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	10/13/2025

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for 2 (Resident #1 and Resident #2) of 3 residents reviewed for catheter care.The facility failed to ensure Resident #1 and #2 received urinary catheter changes as ordered every month. This failure caused Resident #1 emotional distress and Resident #2 experienced a urinary tract infection. Resident #1 reported anxiety regarding the urinary catheter not being changed and Resident #2 was prescribed oral antibiotics on 10/13/25 for urinary tract infection. This failure could place other residents with catheters at risk of infection or emotional distress.Findings included:Record review of Resident #1's face sheet, dated 10/9/25, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including paraplegia (paralysis of the lower body) and neuromuscular dysfunction of the bladder (condition where nurse damage affects bladder control). Record review of Resident #1's quarterly MDS, dated [DATE], section C, revealed a BIMS score of 10 that indicated moderate cognitive impairment and section H revealed an indwelling catheter. Record review of Resident #1's Clinical Physician Orders, dated 10/13/25, revealed a physician's order for indwelling urinary catheter with instructions to change as needed for blockage and/or leaking with a start date of 2/3/25. Record review of Resident #1's care plan, dated 10/13/25, revealed focus of Resident #1 having a catheter and intervention to change catheter, tubing, and bag per order. Record review also revealed focus dated 1/20/25 that Resident #1 refused catheter changes.Record review of Resident #1's August 2025 TAR did not reveal any documentation regarding catheter change. Record review of Resident #1's September 2025 TAR did not reveal any documentation regarding catheter change. Record review of Resident #1's October 2025 TAR did not reveal any documentation regarding catheter change. Record review of Resident #1's progress notes did not reveal any documentation regarding Resident #1 refusing or requesting a catheter change. Record review of Resident #2's face sheet, dated 10/9/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including retention of urine, unspecified and other obstructive and reflux uropathy (condition where urine flows backward from the bladder into the ureters and kidneys). Record review of Resident #2's quarterly MDS, dated [DATE], section C, revealed a BIMS score of 11 that indicated moderate cognitive impairment. Section H revealed indwelling catheter. Record review of Resident #2's Clinical Physician Orders #1, dated 10/13/25 revealed, a physician's order for suprapubic (above the region on the center front wall of the abdomen immediately above the pubic bone) indwelling urinary catheter with instructions to change monthly and as needed with start date of 9/15/25. Record review of Resident #2's September 2025 TAR revealed documentation by LVN B on 9/15/25 for suprapubic indwelling urinary catheter change monthly and as needed. Record review of Resident #2's physician's order notes on 10/13/25 at 12:43 p.m. revealed Macrobid Oral (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Capsule 100 mg with instructions to give 1 capsule by mouth two times a day for UTI for 10 days. Record review also revealed a physician order note on 10/13/25 at 12:39 p.m. of Levofloxacin Oral Tablet 500 mg with instructions give 1 tablet by mouth one time a day for UTI for 10 days. Record review of Resident #2's Care Plan printed and reviewed on 10/13/25 revealed Resident #2 had frequent UTIs as evidenced by catheter with intervention of Staff to provide catheter care every shift and as needed. During an interview and observation on 10/9/25 at 10:09 a.m., Resident #1 said she had a catheter. Resident #1 said the facility staff did not change the catheter every month and if she told the facility staff then they got mad about it. Resident #1 showed me the date on her urinary catheter bag. Observation revealed 8/28/25 was written on the back on the urinary bag and brown coloring in the urinary bag. Resident #1 said the urinary bag smell ed. Resident #1 said she could not feel anything physically below her waist, but she felt anxious regarding the urinary bag not being changed. Observation on 10/9/25 at 2:16 p.m. revealed written on the back of Resident #2's bag was WED 8/27/25 14.00 HRS INSTALLED. During an interview on 10/9/25 at 3:26 p.m., the Unit Manager said the whole urinary catheter was supposed to be changed every 30 days but depended on the facility's policy. The Unit Manager said that they changed the urinary catheter bags if they were dirty. The Unit Manager said the nurses were responsible for changing the urinary catheters. The Unit Manager said there were admission set orders that gave instructions to how often and when the urinary catheters were supposed to be changed. The Unit Manager said once the order for the urinary catheter was in the residents' orders then it goes on the MAR/TAR. Observation on 10/13/25 at 8:16 a.m. of Resident #2 revealed writing on the back of Resident's #2's urinary catheter bag of WED 8/27/25 14.00 HRS INSTALLED which was the same as observed on Thursday 10/9/25. During interview and observation on 10/13/25 at 8:18 a.m., Resident #1 said staff changed her urinary catheter on 10/11/25. Observation of urinary catheter bag revealed no writing on the back of the urinary catheter bag. Observation revealed urinary catheter bag and tubing were clean with no brown substance in the bag. During an interview on 10/13/25 at 11:46 a.m., LVN A said she normally worked on the hallway where Resident #1 and Resident #2 resided. LVN A said residents' catheters were changed once a month and as needed. LVN A said Resident #2 had an appointment at the end of the month for urology. LVN A said she monitored schedules regarding changing catheters. LVN A said there should be a physician's order in the chart regarding changing the urinary catheter. LVN A said if urology was supposed to change the catheter we would keep in contact with the doctor and see what they did and what their orders were as well. LVN A said if a resident's catheter was supposed to be changed by urology that should be specified in the order. LVNA A said she would have to thumb through the chart and see when Resident #2's catheter was last changed. LVN A said it was documented under the progress notes when a catheter was changed, and she would have to look at the order to see when a catheter was supposed to be changed. LVN A said she would have to check when Resident #1's catheter was last changed because Resident #1 was noncompliant with a lot of her care overall. During interview on 10/13/25 at 1:47 p.m., Resident #1 said three months ago she had an appointment, so she refused to let the staff change her catheter until she returned and denied any other refusals regarding changing the catheter.During interview on 10/13/25 at 1:58 p.m., the ADON said urinary catheters, the whole system, were to be changed every 30 days and as needed. The ADON said as far as she knew it was the responsible of the nurses to change the current residents' urinary catheters per the order of the doctor and there were no residents who the doctor changed the resident's urinary catheter. The ADON said the nurse was supposed to document in the electronic MAR when a catheter was to be changed. The ADON said an effect it could have on the resident if a urinary catheter was not changed every 30 days was the resident could have bacteria buildup and possible (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	UTI. The ADON said they did monthly in-services and competencies regarding catheters. During interview on 10/13/25 at 2:40 p.m., the ADON said there was documentation LVN B changed Resident #2's catheter on 9/15/25. During interview on 10/13/25 at 3:30 p.m., the ADON said Resident #1 was resistive to care and the behavior was care planned. The ADON said Resident #1 told them when she wanted her catheter changed. Record review of facility's policy, Catheter/Suprapubic Catheter, Changing Of, dated 6/2019, revealed changing of a catheter would be done by the appropriate licensed nurse when there was a specific physician order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview, and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals for 1 (Resident #1) of 11 residents reviewed for pharmaceutical services.The facility failed to ensure Resident #1 received Acetaminophen-Codeine Tablet 300-30 mg as ordered as evidenced by gaps in administration. This failure could place the residents at risk of not receiving medications as ordered by the physician and unmanaged pain.Findings included: Record review of Resident #1's face sheet, dated 10/9/25, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including paraplegia (paralysis of the lower body).Record review of Resident #1's quarterly MDS, dated [DATE], section C, revealed a BIMS score of 10 that indicated moderate cognitive impairment. Record review of Resident #1's care plan, dated 10/13/25, revealed focus of chronic pain with intervention to anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Record review of Resident #1's Clinical Physician Orders, dated 10/13/25, revealed physician's order for Acetaminophen-Codeine Tablet 300-30 mg with start date of 2/24/25. Record Review of Resident #1's May 2025 MAR revealed code 8 documented on 5/27/25 at 8 a.m. and 4 p.m. for Acetaminophen-Codeine Tablet 300-30 mg with instructions to give 1 tablet by mouth every 8 hours for lower back pain. Code 8 per MAR chart code equaled Other/See Progress Notes. Record Review of Resident #1's June 2025 MAR revealed code 8 documented on 6/28/25 at 8 a.m. and 6/29/25 at 12 a.m., 8 a.m. and 4 p.m. for Acetaminophen-Codeine Tablet 300-30 mg with instructions to give 1 tablet by mouth every 8 hours for lower back pain. Code 8 per MAR chart code equaled Other/See Progress Notes. Record Review of Resident #1's August 2025 MAR revealed code 8 documented on 8/31/25 at 8 a.m. for Acetaminophen-Codeine Tablet 300-30 with instructions to give 1 tablet by mouth every 8 hours for lower back pain. Code 8 per MAR chart code equaled Other/See Progress Notes. Record Review of Resident #1's September 2025 MAR revealed code 8 documented on 9/30/25 at midnight for Acetaminophen-Codeine Tablet 300-30 mg with instructions to give 1 tablet by mouth every 8 hours for lower back pain. Code 8 per MAR chart code equaled Other/See Progress Notes. Record Review of Resident #1's October 2025 MAR revealed code 8 documented on 10/1/25 at midnight, 8 a.m. and 4 p.m. for Acetaminophen-Codeine Tablet 300-30 mg with instructions to give 1 tablet by mouth every 8 hours for lower back pain. Code 8 per MAR chart code equaled Other/See Progress Notes. Record Review of Resident #1's progress notes for date range 9/13-10/14/25 did not reveal any further documentation on 9/30-10/1/25 related to administration of Acetaminophen-Codeine Tablet 300-30 mg related to Code 8 Other/See Progress Notes from the MAR. During an interview on 10/9/25 at 10:09 a.m., Resident #1 said the facility was supposed to have her medication on time. Resident #1 said they do not have her medication, and one would say they called the pharmacy, and the other one said she had not called the pharmacy regarding her Tylenol #3 (Acetaminophen-Codeine) for pain. Resident #1 said this happens every month and had been going on since last year and staff blame the pharmacy that the medication was not available. During an interview on 10/13/25 at 11:46 a.m., LVN A said the medication aide administered scheduled narcotics and the nurse administered as needed narcotics.During an interview on 10/13/25 at 12:02 p.m., MA A said she usually worked on the hallway where Resident #1 resided. MA A said she gave Resident #1 Tylenol #3 (Acetaminophen-Codeine) twice a day. MA A said she had to notify the nurse to reorder Tylenol #3 as the CNAs did not reorder narcotics. MA A said sometimes the doctors were slow and they had to get the Tylenol # 3 out of the automated medication dispensing system. MA A said if she had to get the Tylenol #3 out of the Pyxis (automated medication dispensing (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	system) she had to notify the notify the nurse, wait on pharmscript (specialized pharmacy service provider) that takes about 30 to 40 minutes for approval. MA A said this was only if they did not have any Tylenol #3 but normally the nurse was able to get the medication delivered by 12 that night if we ordered them that morning. MA A said regarding documenting 8 on the MAR she probably let the nurse know and the nurse gave the Tylenol #3 but she did not. MA A said she would not have given the Tylenol #3 because the Tylenol #3 would not have been there. MA A said maybe the Tylenol #3 did not come in on time from the pharmacy was why it would not have been available. MA A said she could not remember why she documented an 8 on the MAR for 8/31/25 but if she put an 8 then she would notify the nurse, and they would give out of the Pyxis (automated medication dispensing system). MA A said she would not know where the nurse documented if they administer the Tylenol #3.During interview on 10/13/25 at 11:46 a.m., LVN A said the nurse ordered narcotics. LVN A said to reorder narcotics she had to notify the physician directly. LVN A denied any issues reordering Resident #1's narcotics and said sometimes the pharmacy took a while. LVN A said she might document in the electronic medical record or sometimes in the 24 hour report regarding if narcotics were reordered. During interview on 10/13/25 at 1:47 p.m., Resident #1 said when she did not get her pain medication, she felt terrible, could not sleep at night, her tailbone hurt, and she got a headache. Resident #1 said she had just been administered pain medication today and denied any current problems with pain medication and said she was doing ok regarding pain right now. During interview on 10/13/25 at 1:58 p.m., the ADON said the nurses reordered narcotics when they saw the medication was running out. The ADON said when there was a week's supply, they reach out to the doctor to obtain a script for refill, and they would send the escript to the pharmacy and we wait on the pharmacy to bring the medication to the building. The ADON denied any problems with reordering narcotics. The ADON said if a narcotic was not refilled in time, then there could be unmanaged pain. The ADON said there were certain narcotics in the Pyxis (automated medication dispensing system) and we should be taking care of it so there was no lapse. The ADON said Resident #1 did s not want to be woken up at midnight for pain medication if she was sleeping and was care planned regarding refusal of medications. During interview on 10/13/25 at 2:40 p.m., the ADON said they have the Tylenol #3 (Acetaminophen-Codeine) in the Pyxis (automated medication dispensing system). The ADON said she knows the Tylenol #3 is here but could not give an answer to why the medication was not given but was an opportunity to educate. Record review of facility's policy Administration of Drugs, dated 6/2019, revealed, It is the policy of this facility that medications shall be administered as prescribed by the attending physician.