no gown. Resident #5's dirty brief was observed on the floor next to her bed and not in the trash can.In an interview on 12/9/25 at 10:03am, CNA D said EBP was when you have to wear a gown and gloves with residents who had G-tubes, open wounds, or residents in isolation. She said the PPE had to be worn anytime she performed patient care, and it was to protect herself from contamination. CNA D said she was unaware EBP was for residents with trachs and without wearing a gown she could get germs on herself and give it to others. She also said she normally threw the brief in the trash can, but she forgot to bring the trash can next to the bed. She said the dirty brief on the floor could cause contamination.In an interview on 12/11/25 at 11:44am, the DON said EBP was for residents who had open wounds, lines, and trachs. She said gown and gloves were required for any patient care like wound care, incontinent care, or medication administration. The DON said EBP was to protect the patient from getting any infection. She said not following EBP could cause cross contamination. She said a dirty brief on the floor caused contamination and then it could be spread around.Record review of the facility's policies and procedures on Enhanced Barrier Precautions (revised March 2024) read in part: Enhanced Barrier Precautions is an infection control intervention designed to reduce the transmission of multidrug-resistant organisms and employs targeted gown and glove use during high-contact resident care activities for targeted residents. Enhanced Barrier Precautions (EBP).expands the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following:.Wounds and/or indwelling medical devices.Examples of chronic wounds: pressure ulcers, diabetic foot ulcers, unhealed surgical (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	12/11/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wounds, and venous stasis ulcers. Examples of indwelling medical devices: central lines [IV line goes in deeper vein and stays longer], urinary catheters [tube into bladder to drain urine], feeding tubes, and tracheostomies.EBP should be employed for the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing briefs, assisting with toileting, device care, and wound care.