STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675321	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at Faith Memorial	811 Garner Rd Pasadena, TX 77502

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39977 Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 out of 21 residents (Resident #1) reviewed for adequate supervision. The facility failed to provide adequate supervision to Resident #1 who had a diagnosis of vascular dementia and eloped from the facility to a tire shop two blocks away from the facility for at least an hour. Resident #1 was severey cognitively impaired, which put her at increased risk of injury. An IJ for Past Non-Compliance was called on 2/20/25 at 3:18pm with the facility Administrator and DON. The noncompliance was identified as Past Non-Compliant. The IJ began on 12/2/24 and ended on 12/5/24. The facility corrected the noncompliance by providing in-servicing and hands-on training regarding elopement for facility staff prior to surveyor entrance. The failures placed residents at risk for elopement which could result in injury, hospitalization , and death. Findings included: Record review of Resident #1's Admission Record dated 2/20/25 revealed she was a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses, personality disorder (a mental health condition characterized by patterns or behavior, thoughts and emotions that deviate significantly from cultural expectations and cause distress and or impairment of functioning), and vascular dementia moderate without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (term for brain changes that affect memory, thinking and can affect behavior but can occur without behavioral or mood changes). (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's MDS (Minimum Data Set) dated August 8, 2024, section A revealed Resident #1 admitted from short-term general hospital. Section C revealed a BIMS (Brief Interview for Mental Status) score of 1 out of 15 indicating significant cognitive impairment. Section E regarding Resident #1 behaviors revealed rejection of care occurred 1 to 3 days. Resident #1 had no wandering behaviors. Section GG regarding Resident #1's Activities of Daily Living (ADL) Assistance revealed the resident needed set-up assistance with eating and oral hygiene, supervision with toilet use, moderate assistance with dressing and personal hygiene and maximum assistance with bathing. Section V regarding (CAAs), Care Area Assessments revealed Resident #1 was reviewed for risks in the following areas: Cognitive loss/Dementia-dated 8/9/24, Communication dated 8/9/24, Urinary incontinence/Indwelling catheter dated 8/9/24, Behavioral symptoms (related to refusals of care) dated 8/9/24, falls dated 8/9/24, Nutritional status dated 8/9/24, pressure ulcers dated 8/9/24 and psychotropic drug use dated 8/9/24. Record review of the facility's daily sign-in sheet dated 12/2/24 revealed staff worked 12-hour shifts from 6 am-6 pm and from 6 pm-6 am. LVN A was working on Resident #1's hall on the day shift and ADON was working on Resident #1's hall on the night shift. Continued review revealed MA A and CNA A were working on Resident #1's hall on the day shift and MA B and CNA B were working on Resident's #1 hall on the night shift. Record review of Resident #1's EMR for assessments on 2/3/25 at 12:22pm revealed no admission elopement risk assessment. Record review of Resident #1's nursing progress notes from 8/2/24 through 12/1/24 revealed staff documented by exception, Resident #1 was ambulatory without an assistive device and had no exit seeking or wandering behaviors prior to the incident on 12/2/24. Record review of facility incident and accident report from 8/2/24 through 2/20/25 at 7:53 pm revealed Resident #1 had an elopement incident on 12/2/24. There were no other elopement incidents or accidents from August 2024 through February 2025. Record review of Resident #1's facility provider investigation report dated 12/2/24 revealed Resident #1 was found by police at a tire shop up the road from the facility and returned to the facility by police and a family member unharmed around 7:50pm. Further record review of report revealed Resident #1 was gone from facility for about 1 hour and had gotten out of the facility through a side door that was no alarmed and was not part of the facility's secured unit. Record review of facility map revealed Resident #1 resided on an L-shaped unit that only had 1 unsecured entry/exit door. Continued record review of report revealed CNA B was the last to see Resident #1 around 6pm and staff did not recognize resident was not inside the facility until ADON received telephone call from Resident #1's family member around 6:30pm. Record review of LVN A's nursing note dated 12/2/25 at 5:46pm revealed the following: received phone call residents family member (sic) that resident was (sic) seen several streets down at tire shop and was obtained by the police and take (sic) to the police station. RP family member to pick her up and bring her to facility charge nurse on floor informed. Record review on 2/5/25 at 3:12pm of the ADON's nursing note dated 12/2/25 at 7:44 pm revealed the following: resident returned to facility and stated that (family member) does not want [Resident #1] to go to the secured unit. Education provided. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's MAR dated 12/1/2024-12/31/2024 revealed it was documented that Resident #1 received two 4:00 pm medications from LVN A, three 5:00pm medications from MA B, and received two medications from LVN B at 8:00pm. Telephone interview with MA A on 2/4/25 at 3:30 pm said Resident #1 had never tried to leave the facility prior to the incident and received her dinner and evening medications on 12/2/24 and could not have been missing from the facility very long. MA A said they had been trained on ANE upon hire and at least quarterly and had also been trained on elopement policy and procedures prior to and after the incident with Resident #1 on 12/2/24. MA A said that the facility conducted a code orange on the day Resident #1 went missing and searched the entire facility including bathrooms and closets and the interior and exterior of the facility. MA A said it was determined on 12/2/24 after the elopement search, that there were no other residents missing. MA A said they had been re-trained on ANE and elopement drills after the incident as well and that the facility conducted at least monthly elopement drills on each shift. MA A said that all doors were alarmed after the incident. Interview on 2/5/25 at 1:15 pm the DON said Resident #1 should have had an admission elopement assessment. The DON said she was working at the facility and helped complete the investigation involving Resident #1's elopement. The DON said it was determined through investigation that Resident #1 got out of a side facility door, and it was not part of the secured unit. The DON said Resident #1 did not have any exit seeking or wandering behaviors prior to the incident on 12/2/24 and the facility conducted a PIP in December 2024, after the incident with Resident #1 occurred and determined they will conduct more frequent elopement drills on each shift and audit admission assessments for all new admissions. The DON said Resident #1 was not injured during the incident and was reassessed and placed on the secured unit after the incident where Resident #1 remained. The DON said an elopement risk assessment was part of the facility's admission paperwork and should have been completed upon Resident #1's admission. The DON said she started working at the facility after Resident #1's admission in August 2024 and the charge nurse at the time of any resident admission was responsible for completing the required assessments which included an elopement risk assessment. Interview and observation on 02/5/25 at 12:42 pm revealed Resident #1 ambulating in the main activity room of facility's secured unit. Resident #1 had finished eating her lunch and was appropriately groomed and dressed. Resident #1 was awake, alert, and oriented and pleasantly confused. She was easily distracted but also easily redirected. Resident #1 did not want to continue speaking with surveyor and declined to be interviewed at that time or at any other time. The IJ began on 12/2/24 and ended on 12/5/24. The facility corrected the noncompliance by conducting a facility QAPI/PIP on elopement and providing in-servicing and hands-on training regarding elopement for facility staff prior to surveyor entrance. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview with MA B on 2/20/25 at 11:26 am revealed they could not remember all the specific details about the elopement of Resident #1 but remembered giving Resident #1 her 5pm medications between 5:00-5:30pm. MA B said Resident #1 was returned to facility around dusk and was not injured and placed on the secured unit after the incident. MA B said Resident #1 never wandered or tried to elope prior to the incident on 12/2/24. MA B said they did not know what staff member first identified Resident #1 was missing or when, but said staff immediately conducted an elopement drill and swept the entire building looking for Resident #1 and did a head count to ensure no other residents were missing. MA B said they had been trained both before and after the incident with Resident #1 on elopement procedures. MA B said that they knew how to check to make sure all exit/entry doors were securely closed and that they responded to any alarms or door sounds immediately to ensure there are no residents trying to elope. Telephone interview on 2/20/25 with LVN A on 2/20/25 at 11:37 am revealed Resident #1 walked around a lot and did not require any assistive devices to ambulate. LVN A said they worked the 6am-6pm shift on 12/2/24 with Resident #1. LVN A said that Resident #1 was sometimes confused but was awake, alert, and oriented to person and place and had never tried to leave the facility prior to the incident on 12/2/24. LVN A said Resident #1 would greet other resident's family members and visitors as they arrived and left the facility but had never tried to leave the facility on her own. LVN A said she did not recall any specific times she last saw Resident #1 on 12/2/24 or when Resident #1 returned to the facility but heard about the incident after it happened. LVN A said she would have given Resident #1 her 4:00pm medications. LVN A said they had been trained by the facility on ANE and had elopement drills before and after the incident on 12/2/24. LVN A said they learned how to split up the search to conduct a more thorough and timelier search of the interior and exterior of the facility to get a more immediate head count and to immediately report to the abuse coordinator/administrator. LVN A said they also learned how to check all the exit/entry doors were secured and closed. LVN A said they learned to ensure an admission elopement assessment had been completed on all new admissions and to document any wandering or exit seeking behaviors. LVN A said the ADON was the charge nurse for Resident #1 at the time of the incident because the scheduled charge nurse called in to say they would be late. Telephone interview on 2/20/25 at 4:11pm with LVN B revealed they gave Resident #1 two medications at 8:00pm on 12/2/24. LVN B said Resident #1 was back at the facility and moved to secured unit by that time. LVN B said before the incident Resident #1 had never tried to escape, elope, or leave. LVN B said they were trained upon hire and at least monthly on ANE and elopement procedures. LVN B said they learned how to split up the search to conduct a more thorough and timelier search of the interior and exterior of the facility to get a more immediate head count and to immediately report to the abuse coordinator/administrator. LVN A said they also learned how to check all the exit/entry doors were secured and closed. LVN B said they also learned to ensure an admission elopement assessment had been completed on all new admissions and to document any wandering or exit seeking behaviors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 2/20/25 at 4:15 pm with MA C revealed they worked the evening shift 12/2/24 and were trained on ANE and elopement procedures prior to the incident with Resident #1 on 12/2/24. MA C said Resident #1 had not tried to elope or get out of the facility prior to the incident on 12/2/24. MA C said Resident #1 liked coffee and walked around the facility but not wandering or going in and out of other resident rooms. MA C said after a couple of times after family members came to see Resident #1 or took her out on pass Resident #1 would seem sad but still never tried to elope until 12/2/24. MA C was unsure if Resident #1 had any visitors that day or if Resident #1 had been out on pass. MA C said the ADON initiated an elopement drill which the facility called a and they searched entire building inside and outside after Resident #1 was missing. MA C said that she knew that code orange was facility code for elopement and that an immediate search and lock down of facility needed to be conducted both inside and outside of the facility in addition to resident head count and Administrator notification if resident could not be found. Telephone interview on 2/20/25 at 4:32pm with CNA B revealed they were the assigned CNA and worked with Resident #1 on 12/2/4 during the evening shift. CNA B said they last saw Resident #1 at 6pm. CNA B said they gave Resident #1 a shower before dinner and remembered seeing Resident #1 seated in the activity room/communal area because there was an activity in progress. CNA B said they went to give another resident a shower and by the time the other shower was finished 30-40 minutes later they were told by LVN A to start a code orange. CNA B said they looked everywhere for Resident #1 and the ADON and other staff also went outside looking for Resident #1. CNA B said they looked in every resident room, every bathroom, every closet, and it was confirmed Resident #1 was missing but all other residents were accounted for. CNA B said they did not see Resident #1 return but heard the resident went to secured unit and ADON was managing it. CNA B said everyone was retrained on ANE and elopement drills and procedures immediately after the incident. CNA B said they had been trained on elopement procedures before the incident on 12/2/24. CNA A said they knew to look in all closets, bathrooms, resident rooms, and areas both inside and outside facility and to conduct a resident head count to ensure which residents were accounted for and which one may be missing. CNA A said they also learned to report any missing resident to administrator immediately if resident not found and to check all entry/exit doors to ensure they were secure. Telephone interview on 2/20/25 at 4:50pm with the ADON revealed they only worked a few months at the facility and remembered the incident with Resident #1 who somehow got out of the facility side door. The ADON said Resident #1 was calm and had not tried to exit the facility before 12/2/24. The ADON said they were covering for 6pm-6am shift charge nurse and helping the floor because the assigned 6pm-6am nurse was running late. The ADON said they last saw Resident #1 around 6:00pm-6:30pm. The ADON said they were trained on ANE and a code orange before hire and after the incident. The ADON said they believed they were called around 6:30 by Resident #1's family member saying the police had Resident #1 by a tire shop up the road and were bringing Resident #1 back to the facility. The ADON said they immediately initiated a code orange and confirmed Resident #1 was missing but no other residents. The ADON said when police arrived with Resident #1 accompanied by family member, they had staff complete an SBAR, skin, elopement risk and pain assessments as well as an incident report and Resident #1 was placed on secured unit. Interview on 2/20/25 at 4:55pm with Housekeeper said they had been trained monthly on elopement drills and at least quarterly on ANE. Housekeeper said code orange meant a resident had eloped and to monitor exit/entry doors and help search for resident inside and outside of facility as assigned by the charge nurses. Housekeeper said they were to report any resident elopement immediately to Administrator. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with CNA C on 2/20/25 at 5:03pm who worked 6am-6pm shift but worked 6pm-6am shift too at times. CNA C said they knew to look in all closets, bathrooms, all resident rooms, and areas both inside and outside facility and to conduct a resident head count to ensure which residents were accounted for and which one may be missing. CNA A said they also learned to report any missing resident to administrator immediately if resident not found and to check all entry/exit doors to ensure they were secure. Interview with SW on 2/20/25 at 5:08pm they said they had been trained on ANE and the facility code orange or elopement drill upon hire in November 2024 and after incident with Resident #1. SW said elopement drills were monthly and they learned to notify Administrator/Abuse Coordinator immediately and do a sweep search of building, all areas inside and outside and monitor and check exit/entry doors to ensure they remained secured. The SW said they would be part of the follow up safety rounds and psychosocial assessments for residents after any elopement. Interview with Receptionist on 2/20/25 at 5:12pm they said they had been trained upon hire 2/3/25 on ANE and resident elopement. Receptionist said they were trained to monitor main front entry/exit and unsure door remained securely closed and only opened via code. Receptionist showed a binder of current facility resident face sheets with resident photos to assist with identifying residents. Receptionist said they were trained code orange meant a resident had eloped and to monitor exit/entry doors and help search for resident inside and outside of facility as assigned by the charge nurses. Receptionist said they also learned to report any missing resident to administrator immediately if resident not found and to check all entry/exit doors to ensure they were secure. Record review of the facility's Elopement policy dated Revised May 2024 revealed the following Elopement Mitigation Strategies: *Appropriateness of resident placement within the facility upon admission and during their stay. *Completion of routine elopement risk assessments. *Providing the resident with appropriate supervision *Conducting routine elopement drills . Missing Resident 1. Once it has been established that a resident is missing, activate the emergency response paging system Code Orange, Room***to engage all staff in the search process. a. Establishing that a resident is missing should involve: i. Reviewing the resident's capacity for leaving the facility. ii. Reviewing if the resident signed out of the facility. iii. Contacting the resident's responsible party/and or family to identify if the resident left with them . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility's Abuse and Neglect in-service acknowledgement dated 12/2/24 revealed nursing staff received education on being expected to follow federal guidelines for ANE, prevention of ANE, reporting of ANE, and investigating allegations of ANE. The signature page included ADON, the nurse who was assigned to Resident #1 on 12/2/24 the evening of the elopement. The ADON, LVN A, LVN B, MA A, MA B, MA C, CNA A and CNA B were all interviewed about this in-service. Record review of facility's Elopement in-service acknowledgement dated 12/2/24 revealed nursing staff received education on facility staff received education on what to do when a resident was missing or eloped and calling of a Code Orange, the code used by the facility to communicate to all staff that a resident was missing or eloped. The signature page included ADON, MA A, MA B and CNA A who were the staff assigned to Resident #1 on 12/2/24 the evening of the elopement. The ADON, LVN A, LVN B, MA A, MA B, MA C, CNA A and CNA B were all interviewed about this in-service. Record review of facility's Facility Elopement Drill: Elopement/Missing Resident in-service acknowledgement dated 12/5/24 revealed facility staff received education on what to do when a resident was missing. The ADON, LVN A, LVN B, MA A, MA B, MA C, CNA A and CNA B were all interviewed about this in-service. Record review of facility's Code Orange Drill in-service acknowledgement dated 12/5/24 revealed nursing staff received education on what to do when a resident is missing or eloped. The ADON, LVN A, LVN B, MA A, MA B, MA C, CNA A and CNA B were all interviewed about this in-service. Record review of the facility Wander/Elopement Drill Report revealed there were elopement drills conducted on 12/5/24 at 5:40 am, 10:00 am and 6:45 pm. The signature pages included the ADON, LVN A, MA A, MA B, CNA A and CNA B who were the staff assigned to Resident #1 on 12/2/24 the evening of the elopement. Record review of facility's QAPI Action Plan dated 12/2/24 revealed the following: PIP opportunity Elopement .Date initiated 12/2/24 .Issue: Elopement procedures were not accurately followed .Immediate Intervention: Elopement drill performed. Educated all staff regarding policies and procedures for elopement. Re-education: Inservice all staff on the importance of immediately identifying elopement risks and immediate interventions to ensure the safety of residents . Record review of facility Wander/Elopement Drill Report revealed there was an elopement drill conducted on 1/7/25 at 10:10 am and 8:43pm. Record review of facility's 2025-2026 QAPI Committee Meeting Performance Improvement Plans .Current Active PIP's .Elopement Procedures, Admission Process .Incidents and Accidents .Action Items .Ensuring accurate and timely completion of documentation.