

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Paradigm at Faith Memorial		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records on each resident that are accurately documented for 1 (Resident #1) of 9 residents reviewed for resident records. Resident #1's Medication Administration Record showed medications were administered on 11/6/25 and 11/8/25 after Resident #1 left the facility on [DATE]. The failure could place residents at risk of an inaccurate medical record. Findings include: Record review of Resident #1's face sheet dated 11/17/25, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including Unspecified Sequelae of Cerebral Infarction (Stroke). Record review of Resident #1's admission MDS dated [DATE], section C revealed a BIMS score of 13 that indicated cognition was intact. Section N revealed Resident #1 was taking an antidepressant and an anticoagulant. Record review of Resident #1's nursing progress note dated 11/3/25 at 6:26 p.m. written by LVN A revealed Resident Out of facility with family. Record review of Resident #1's nursing progress notes 10/23/2025 to 11/10/2025 revealed no notes regarding Resident #1 returning to the facility after leaving on 11/3/25. Record review of Resident #1's physician orders revealed orders for Cholecalciferol 1000 units, Isoniazid 300 mg, Aspirin 81 mg, Cyanocobalamin 1000 mcg, Ezetimibe 10 mg, Isoniazid 300 mg, Metoprolol Succinate ER 50 mg, Pyridoxine 50 mg, Brimonidine Tartrate, Polyethylene Glycol 3350 Oral Powder 1 scoop, Sennosides 8.6 mg, Polyethylene Glycol 3350 Oral Powder, Sennosides 8.6 mg, Latanoprost Ophthalmic Solution 0.005%, Pravastatin 20 mg and Trazodone 50 mg 0.5 tablet. Record review of Resident #1's November 2025 MAR revealed the following: MA A documented the following medications were administered: 11/06/25 at 8:00a.m.*Cholecalciferol 1000 units 11/06/25 at 9:00 a.m.*Aspirin 81 mg *Cyanocobalamin 1000 mcg, *Ezetimibe 10 mg *Isoniazid 300 mg *Metoprolol Succinate ER 50 mg, *Pyridoxine 50 mg, *Polyethylene Glycol 3350 Oral Powder, *Sennosides 8.6 mg *Brimonidine Tartrate 11/06/25 at 1:00p.m.*Brimonidine Tartrate. MA B documented the following medications that were administered: 11/08/25 at 8:00a.m.*Aspirin 81, *Cyanocobalamin 1000 mcg, *Ezetimibe 10 mg, Isoniazid 300 mg, *Metoprolol Succinate ER 50 mg, *Pyridoxine 50 mg, *Brimonidine Tartrate *Polyethylene Glycol 3350 Oral Powder *Sennosides 8.6 mg 11/08/25 at 1:00p.m.*Brimonidine Tartrate 11/08/25 at 5:00p.m.*Brimonidine Tartrate *Polyethylene Glycol 3350 Oral Powder *Sennosides 8.6 mg 11/08/05 at 6p.m.*Latanoprost Ophthalmic Solution 0.005% was administered 11/08/25 at 8:00p.m.* Pravastatin *Trazodone 50 mg 0.5 tablet During interview on 11/12/25 at 10:46 a.m., Resident #1's family member said Resident #1 was picked up from the facility on 11/3/25 and did not return to the facility. During interview on 11/13/25 at 2:24 p.m., LVN B said Resident #1 left the facility on a pass with a family member on 11/3/25 around shift change which was 6 p.m. and did not return to the facility. During interview on 11/17/25 at 9:46 a.m., MA A said they would not know if a resident was not at the facility until they asked the nurse and that residents were never taken out of the electronic medical system. MA A said they could not remember if Resident #1 was at the facility on 11/6/25 when they documented that medications were given. During interview on 11/17/25 at 9:56 a.m., MA B said they documented after medications were given to a resident in the electronic medical record after each individual resident. MA B said it would be on the resident's MAR if the resident was out on leave. MA B said they thought Resident #1's family had taken him out on the weekend but could not remember what day. During interview on 11/17/25 at 11:36 a.m., the DON said staff were supposed to chart immediately after administration of medications and go to the laptop to document that the medication was given. The DON said the expectation regarding medication administration was for the staff to lay eyes on the resident, follow the rights of medication and were giving medications at the right time to the right person. The DON said she interviewed residents to make sure they were getting the care they were supposed to and observed staff to make sure they were doing what they were supposed to. During interview on 11/17/25 at 11:56 p.m., the Administrator said that every resident could be affected if staff members were documenting that medications were given but the resident was not present at the facility, and they would question if medications were being given or being given to the right person or right time. During interview on 11/17/25 at 1:28 p.m., the Unit Manager said that once Resident #1 left they did not return to the facility. The Unit Manager said the expectation is that staff chart medications were given right after they were given. Record review of the facility's policy Medication Administration and Management revised 6/2019 revealed The authorized licensed and or certified/permitted medication aide or by state regulatory guidelines staff member documents that the medication is given in the correct slot of MAR before</p>