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	01/07/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure each resident was free from abuse for 1 of 3 residents (Resident #1) reviewed for abuse in that: The facility failed to ensure each resident was free from verbal abuse when CNA A cussed at and threatened Resident #1 on 12/31/2025. These failures placed residents, who resided in the facility, at risk of abuse, and mental anguish and fearfulness.Findings includedRecord review of Resident #1's Facesheet generated on 01/04/2026 at 10:27 a.m. reflected an [AGE] year-old who admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that include vascular dementia (problems with blood flow to the brain leading to changes in memory, thinking, and behavior), severe, with anxiety (feeling of worry, nervousness, or unease), cognitive communication deficit (condition that affects an individual's ability to communicate effectively due to impairments in cognitive processes such as attention, memory, reasoning, and problem-solving), anxiety disorder (excessive and persistent worry and fear), restlessness and agitation, post-traumatic stress disorder (a mental health condition that's caused by extremely stressful or terrifying events), chronic, ataxic gait (lack of coordination and balance), other lack of coordination, depression (persistent feelings of sadness, loss of interest, and range of emotional and physical problems), and psychotic disorder (severe mental health condition characterized by a disconnection from reality, which manifests as hallucinations) with delusions due to known physiological condition. Record review of Resident #1's Minimum Data Set (MDS) dated [DATE] reflected the resident's brief interview for mental status (BIMS) score was of 03 out of 15. A score of 0 to 7 suggests severe cognitive impairment. A score of 15 indicates intact cognitive function. Record review of Resident #1's Care plan reflected:Focus: Resident #1 had episodes of behaviors and was at risk for further increased episodes and injury:07/29/2024 Cursing and yelling at roommate, as resident does not want a roommate, and feels he should have a room to himself.08/14/2024 Walked up to female resident and hitting her in the face.08/23/2024 Hit another resident on their right shoulder.08/26/2024 Walking in secured unit cursing and attempted to hit staff.09/29/2024 Hit another resident with open hand to back of head.10/2/2024 Hit another resident in forearm.10/30/2024 Resident went into another resident's room, sat on her bed and pulled her hair.01/2/2025 Pushed another resident on the shoulder.04/14/2025 Resident will sometimes get on floor with his blankets instead of getting in bed to sleep.06/12/2025 Yelling and attempting to hit at another resident. No contact occurred.09/16/2025 Swinged fist at nurse on unit.10/16/2025 Pushed another resident's breakfast tray. Attempted to redirect.Goal: Resident #1 will decrease behavioral episodes through behavioral monitoring and interventions through target date of 12/18/2025. Date initiated/revisions: 07/02/2024.Interventions/Tasks: 01/02/2025 Medication evaluation by psychiatric services, date initiated on 01/03/2025.01/02/2025 Separate residents, date initiated on 01/03/2025.10/03/2024 Sent to Veterans Administration (VA) emergency room (ER) for evaluation, returned same day. Psych services notified, labs ordered, VA case manager (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified, Ombudsman notified, date initiated on 10/03/2024.10/30/2024 Attempt to move to quieter area, distract with conversation, date initiated on 10/31/2024.Focus: Resident #1 requires a secure unit, date initiated on 07/16/2024.Goal:Resident's safety would maintain through appropriate supervision and a structured/supportive environment through the review date of 12/18/2025, date initiated on 07/16/2024.Interventions/Tasks:Administer medications as ordered, date initiated: 07/16/2024.Behavior Control: utilize techniques such as redirection, distraction, and calming, date initiated on 07/16/2024.Encourage the resident's participate in ADL care as indicated date initiated on 07/16/2024.Monitor and encourage adequate fluid intake throughout the day, date initiated on 12/01/2025Monitor for changes in the resident's routine and report to the Physician as needed, date initiated on 07/16/2024.Plan and facilitate activities that are meaningful and appropriate for the resident's cognitive and physical abilities, date initiated 12/01/2025.Promote a consistent daily routine for structure and predictability in the resident, date initiated on 07/16/2024.Focus:Resident #1 had impaired cognition and was at risk for further decline and injury r/t neurocognitive deficits.Medication to slow disease process, date initiated/revision on 08/16/2024.Goal:Resident #1 will be met and dignity maintained over the next 90 days/target date of 12/18/2025, date initiated/revised on 08/16/2024. Revision on: 08/16/2024.Interventions/Tasks:Allow time for tasks and responses, date initiated 08/16/2024.Explain all procedures using terms gestures the resident can understand, date initiated 08/16/2024.Involve in care to maintain or increase level of independence, date initiated: 08/16/2024.Praise for tasks the resident completes, date Initiated: 08/16/2024.Repeat information as needed, date initiated 08/16/2024.Focus:Resident received anticoagulant therapy and was at risk for increased bleeding and bruising et cetera (etc.), date initiated 08/16/2024.Goal:Resident would be free of complications of increased bleeding, bruising etc. over the next 90 daysInterventions/Tasks:Encourage resident to be as active as possible Date Initiated: 08/16/2024. During an observation on 01/04/2026 at 03:50 p.m. Resident #1 in secure unit, sitting calmly in common area watching television. Resident's arms crossed, no visible bruising noted. Resident #1 did not respond to words or gestures when spoken to. During an observation on 01/04/2026 at 05:43 p.m. Resident #1 lay in his bed awake facing the door. Observed Resident #1's wrist and forearm, resident's arm red, white, blue and black in color. Resident #1 did not respond to questions asked with neither words nor gestures. During an interview on 01/04/2026 at 05:14 p.m. CNA E stated that she had been employed with the facility for 2 months and worked a 2 p.m. to 10 p.m. rotating shift on the secured unit. She stated that Resident #1's was easily provoked when presented with verbal aggression and hostility. She stated she had witnessed Resident #1's physical aggressive towards a female resident just a few days prior after the female resident bulled him. She stated that Resident #1 was redirected, and he would respond by walk away mumbling. She stated she came on shift on 01/04/2026 and learned Resident #1 had bruising to his wrist but was unaware of how the bruising occurred. During an interview on 01/04/2026 at 05:54 p.m. with Director of Nursing (DON) and Administrator (ADM) both stated that at 01/03/2026 at 06:30 a.m. Registered Nurse (RN) A reported that Resident #1 had bruising to his right wrist. DON stated on 01/03/2026 course of investigating CNA B reported that on 01/01/2026 between her 10 p.m. to 01/02/2026 6 a.m. shift that CNA A came on to the secure unit and told her that while working the secure unit on 12/31/2025 that CNA A had an encounter with Resident #1 where he had come around the nurse's station and tried to hit CNA A. DON stated that CNA A redirected Resident #1 by telling the resident, Mother fucker, you better not hit me or I'm going to show you. DON stated that both CNA B and CNA A were suspended pending an investigation as of 01/04/2026. DON stated that CNA B had also observed bruising to the resident's right wrist on 01/02/2026 and failed to report the bruising to a charge nurse. DON stated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that CNA B was suspended for failure to report the allegation of verbal abuse timely and CNA A was suspended for verbal abuse with termination pending. DON stated she provided both CNAs with one-on-one (1:1) in-service training. DON stated that Resident #1 had been known to flare his arms uncontrollably to protect himself when he felt verbally or physically threatened and he was very sensitive to loud noises. DON stated that Resident #1 had been diagnosed with vascular dementia with anxiety, post-traumatic stress disorder (PTSD), restlessness and agitation, physical disorder with delusions, depression, and anxiety. DON stated that Resident #1 received the following medications: Risperidone, Divalproex Sodium, Memantine, and Trazodone. DON stated that Resident #1's last had psychiatric services assessment on 11/28/2025 with no changes to his medications. DON stated that Resident #1's had aggressive behaviors that had improved substantially over time. DON started giving the resident a cookie quickly settled him down. ADM stated that CNA A's employment status was pending termination because of the allegation of verbal abuse. ADM stated that CNA B was suspended for failure reporting the allegation of verbal abuse and bruising to Resident #1's right wrist immediately upon learning of both events. ADM stated that the facility conducted safety surveys in the secure unit finding no witnesses nor other victims. ADM stated Resident #1 seemed like his normal self as of 01/04/2026 and had not expressed any pain. ADM stated that the resident does not have the mental capacity to provide a statement and had not expressed any pain or discomfort. ADM stated the incident was reported to the local law enforcement agency, the resident's medical doctor (MD) and Family A. ADM stated that she was the facility's abuse coordinator and that all allegations of abuse were to be reported to her immediately.During an interview on 01/04/2026 at 06:43 p.m. Registered Nurse (RN) A stated she worked for the facility for 3-years. She started her 01/03/2026, shift at 6 a.m. as the nurse for the secure unit. She stated while rounding/checking on residents found at 06:30 a.m. that Resident #1 had bruising on his right wrist up his forearm with a paler white in between the discoloration. She asked the resident what happened to his wrist, but he had not provided her with an explanation. She stated she had not believed the resident was aware of how the bruise had occurred. She stated that she immediately reported the incident to DON and resident's MD and began her skin and pain assessments. She stated Resident #1 was easily bothered by loud noises which caused him to become extremely agitated and exit seeking. She stated that he had PTSD from his war years in the Vietnam War. She stated he used to tell her stories about how he had been a tunnel rat (courageous soldiers in the Vietnam War, who crawled into enemy tunnel systems to clear them of troops, booby traps, and intelligence, armed with little more than a pistol, flashlight, and knife, facing extreme claustrophobia, deadly traps, and close-quarters combat in the dark, making it one of the war's most terrifying roles). She stated that keeping his space quiet kept the resident calm. She stated that she was familiar with CNA A as being the CNA that last worked the overnight shift in the secure unit from 10 p.m. to 6 a.m. on 12/31/2025 into 01/01/2026. She stated because they worked different shifts, she was not familiar with CNA A's work ethics or personality.During an interview on 01/04/2026 at 07:13 p.m. RN B stated she worked for the facility for 2-years. She stated she primarily worked the secure unit and the front half of Hall-1 from 6 p.m. to 6 a.m. She stated she last came on shift on 01/03/2026 and was informed by RN A that Resident #1 had a reportable incident, bruising to his right wrist. She stated she was not aware after being off on 01/01/2026 and 01/02/2026, last working 12/30/2025 and 12/31/2025 and had not received any reports of bruising to the Resident #1's wrist. She stated on 12/31/2025, New Year's Eve fireworks and gunshots were going off throughout the shift in the facility's neighborhood and the residents on the secure unit were extremely agitated and restless including Resident #1. She stated Resident #1 was nonverbal and had a diagnosis of dementia and on 12/31/2025 he was exit (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seeking and paced back and forth. She stated she passed him cookies and water both shifts to try and calm his agitation, with no avail. She stated that CNA A worked from 6 p.m. to 6 a.m. both 12/30/2025 and 12/31/2025. She stated the facility was short staffed both those shifts, and CNA A had to cover half the residents outside of the secure unit in addition to the secure unit residents. She stated that CNA A had a loud and assertive personality and Resident #1 had not been fond of CNA A who was too loud for him. She stated on 12/31/2025, CNA A reported to her that Resident #1 would not go to sleep and continued to pace amongst the other residents. She stated that CNA A had expressed on many occasions that she was not happy working the secure unit. She stated that it takes a certain type of individuals to work with dementia patients and did not believe CNA A was one of them. She also stated that she had to redirect CNA A on both the 12/30/2025 and 12/31/2025 shifts to not leave the unit without letting her know to cover the residents. She stated that the residents in the secure unit have PRN medications that can be given if they exhibit behaviors of agitation. She stated that CNA A had not asked for any of the residents to receive PRN medication to calm their aggression or restlessness. During an interview on 01/06/2026 at 11:36 a.m. CNA A stated that she had worked for the facility since 2022 on a rotating 10 p.m. to 6 a.m. shift. She stated she last worked the secure unit and half of Hall-3 on 12/30/2025 and 12/31/2025 and on 01/02/2026 and 01/03/2026 on Hall-3 which was her preferred hall to work. She stated on 12/30/2025 and 12/31/2025 the facility was short staffed, and she was responsible for caring for a total of 30-residents. She stated because of the New Years Eve holiday, fireworks and gunshots were going off throughout the shifts in the facility's neighborhood making the residents on the secure unit extremely agitated, restless, and exit seeking. She stated that she had to remain behind the nurse's station most of the evening because every resident on the secure unit was pacing and searching for an exit. She stated that Resident #1 felt like she was trying to attack him and he came up to her and banged on the nurse's station desk. She stated she felt safe because the desk kept enough space between her and the residents. She stated in addition the residents were going into each other's rooms and the common areas and picking up items they would not normally touch, hitting on the exit door, and she had to constantly redirect them from running and bumping into each other, and swing their arms towards her and the computer where she was charting. She stated that she informed RN B of the residents' behaviors and RN B only advised her to keep moving and keep redirecting them. She stated at one point she had to take the computer back to RN B to keep the residents from breaking. She stated she left the secure unit several times to check on residents on Hall-3 and stated she alerted RN B to cover the hall when she left. She stated she returned to shift on 01/02/2026 worked on Hall-3 and CNA B worked the secure unit. She stated she told CNA B about how crazy 12/31/2025's shift was with all the resident in the secure unit were exit seeking the entire shift. She stated while she was sharing the story with CNA B, CNA stated cuss words may have been used to describe the events of the evening but not used to cuss or threatened to hurt Resident #1 if he hit her or any of the residents. She stated at no time had Resident #1 attempted to hit her or flare his arms near her by accident or on purpose where she would have had to protect herself, nor was she aware if he had hit himself, others, or others hit him where he could have bruised his wrists. She stated she was familiar with the aspects of abuse and named: financial, verbal, physical, mental, and sexual as forms of abuse. She stated that she had an in-service training on abuse, neglect, and exploitation (ANE) almost once every month. She stated she received a call on 01/04/2026 just before her shift that she was being suspended pending an ANE allegation and on 01/06/2026 received another call from the ADM that she had been terminated related to allegations of ANE. She stated that she had never had a write up or been fired from a job and had never been accused of ANE. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/06/2026 at 12:14 p.m. CNA B stated she worked for the facility since 10/20/2023 and worked the 10 p.m. to 6 a.m. shift on the secure unit. She stated she had been off shift last working before 12/25/2025. She stated she returned to work on 01/02/2026 at 10 p.m. and while on shift CNA A told her that on 12/31/2025 the shift CNA worked while on the secure unit was crazy. CNA B stated CNA A stated Resident #1 was upset and came around the desk raised his hand up and tried to hit CNA A. CNA B stated CNA A told Resident #1, Mother Fucker, you better not hit me. She stated on 01/02/2026 around 11 a.m. she received a text message from DON asking her about any incident that occurred with Resident #1. She stated she replied that CNA A had cussed and threatened Resident #1 on the 12/31/2025 overnight shift. She stated that she and CNA A were suspended pending an investigation for failure to report and document the verbal abuse. She stated she had never been written up or had any disciplinary action. She stated that she should have reported what CNA A had cussed and threatened Resident #1 immediately upon learning. She stated she was unsure why she had not because she normally reported everything. She stated Resident #1 had not been known to be aggressive, unless he was irritable or provoked to act aggressive. She stated that forms of ANE were emotional, physical, verbal, and, financial and she received in-service training on ANE often. During an interview on 01/06/2026 at 01:05 p.m. MD stated that he was Resident #1's physician and the facility informed him that Resident #1 had bruising to the right wrist on 01/04/2026. He stated that the resident had sensitivity to noises such as loud commotions and yelling. He stated those factors would trigger Resident #1 who had a diagnosis of PTSD and could cause the resident to become aggressive and lash out. He stated the resident was under the care of a physiatrist who was managing the resident's behaviors with Risperidone, Trazodone, Divalproex Sodium, and Memantine. He stated that the resident was redirectable, but if provoked he would physically lash out. He stated that he had prescribed Resident #1 aspirin which could contribute to easy bruising. He stated the facility was unable to determine how the resident obtained the bruising but if a staff member had aggressively approached the resident, he had the tendency to swing his arms in a protective manner and could have hit his arm or wrists on something. He stated fireworks and gunshots sounds would trigger that resident's fight and flight response which could result in aggressive behavior. During an interview on 01/06/2026 at 01:28 p.m. Resident #1's Family A stated that she had been informed by the facility of the bruising on the resident's wrist. She stated that the facility had not been able to determine the cause of the bruise. She stated that the resident was not on blood thinners and had been known to easily bruise. She stated that the resident had many injuries over the years due to his poor balance and gait. She stated the resident was diagnosed with PTSD resulting from his days as a Vietnam soldier. She stated that if anyone displayed dominance over the resident it would trigger the fear of being in battle again. Record review of Resident #1's Progress Notes dated 01/03/2026 at 07:00 a.m. completed by RN A reflected: Observed purple area on the top of resident's hand to the wrist then a white area and at the wrist to forearm a purple area. No open area, no edema, no pain, and Resident #1 stated he did know how discoloration occurred. Injury Type: bruising to back of right hand. Record review of Resident #1's Change of Condition Communication dated 01/03/2026 at 07:00 a.m. completed by RN A reflected Resident #1's change in condition regarding his skin on his right arm. While making rounds RN A observed resident in secure unit while in bed facing the door. Right arm lying next to his face and observed the right arm had a purple color from the top of the hand to the wrist then a white area and then a purple color on the forearm. Resident asked how he got discoloration, but resident was unaware and noted not having any pain. Resident's MD and RP notified and x-rays ordered and performed. Record review of Resident #1's Skin assessment dated [DATE] at 07:16 a.m. completed by RN A reflected Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors.The assessment process is ongoing and should change with any new needs identified:1. Elimination of any physiological concerns will be the first consideration; pain, infections, medication side effects sleep deprivation, elimination issues .2. Document and track mood and behaviors and document non-pharmacological attempts to intervene with mood or behavior issues on the behavior monitoring forms as they occur per facility guidelines. Ensure you have identified the target mood or behavior on the behavior monitoring forms not just the diagnosis. All psychotropic medications must be monitored by nursing each shift. A psychotropic is any drug that affects brain activities associated with mental process and behaviors.The following medications must have a behavior monitoring form;A. AntipsychoticB. AntidepressantC. AntianxietyD. Hypnotic3. Review your behavior documentation including Behavior Interventions Monthly Flow record for accuracy and patterns. Time of day, week or month behaviors occurs, what task was being performed, or staff member or another patient/resident involved when behavior occurs.4. Assess needs related to:A. Eliminating hunger or thirstB. Ruling out the need for rest or sleepC. Eliminating pain as a sourceD. Eliminating warmth or cold as a sourceE. Physiological or medical problems (e.g. blood sugar changes, dialysis issue .)F. Attending to toileting needsG. Ensure hygiene needs are metH. Shift change issues-time to go home, new staff.Diagnosis Review:A key element to the assessment process is to review of the resident diagnosis. Knowledge of the epidemiology anticipated can be very helpful in understanding possible root causes of mood and behavior issues.Looking at mental health diagnosis can be helpful and we will review a few; however, do not overlook other diagnosis that can have a profound effect of mood and behavior's such as: COPD, Lupus, and Arthritis (any diagnosis associated with pain), and blindness, deaf or hard of hearing . Record review of policy titled Nursing Policies and Procedures and revised date 06/2019 reflected Subject: Combative Resident, Care and Safety Policy: The Facility has procedures in place to protect the health and safety of residents, staff, visitors and others in the care or proximity of a combative resident.Procedures: 1. Any person who identifies a resident with a change in behavior or an escalation of behavior which may lead to physical combativeness, reports observation to a licensed nurse2. A licensed professional, e.g., nurse, social worker, licensed independent practitioner evaluates the resident and may intervene with behavior de-escalation techniques, if appropriate3. Individuals deemed to be combative or otherwise dangerous to self or others may be placed on close observation, which may include but is not limited to:A. Relocating individual to a less stimulating environmentB. Conducting frequent checks on the individual (e.g., every 10, 15 or 30 minutes)C. Providing a one-on-one staff member for continuous observation and intervention D. Redirecting attention or use of other therapeutic techniques for de-escalation4. Notification of change in condition and escalation of behaviors is made to:A. Physician or licensed independent practitionerB. Family or responsible partyC. Law enforcement, emergency medical services or others as may be necessary or appropriate to ensure the safety and well-being of the combative person or persons inproximity to the situation5. Transfers and Communication:A. Combative or persons exhibiting dangerous behaviors may have treatment and care needs outside the scope of the Facility. In these cases, and to ensure the most appropriate services, the physician may order a transfer to a different level of care.B. Prior to transfer, the licensed nurse or other professional provides handoff communication to:1) Receiving facility or care provider2) Transferring emergency medical services providerC. Handoff communication includes but is not limited to:1) Current evaluation and observations related to behaviors, risks, etc.2) Information related to current medical and mental conditions3) Advance directives4) Other pertinent information

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Paradigm at Faith Memorial	811 Garner Rd Pasadena, TX 77502

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to report an allegation of abuse to the state survey agency within 5-working days of the incident for 1 (Residence #1) of 3 residents reviewed for abuse. On 01/01/2026 Certified Nursing Aide (CNA) A failed to report verbal abuse to abuse coordinated immediately or within 2-hours that CNA B had cursed and threatened Resident #1 on 12/31/2025. These deficient practices could place residents at risk for abuse, neglect, exploitation, and/or mistreatment. Findings included:Record review of Resident #1's Facesheet generated on 01/04/2026 at 10:27 a.m. reflected an [AGE] year-old who admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that include vascular dementia (problems with blood flow to the brain leading to changes in memory, thinking, and behavior), severe, with anxiety (feeling of worry, nervousness, or unease), dysphagia (difficulty swallowing), oropharyngeal phase (challenges transferring food from the mouth to the throat), hypertension (the force of blood against the artery walls is consistently too high), hyperlipidemia (high levels of fat in the blood, increasing the risk of heart attack or stroke), cognitive communication deficit (condition that affects an individual's ability to communicate effectively due to impairments in cognitive processes such as attention, memory, reasoning, and problem-solving), depression (persistent feelings of sadness, loss of interest, and range of emotional and physical problems), anxiety disorder (excessive and persistent worry and fear), post-traumatic stress disorder (a mental health condition that's caused by extremely stressful or terrifying events), chronic, ataxic gait (lack of coordination and balance), other lack of coordination, psychotic disorder (severe mental health condition characterized by a disconnection from reality, which manifests as hallucinations) with delusions due to known physiological condition, and restlessness and agitation. Record review of Resident #1's Minimum Data Set (MDS) dated [DATE] reflected the resident's brief interview for mental status (BIMS) score was of 03 out of 15. A score of 0 to 7 suggests severe cognitive impairment. A score of 15 indicates intact cognitive function. Record review of Resident #1's Care plan reflected:Focus: Resident #1 had episodes of behaviors and was at risk for further increased episodes and injury:07/29/2024 Cursing and yelling at roommate, he does not want roommate, thinks it is his room only08/14/2024 Walked up to female resident and hit her in the face.08/23/2024 Hit another resident on rt shoulder 09/29/2024 Hit another resident with open hand to back of head.10/2/2024 Hit another resident in forearm 08/26/2024 Walking in secured unit cursing, attempting to hit staff.10/30/2024 Resident went into another resident's room, sat on her bed and pulled her hair.01/2/2025 Pushed another resident on the shoulder.04/14/2025 Resident will sometimes get on floor with his blankets instead of getting in bed to sleep.06/12/2025 Yelling and attempting to hit at another resident. No contact occurred.09/16/2025 Swinged fist at nurse on unit. 10/16/2025 Pushed another resident's breakfast tray. Attempted to redirect.Date Initiated: 07/16/2024.Goal: Resident #1 will decrease behavioral episodes through behavioral monitoring and interventions through target date of 12/18/2025. Date initiated/revisions: 07/02/2024.Interventions/Tasks: 01/02/2025 Medication evaluation by psych services, date initiated on 01/03/2025.01/02/2025 Separate residents, date initiated on 01/03/2025.10/03/2024 Sent to Veterans Administration (VA) emergency room (ER) for evaluation, returned same day. Psych services notified, labs ordered, VA case manager notified, Ombudsman notified, date initiated on 10/03/2024.10/30/2024 Attempt to move to quieter area, distract with conversation, date initiated on 10/31/2024.Focus: Resident #1 requires a secure unit, date initiated on 07/16/2024.Goal:Resident's safety would maintain through appropriate supervision and a structured/supportive environment through the review date of 12/18/2025, date initiated on (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/16/2024.Interventions/Tasks:Administer medications as ordered, date initiated: 07/16/2024.Behavior Control: utilize techniques such as redirection, distraction, and calming, date initiated on 07/16/2024.Encourage the resident to participate in ADL care as indicated date initiated on 07/16/2024.Monitor and encourage adequate fluid intake throughout the day, date initiated on 12/01/2025Monitor for changes in the resident's routine and report to the Physician as needed, date initiated on 07/16/2024.Plan and facilitate activities that are meaningful and appropriate for the resident's cognitive and physical abilities, date initiated 12/01/2025.Promote a consistent daily routine for structure and predictability in the resident, date initiated on 07/16/2024.Focus:Resident #1 had impaired cognition and was at risk for further decline and injury r/t neurocognitive deficits.Medication to slow disease process, date initiated/revision on 08/16/2024.Goal:Resident #1 will be met and dignity maintained over the next 90 days/target date of 12/18/2025, date initiated/revised on 08/16/2024. Revision on: 08/16/2024.Interventions/Tasks:Allow time for tasks and responses, date initiated: 08/16/2024.Explain all procedures using terms gestures the resident can understand date initiated 08/16/2024.Involve in care to maintain or increase level of independence, date initiated: 08/16/2024.Praise for tasks the resident completes, date Initiated: 08/16/2024.Repeat information as needed, date initiated 08/16/2024.Focus: Resident received anticoagulant therapy and was at risk for increased bleeding and bruising et cetera (etc.), date initiated 08/16/2024.Goal:Resident would be free of complications of increased bleeding, bruising etc. over the next 90 daysInterventions/Tasks:Encourage resident to be as active as possible Date Initiated: 08/16/2024. During an observation on 01/04/2026 at 03:50 p.m. Resident #1 sat on a couch watching television in the common area of the security unit with his arms crossed. Resident #1 did not respond to words or gestures when spoken to. During an observation on 01/04/2026 at 05:43 p.m. Resident #1 was lying on his bed facing the door. Between Resident #1's wrist and forearm, resident's arm had red, white, blue and black discoloration. Resident #1 did not respond to questions asked with neither words nor gestures. During an interview on 01/04/2026 at 05:14 p.m. CNA E stated that she had worked for the facility for 2 months on a 2 p.m. to 10 p.m. rotating shift on the secured unit. She stated that she had been responsible for Resident #1's care when she worked her shifts. She stated that the resident was easily provoked when presented with aggression and she had witnessed Resident #1 be physically aggressive towards another resident after the other resident bulled him. She stated that Resident #1 could be redirected, and he would walk away mumbling. During an interview on 01/04/2026 at 05:54 p.m. with Director of Nursing (DON) and Administrator (ADM) both stated in the course of investigating a reported incident on 01/04/2026, CNA B reported to them that on 01/01/2026 between her 10 p.m. to 01/02/2026 6 a.m. shift that CNA A came on to the secure unit and told her that while working the secure unit on 12/30/2025 and/or 12/31/2025 that CNA A had an encounter with Resident #1 where he had come around the nurse's station and tried to hit CNA A, and CNA A redirected Resident #1 by telling the resident, Mother fucker, you better not hit me or I'm going to show you. DON stated that both CNA B and CNA A were both suspended pending an investigation as of 01/04/2026. DON stated that CNA B was suspended for failure to report the allegation of verbal abuse timely and CNA A was suspended for verbal abuse. DON stated both CNAs received one-on-one (1:1) in-service training with the DON. DON stated that Resident #1 had been known to flare his arms uncontrollably to protect himself when he felt verbally or physically threatened. DON stated that he was also very sensitive to loud noises. DON stated that Resident #1 had been diagnosed with vascular dementia with anxiety, restlessness and agitation, post-traumatic stress disorder (PTSD), physical disorder with delusions, anxiety, and depression and was receiving the following medications: Risperidone, Divalproex Sodium, Memantine, and Trazodone. DON stated that Resident #1's last (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	psychiatric services assessment was on 11/28/2025 and there were no changes to his medications at that time. DON stated that Resident #1's aggressive behaviors had improved substantially over time. DON stated simply giving the resident a cookie quickly settled him down. ADM stated that CNA A's employment status was pending termination due to the verbal abuse. ADM stated that CNA B was suspended for failure to report the allegation of verbal abuse immediately upon learning of the allegation and failure to report the change of condition to the nurse immediately upon observing Resident #1's arm discoloration. ADM stated that the facility conducted safety surveys in the secured unit with no witness to the allegations, and at that time Resident #1 seemed like his normal self. ADM stated they reported the incident to the local police authorities, resident's medical doctor (MD) and Family A. ADM stated that she was the facility's abuse coordinator. During an interview on 01/04/2026 at 06:43 p.m. Registered Nurse (RN) A stated she worked for the facility for 3-years. She stated Resident #1 was easily bothered by loud noises which caused him to become extremely agitated and exit seeking. She stated that he had PTSD from his war years in the Vietnam War. She stated he used to tell her stories about how he had been a tunnel rat (courageous soldiers in the Vietnam War, who crawled into enemy tunnel systems to clear them of troops, booby traps, and intelligence, armed with little more than a pistol, flashlight, and knife, facing extreme claustrophobia, deadly traps, and close-quarters combat in the dark, making it one of the war's most terrifying roles). She stated that keeping his space quiet kept the resident calm. She started her 01/03/2026, shift at 6 a.m. as the nurse for the secure unit. She stated while rounding/checking on residents found at 06:30 a.m. that Resident #1 had bruising on his right wrist up his forearm with a paler white in between the discoloration. She asked the resident what happened to his wrist, but he had not provided her with an explanation. She stated she had not believed the resident was aware of how the bruise had occurred. She stated that she immediately reported the incident to DON and resident's MD. She stated that she had not received any information on how the bruising could have come about. She stated that she was familiar with CNA A as being the CNA that last worked the overnight shift in the secure unit from 10 p.m. to 6 a.m. on 12/31/2025 into 01/01/2026. She stated because they worked different shifts, she was not familiar with CNA A's work ethics or personality. During an interview on 01/04/2026 at 07:13 p.m. RN B stated she worked for the facility for 2-years off and on as the nurse for the secure unit and the front half of Hall-1 from 6 p.m. to 6 a.m. She stated she last came on shift on 01/03/2026 and was informed by RN A that Resident #1 had a reportable incident and was asked had anything occurred on the unit that could have caused the bruising. She stated she was not aware after being off on 01/01/2026 and 01/02/2026. She stated she had last worked on 12/31/2025 into 01/01/2026. She stated as a result of the celebration of the 2026 new year fireworks and gunshots were going off throughout the shift in the facility's neighborhood making the residents on the secure unit extremely agitated and restless, and stated that Resident #1 was no exception. She stated Resident #1 was nonverbal and had a diagnosis of dementia and on 12/31/2025 he was having a bad evening pacing back and forth exit seeking. She stated she passed him cookies and water both shifts to try and calm his agitation. She stated that CNA A worked from 6 p.m. to 6 a.m. both 12/30/2025 and 12/31/2025 and the facility was short staffed, and CNA A had to cover half the residents outside of the secure unit in addition. She stated that CNA A had a loud and assertive personality and Resident #1 had not been fond of CNA A who was too loud for him. She stated on 12/31/2025, CNA A reported to her that Resident #1 would not go to sleep and continued to pace amongst the other residents. She stated that CNA A had expressed on many occasions that she was not happy working the secure unit. She stated that it takes a certain type of individuals to work with dementia patients and did not believe CNA A was one of them. She also stated (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that she had to redirect CNA A on both the 12/30/2025 and 12/31/2025 shifts to not leave the unit without letting her know to cover the residents. She stated that the residents in the secure unit have PRN medications that can be given if they exhibit behaviors of agitation. She stated that CNA A had not asked for any of the residents to receive PRN medication to calm their aggression or restlessness. During an interview on 01/06/2026 at 11:36 a.m. CNA A stated that she had worked for the facility since 2022 on a rotating 10 p.m. to 6 a.m. shift. She stated she last worked 01/02/2026 and 01/03/2026 on Hall-3 which was her normal and preferred hall to work. She stated she last worked the secure unit and half of Hall-3 on 12/30/2025 and 12/31/2025. She stated on that shift she was responsible for caring for a total of 30-residents as they were short-staffed those evenings. She stated those were a lot of residents to care for by herself, especially because in celebration of the 2026 new year, fireworks and gunshots were going off all throughout the shifts in the facility's neighborhood making the residents on the secure unit extremely agitated and restless. She stated that she had to remain behind the nurse's station most of the evening because every resident was on the floor pacing and searching for an exit. She stated that Resident #1 was no exception and felt like she was trying to attack him as he would come up to her and bang on the desk. She stated she felt safe because the desk kept enough space between her and the residents. She stated in addition the residents were going into each other's rooms and the common areas and picking up items they would not normally touch, hitting on the exit door, and she had to constantly redirect them from running and bumping into each other, and swing their arms towards her and the computer where she was charting. She stated that she informed RN B of the residents' behaviors and RN B only advised her to keep moving and keep redirecting them. She stated at one point she had to take the computer back to RN B to keep the residents from breaking. She stated she had to leave the secure unit several times to check on, reposition, and change the residents on Hall-3. She stated that she would alert RN B that she was leaving the hall but could not say if RN B stayed in the hall while she was gone. She stated when she returned to shift on 01/02/2026 she worked on Hall-3 and CNA B was working the secure unit. She stated on that shift she told CNA B about how crazy 12/31/2025's shift was as all the residents on the secure unit were awake and exit seeking through the whole shift and how it had never been that busy of an evening. She stated while she was sharing the story with CNA B, CNA stated cuss words may have been used to describe the events of the evening but not used to cuss or threatened to hurt Resident #1 if he hit her or any of the residents. She stated at no time had Resident #1 attempted to hit her or flare his arms near her by accident or on purpose where she would have had to protect herself, nor was she aware if he had hit himself, others, or others hit him where he could have bruised his wrists. She stated she was familiar with the aspects of abuse and named: financial, verbal, physical, mental, and sexual as forms of abuse. She stated that she had an in-service training on abuse, neglect, and exploitation (ANE) almost once every month. She stated she received a call on 01/04/2026 just before her shift that she was being suspended pending an ANE allegation and on 01/06/2026 received another call from the ADM that she had been terminated related to allegations of ANE. She stated that she had never had a write up or been fired from a job and had never been accused of ANE. During an interview on 01/06/2026 at 12:14 p.m. CNA B stated she worked for the facility since 10/20/2023 and worked the 10 p.m. to 6 a.m. shift on the secure unit. She stated she had been off shift last working before 12/25/2025. She stated she returned to work on 01/02/2026 at 10 p.m. and while on shift CNA A told her that on 12/31/2025 the shift CNA worked while on the secure unit was crazy. CNA B stated CNA A stated Resident #1 was upset and came around the desk raised his hand up and tried to hit CNA A. CNA B stated CNA A told Resident #1, Mother Fucker, you better not hit me. She stated Resident #1 had (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not been known to be aggressive, unless he was irritable or provoked to act aggressive. She stated on 01/02/2026 around 11 a.m. she received a text message from DON asking her about any incident that occurred with Resident #1. She stated she then texted DON back sharing what CNA A had cussed at and threatened Resident #1 on shift 12/31/2025. She stated that she and CNA A were suspended and taken off the schedule pending an investigation. She stated that she should have reported what CNA A had cussed and threatened Resident #1 immediately and stated she was not sure why she had not. She stated that she normally reported every little thing. She stated that forms of ANE were physical, emotional, verbal, and, financial and she received in-service training on ANE all the time. She stated she was suspended for failure to report and document the verbal abuse. She stated she had never been written up or had any disciplinary action. During an interview on 01/06/2026 at 01:05 p.m. MD stated that he was Resident #1's physician. He stated that the resident had sensitivity to noise, yelling, and commotion. He stated those factors triggered the resident's PTSD causing the resident to feel threated and he would become aggressive and lash out verbally aggressive towards others. He stated the resident was under the care of a physiatrist who was managing the resident's behaviors with Risperidone, Divalproex Sodium, Memantine, and Trazodone. He stated that the resident was redirectable, but if provoked as proven on event from 12/21/2025 when another resident bullied him, and he physically lash out. He stated the facility informed him that Resident #1 had bruising to the right wrist on 01/04/2026. He stated that he had prescribed Resident #1 aspirin which could contribute to easy bruising. He stated the facility was unable to determine how the resident obtained the bruising but if a staff member had aggressively approached the resident, he had the tendency to swing his arms in a protective manner and could have hit his arm or wrists on something. He stated fireworks and gunshots sounds would trigger that resident's fight and flight response which could result in aggressive behavior. During an interview on 01/06/2026 at 01:28 p.m. Resident #1's Family A stated that she had been informed that the resident had bruising on his wrist, but that the facility had not been able to determine what had been the cause. She stated that the resident had been known to lose his balance often causing many injuries over the years. She stated that if anyone displayed dominant over the resident it would trigger the resident's PTSD from his days as a Vietnam soldier. She stated the resident would begin to fear he was back in battle again. She stated that the resident was not on blood thinners and had been known to easily bruise. Record review of Resident #1's Progress Notes dated 01/03/2026 at 07:00 a.m. completed by RN A reflected: Observed while making rounds on secure unit, Resident #1 in his room lying on his left side with his right arm lying next to his face, no blanket on resident. Observed a purple area on the top of resident's hand to the wrist then a white area and at the wrist to forearm a purple area. No open area, no edema, no pain, and Resident #1 stated he did know how discoloration occurred. Injury Type: bruising to back of right hand. Record review of Resident #1's Change of Condition Communication dated 01/03/2026 at 07:00 a.m. completed by RN A reflected Resident had a change in condition to skin on his right arm. What occurred: While making rounds observed resident in secure and was lying on his left side facing the door in his bed with his right arm lying next to his face. Observed the right arm had a purple color from the top of the hand to the wrist then a white area and then a purple color on the forearm. Asked resident how he got discoloration, resident stated he did not know. Asked if the area was painful resident stated no. RP notified at 07:15 a.m. MD notified at 09:30 a.m. and x-rays performed. Record review of Resident #1's Skin assessment dated [DATE] at 07:16 a.m. completed by RN A reflected Resident #1's skin was intact, right hand to forearm was purple in color. Area on top of hand by the wrist was white in color and below that, a purple area on forearm below the wrist. No open area and no edema to skin area. Record (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #1's Pain assessment dated [DATE] at 07:16 a.m. completed by RN A reflected Resident #1 was checked for non-verbal sounds for example. (e.g.), crying, whining, gasping, moaning, or groaning), vocal complaints of pain (e.g., that hurts, ouch, stop), and facial expressions (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw). Resident stated he does not have pain. Record review of Resident #1's radiography (x-ray) dated 01/03/2026 to right forearm, lateral views of the right forearm demonstrate a diffuse osteoporosis (loss of bone density). There is no dislocation or fracture. No bony erosion or destruction is present. The soft tissues are unremarkable. There is no radiopaque foreign body. Impression: The bones are osteoporotic. There is no dislocation or fracture. Record review of Resident #1's Orders reflected:- RisperDAL Oral Tablet 1 milligrams (mg) (Risperidone) to be given 1.5 tablet by mouth at bedtime related (r/t) to psychosis, start date 11/05/2025.- Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) to be given 2 capsule by mouth 3 times (x) a day for behavior, start date 10/15/2025.- Memantine HCl tablet 10 mg to be give 10 mg by mouth 2x a day for neurocognition, start date 07/10/2025. - Donepezil HCl Oral Tablet 10 MG (Donepezil Hydrochloride) Give 1 tablet by mouth at bedtime for neurocognitive, start date 07/10/2025.- TraZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 25 mg by mouth every 12 hours as needed (prn) for major depressive disorder, start date 10/21/2025. Record review of text messages from DON's phone to CNA B on 01/03/2026 reflected CNA A worked the secure unit on 01/01/2026 from 10:00 p.m. to 6:00 a.m. and CNA A came onto the secure unit during that shift and explained that during CNA A's shift 12/30/2025 and 12/31/2025 from 10 p.m. to 6:00 a.m., CNA A had an encounter with Resident #1 trying to hit CNA A when CNA A was behind the desk. CNA B further explained that CNA A had to redirect Resident #1 back to the other side of the desk and told Resident #1 he better not hit CNA A. CNA B stated CNA A told Resident #1, Mother fucker you better not hit me or I'm gonna show you. Record review of text messages from DON's phone to CNA A on 01/03/2026 reflected CNA A was not aware of any bruising on Resident #1 on 12/30/2025 and 12/31/2025. Record review of CNA B's 01/03/2026 statement to the facility reflected that on she worked on the secure unit 01/01/2026. On 01/02/2026 she noticed bruising to Resident #1's right forearm while providing care. She stated she assumed the bruising was old and therefore had not reported the bruising. Record review of CNA A's criminal background check reflected the facility last performed a check on 10/03/2025 finding no results found. Record review of CNA B's criminal background check reflected the facility last performed a check on 07/18/2025 finding no results found.

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	01/07/2026

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

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(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 interviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 of 3 residents (Resident #2) reviewed for care plans. The facility failed to ensure a comprehensive care plan for a behavior of resident placing his hand in him soiled brief with bowel movement and placing his hand in his mouth was implemented for Resident #2 This failure placed residents at risk of not receiving care and treatment to meet the resident's physical, mental, and psychosocial needs.Findings include: Record review of Resident #2's Facesheet generated on 01/04/2026 reflected a [AGE] year old male who admitted to the facility on [DATE] as his own responsible party (RP) with medical diagnosis including bipolar disorder (a serious mental illness causing extreme shifts in mood, energy, and activity levels, ranging from manic highs (euphoria, irritability, high energy) to depressive lows (sadness, hopelessness, low energy), schizoaffective disorder (a mood disorder featuring periods of hallucinations, delusions, and disorganized thinking) depressive type, and gastro-esophageal reflux disease (a condition where the stomach acid frequently flows back into the esophagus (canal that connects the throat to the stomach), irritating its lining, causing symptoms like heartburn, regurgitation (food/fluid coming up). Record review of Resident #2's Minimum Data Set (MDS) dated [DATE] reflected the resident's Brief Interview for Mental Status (BIMS) was 11 out of 15 reflecting moderate cognition impairment for the resident. (A score of 13-15 would indicate intact cognition.) Resident received a Preadmission Screening and Resident Review (PASRR: in-depth assessment reviews records, interviews individuals/families, and involves mental health/intellectual development professionals to create personalized placement and treatment plans) positive level II (suspicion of serious mental illness evaluation), for serious mental illness, and was incontinent for both bladder and bowel and required helper assistance with toileting. Record review of Resident #2's Care Plan reflected:Focus:PASRR positive status related (r/t) mental illness and severe signs and symptoms on admission, revision dated 12/29/2025. Resident #2's Care Plan had not reflected any focused behaviors associated with digging in is brief, eating, or smearing his feces.Focus:Resident #2 had increased episodes and injury behaviors of smearing feces.Goal:Resident #2 had behavioral monitoring and interventions in place to decrease episode behaviors, date revised 01/04/2026.Interventions/tasks:Resident #2 had staff explain procedures with use terms/gestures the resident could understand and encourage the resident to attend social activities of preference, and report to MD progression/declines for ordered psychiatric consults as ordered within resident's clinical chart. Record review of Resident #2's Progress Note dated 01/05/2026 at 08:45 p.m. reflected Nurse Practitioner (NP) performed an evaluation r/t to Resident #2 chief complaint of diarrhea. Record review of Resident #2's Progress Note dated 01/05/2026 at 08:53 p.m. reflected MD ordered Resident #2 to receive monitoring for signs of dehydration and/or electrolyte imbalances due to report of loose stools approximately once a day. Ordered labs on 01/05/2026 to include a comprehensive panel of assess electrolyte status and continue current treatment/monitoring for improvement. During an interview on 01/07/2026 at 01:12 p.m. Resident #2 stated he had been experiencing repeated days of diarrhea and on occasion reached to the back of his brief to rub due to discomfort. He stated afterwards he had found that his hands and fingernails were soiled with feces, and unbeknown to him would rub his hand on his face and BM would get in his beard, on the sides of his mouth. He stated that behavior had become a repeated pattern. He stated he could not remember if care staff assist him with (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his soiled hands or brief but stated that he believed they had as his hands would be cleaned. During an interview on 01/04/2026 at 05:54 p.m. with Administrator (ADM) and Director of Nursing (DON) both agreed that no issues had been reported relating to Resident #2 having dug into his soiled brief and putting feces on/in his mouth. DON stated had they been made aware of the resident's behavior being more than a one-time occurrence, the behavior should have been care planned and progress notes made noting the behavior. DON stated that the resident had diagnosis of schizoaffective, anxiety, and bipolar disorders and from her knowledge had transitioned within the facility well. During an interview on 01/04/2026 at 7:05 p.m. Medication Aide (MA) stated that on 01/02/2026 sometime during her 02:00 p.m. to 10:00 p.m. (exact time unknown) shift she observed Resident #2 place a hand in his adult brief and pulled out feces and would have placed that soiled hand into his mouth had she not immediately intervened. She stated she asked the resident what he was doing and whether he was about to eat his feces. She stated the resident stopped, and she quickly left the room to locate his certified nursing aide (CNA), only to find that CNA was assisting another resident. She stated that she returned to the resident and washed his hands and changed his brief as she was also a CNA asking him again was he going to place his soiled hand in his mouth. She stated the resident asked what she was talking about and seemed confused by her questions. She stated that she should have reported the incident to LVN A who was his charge nurse due to infection control issue and maintaining the resident's dignity and respect but had not. She stated she thought his behavior had already been care planned. She stated failing to report the resident's behavior placed him at risk of repeated undocumented behaviors, illness, and put the facility at risk for cross contamination. She stated on 01/04/2026 she received a training in-service on reporting changes in conditions, residents' dignity and respect, and infection control. During an interview on 01/06/2026 at 04:42 p.m. LVN A stated she was Resident #2's nurse and had not been made aware of behaviors relating to him pulling feces out of his brief and placing his hand into his mouth. She stated had she been made aware, the behavior would have been reported immediately to the DON, ADM and his MD. She stated that his behavior fell under a change of condition and by reporting to his MD would expect a psychiatric evaluation order to be put in place and the resident's care plan updated. She stated the incident going undocumented and unreported placed the resident at risk for repeated behaviors and receptive to illness, and infection. She stated it further placed the facility at risk for infection control and cross contamination issues. During a confidential interview at undisclosed time, an anonymous person stated Resident #2 had been known to have feces under his fingernails, on his hands, beard, sides of his mouth, and in his mouth and teeth. The anonymous person stated the incidents occurred sometime during the New Year's Day holiday week during lunch time meal pass. The anonymous person stated she could not provide specific dates/times. The anonymous person stated an unknown male staff reported to LVN B that Resident #2 was observed with feces in his mouth and in his beard, and on his hands. The anonymous person stated LVN B entered the resident's room and upon seeing the resident's condition said, Oh, I'm not dealing with that and walked out the room. The anonymous person stated the incident was not further reported leaving the non-care staff to clean the resident's hands, but eventually, that male staff said, This is too far gone, and it's an infection control issue and had to leave the resident to finish his tasks. The anonymous person stated that Resident #2 behavior had been a recurring event that has continued to go on undocumented and further addressed without any type of isolation or monitoring. During an interview on 01/07/2026 at 11:52 a.m. LVN B stated that about a week ago Physical Therapist Assistant PTA had come and asked her to observe the fingernails of Resident #2. She stated upon observation Resident #2's appeared to have dried chocolate under his fingernails, on his hand, and on and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	around his mouth. She stated the resident was drooling and saw some of the same chocolate on his pillow. She stated she called an aide who she could not recall their name to help clean up the resident, change his brief, and repositing him in his bed. She stated she educated the resident about pressing his call light when he needed changing and asked the resident what was under his fingernails. She stated at first the resident responded that he had not known and then stated to her, Oh yea that is poop. She stated that she had not suspected that the substance was feces and had not sensed an odor of feces when cleaning up the resident. She stated had she known that the resident had feces on his hand or face she would have reported to LVN A who was the resident's nurse. She stated that incident would be considered a change in condition and required immediate reporting to the resident's MD and RP. She stated interventions would then be put in place for Resident #2 to be redirected to follow the infection control policy. She stated that the resident had to be redirected often about notifying staff when he had a soiled brief so he could be changed. She stated she believed she documented the incident in progress notes on that date but stated that she had not reported the incident to the resident's MD because she was pulled into assistance and was sure if that was behavior that required reporting LVN A would have already been reported. During an interview on 01/07/2026 at 12:06 p.m. PTA stated on or about 12/29/2025 he entered Resident #2's room for therapy services and observed the resident in bed with what appeared to be feces on his hand. He stated that he came closer and could smell the foul odor of feces from the resident and then noticed a tinge of brown in the resident's mustache and beard and on the resident's chin. He stated then the resident began speaking and the smell of feces increased and he could see feces in the resident's mouth and on his teeth. He stated he immediately searched for a nurse finding LVN B who he felt was a reliable nurse to share his finding. He stated LVN B observed the resident and left the room stating she was reporting the incident to LVN A. He stated none returned to clean the resident and lunch trays were being passed so he put on gloves and used sanitation wipes to clean resident's hands and fingernails. He stated while cleaning, Resident #2 told him that he had reached back into his brief, brought his hand around and had not realized that his hands had gotten soiled with feces. He stated he disposed of the wipes in the resident's bathroom trashcan, washed his hands, and left the resident returning to the rehab department. He stated he informed the Director of Rehabilitation (DOR) of the incident. He stated he had not had an in-service training on infection control since being employed, and felt the facility needed to do better on their infection control monitoring and practices. He stated he had not felt the resident had the mental cognition to inform staff when he soiled his briefs and saw the resident a few times a week for therapy services in the resident's room. He stated that the resident was not compliant with therapy services, and he had to continuously motivate the resident to get him out of bed. He stated that OTA and himself assisted with feeding residents during meals and stated that this was not the first incident where the resident was found with feces on his hand. During an interview on 01/07/2026 at 12:37 p.m. DOR stated that she had not been made aware of Resident #2 digging in his soiled brief by PTA. She stated on 01/05/2026 the facility had an interdisciplinary team (IDT) meeting which consisted of DON, ADM, MDS, and herself to discuss Resident #2 issue digging in his brief. She stated that the facility had set additional monitoring in place as an intervention for Resident #2's behavior. She stated that the resident had not been at the facility long and she had previously observed the resident eating in the dining room with no issues. During an interview on 01/07/2026 at 02:59 p.m. Family A stated that the facility had not made her aware of any past or present abnormal behaviors of Resident #2's. She stated that the resident had received psychiatric services from a psychiatric physician every 3 months for medications refills to treat some current diagnosis. During (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 01/07/2026 at 03:35 p.m. Assistant Director of Nursing (ADON) stated that on 01/04/2026 ADM and DON informed her that that Resident #2 had smeared feces, but on 01/07/2026 at 03:35 p.m. the feces had been in/on his mouth and beard. She stated LVN B had apparently told LVN A that the resident had placed his hand in his mouth after digging in in brief finding feces on his hand, then told LVN B he had not dug in his brief. She stated all she knew was LVN B made him clean his nails and face and then MDS care planned that he had smeared feces. She stated as the infection control preventionist (IP) she was informed and began in-service training on 01/04/2026 with the staff on infection control to educate on redirect the resident the best they could. She stated knowing that occurrence makes the incident a change in condition and required his MD to be notified. She would expect the MD would refer to the resident for a psychiatry evaluation. She stated that progress notes would be updated and reflect the incident, and the RP contacted and asked whether he/she had been of that behavior to understand if it had gone on in the past. She stated that interventions were put in place to increase rounds to monitor resident for increased behaviors and assure his brief was changed more frequently to avoid the behavior. She stated it would have been her expectation that staff followed infection control procedures by reporting and documenting the incidents. She stated the risk of not reporting placed Resident #2 and other residents at risk for illness and disease. She stated that the facility had in-service training on infection control monthly and as needed. During an interview on 01/07/2025 at 03:45 p.m. MDS stated on 01/04/2026 she had been made aware that Resident #2 had smeared his feces and updated his care plan to reflect that behavior on 01/04/2026. She stated she had not known that resident had feces in and around his mouth she would have called an IDT care conference meeting with all the department head managers to discuss the behavior and make both the physician and family aware. She stated that Resident #2 would receive education on the importance of infection control, and the IDT will be conducted an all-staff in-service on reporting a residents change in condition infection control. Record review of policy titled Policies and Procedures Baseline Care Plan with a revised date of 06/2024 reflected PolicyThe Facility will implement a Baseline Care Plan to ensure continuity of care and communication, prevent adverse events, and inform the resident and/or responsible party of the initial care and services.Procedure A Baseline Care Plan will be developed within 48 hours of admission. A Comprehensive Care Plan may be developed in place of the baseline care plan if the comprehensive plan is developed within 48 hours of admission and meets the Comprehensive Care Plan requirements. At minimum, the Baseline Care plan will address:o Initial goals based on admission orderso Physician orderso Dietary orderso Therapy serviceso Social serviceso PASRR recommendation, if applicable Baseline Care Plan Summaryo The Facility will provide a Baseline Care Plan Summary (Baseline Care Plan itself) to the resident and/or responsible party.o The timeline of delivery will be by the completion of the Comprehensive Care Plan.o The Medical Record will reflect evidence that the Baseline Care Plan Summary was provided to the resident and/or responsible party. Updates to Plan of Careo Updates to the Resident's plan of care after the completion of the Baseline Care Plan will be made in the Comprehensive Care Plan.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview, and record review, the facility failed to notify the resident's physician, as applicable, promptly after a significant change in the mental or physical condition of a resident who had mental illness or intellectual disability for 1 of 3 residents (Residents #1) reviewed for Significant Change Notification. The facility failed to notify the medical doctor (MD) after Resident #2 was found with feces in/on his mouth. The facility failed to document Resident #2 having feces in/on his mouth. This failure could place residents requiring psychiatric services at risk of not having their special needs assessed and met by the facility.Findings include: Record review of Resident #2's Facesheet generated on 01/04/2026 reflected a [AGE] year old male who admitted to the facility on [DATE] as his own responsible party (RP) with medical diagnoses including gastro-esophageal reflux disease (a condition where the stomach acid frequently flows back into the esophagus (canal that connects the throat to the stomach), irritating its lining, causing symptoms like heartburn, regurgitation (food/fluid coming up), schizoaffective disorder (a mood disorder featuring periods of hallucinations, delusions, and disorganized thinking) depressive type, cognitive communication deficit (difficulty speaking, listening, reading, or writing due to impaired thinking skills like memory, attention, problem-solving, and organization), and bipolar disorder (a serious mental illness causing extreme shifts in mood, energy, and activity levels, ranging from manic highs (euphoria, irritability, high energy) to depressive lows (sadness, hopelessness, low energy). Record review of Resident #2's Minimum Data Set (MDS) dated [DATE] reflected the resident's Brief Interview for Mental Status (BIMS) was an 11 out of 15 reflecting Resident #2 had moderate cognition impairment. (A score of 13-15 would indicate intact cognition.) He received a Preadmission Screening and Resident Review (PASRR: in-depth assessment reviews records, interviews individuals/families, and involves mental health/intellectual development professionals to create personalized placement and treatment plans) positive level II (suspicion of serious mental illness). He required assistance with toileting and was incontinent for both bladder and bowel. Record review of Resident #2's Care Plan reflected:Focus:Resident #2 had a PASRR positive status related (r/t) to signs and symptoms of severe mental illness on admission, revision date of 12/29/2025. (The Care Plan had not reflected focused behaviors r/t to digging in his brief, eating or smearing feces.)Focus:Resident #2 was at risk for further increased episodes and injury behaviors of smearing his feces.Goal: Through behavioral monitoring and interventions, Resident #2 will have decreased behaviors and episodes, dated 01/04/2026.Interventions/Tasks Encourage:Resident #2 will be explained procedures by using terms/gestures the resident can understand and encouraged to attend social activities of preference, report progression/declines to MD for psychiatric consultants as ordered in resident's chart. Record review of Resident #2's Progress Note dated 01/05/2026 at 08:45 p.m. reflected Nurse Practitioner (NP) performed an evaluation with Resident #2 with a chief complaint of diarrhea. Record review of Resident #2's Progress Note dated 01/05/2026 at 08:53 p.m. reflected MD ordered Resident #2 receiving monitoring for signs of dehydration and/or electrolyte imbalance, after reporting loose stools approximately once daily. Labs were ordered on 01/05/2026 to include a comprehensive panel to assess electrolyte status, to continue current treatment and monitor for improvement. During an interview on 01/07/2026 at 01:12 p.m. Resident #2 stated he had been experiencing repeated days of diarrhea and on occasion dug in his soiled brief in the back due to discomfort. He stated afterwards (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that his hands and fingernails were found to be soiled with feces, and he had rubbed his face, beard, sides of his mouth and maybe placed his hands in his mouth with his soiled hands. He stated that behavior had been an ongoing habit, and he was unaware when his hands were soiled with feces until after he had already but his hands in his mouth. He said he could not recall care staff being called to assist him with his soiled hands or brief but stated that he would be cleaned by the staff once they discovered him soiled. During an interview on 01/04/2025 at 05:54 p.m. with Administrator (ADM) and Director of Nursing (DON) both stated that they were not aware of any issues reported to Resident #2's MD for feces on/in his mouth from digging in his soiled brief. DON stated that the resident had schizoaffective, anxiety, and bipolar disorders and from her knowledge had been doing well at the facility. DON stated that now that they had been made aware of the resident's behavior, they needed to determine whether the behavior was a one-time occurrence or repeated behavior. She stated that if the behavior was repeated, his care plan should reflect the behavior to make other staff aware. During an interview on 01/04/2026 at 7:05 p.m. Medication Aide (MA) stated that on 01/02/2026 sometime between her shift of 2:00 p.m. to 10:00 p.m. (exact time unknown) while passing medication to Resident #2's she observed Resident #2 place his hand in his adult brief and pulled up feces. She stated then she observed Resident #2 attempting to place that soiled hand into his mouth. She stated that she immediately intervened and asked the resident What are you doing? You are not about to eat that are you? referring to the resident placing his feces into his mouth. She stated he stopped and then she left the room to locate his CNA, but she was assisting another resident, so she returned to the resident's room and washed his hands and changed his brief. She asked the resident again about placing his soiled hands in his mouth, and the resident asked her what was talking about? She stated the resident seemed confused by her questions as if the incident had not taken place. She stated she had not documented or reported the incident to anyone because she thought his behavior had already been reported and care planned. She stated that she should have reported the incident to LVN A who was his charge nurse due to infection control issues and maintaining the resident's dignity and respect. She stated that she received a training in-service on reporting changes in conditions, residents' dignity and respect, and infection control on 01/04/2026. She stated failing to report Resident #2's behavior could continue the behavior and place the resident and others at risk of illness and cross contamination. During an interview on 01/06/2026 at 04:42 p.m. LVN A stated she was Resident #2's nurse and worked for the facility for about a month on the 6:00 p.m. to 6:00 a.m. shift. She stated she had not been made aware of behaviors Resident #2 was exhibiting relating to him pulling feces out of his brief and placing his hand into his mouth. She stated had she been made aware, she would have reported the behavior to the DON, ADM and his MD as a change of condition and would have expected his MD to order a psychiatric evaluation. She stated the incident going undocumented and unreported placed the resident at risk for repeated behavior, illness, and infection, place the facility at risk for infection control and cross contamination issues, and further place the resident at risk for loss of dignity and respected. During a confidential interview at undisclosed time, an anonymous person stated Resident #2 had been known to have feces under his fingernails, on his hands, beard, sides of his mouth, and in his mouth and teeth. The anonymous person stated the incidents occurred sometime during the New Year's Day holiday week around lunch time meal pass. The anonymous person stated she could not provide specific dates/times. The anonymous person stated an unknown male staff reported to LVN B that Resident #2 was observed with feces in his mouth and in his beard, and on his hands. The anonymous person stated LVN B entered the resident's room and upon seeing the resident's condition said, Oh, I'm not dealing with that and walked out of the room. The anonymous person stated the (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident was not further reported leaving the non-care staff to clean the resident's hands, but eventually, that male staff said, This is too far gone, and it's an infection control issue and had to leave the resident to finish his tasks. The anonymous person stated that Resident #2's behavior had been a recurring event that had gone on undocumented and without any type of isolation or monitoring. During an interview on 01/07/2026 at 11:52 a.m. LVN B stated that about a week ago Physical Therapist Assistant PTA asked her to observe Resident #2's fingernails for what she thought was chocolate dried under his fingernails. She stated upon observing the resident she again stated he had what appeared to be chocolate under his nails, and on his hand, and on and around his mouth. She stated the resident was drooling and saw some of the same chocolate on his pillow. She stated she called an aide whose name could not be recalled to help clean up the resident and change his brief. She stated she educated the resident about pressing his call light when he needed changing and asked the resident what was under his fingernails. She stated at first the resident responded that he had not known and then stated to her, Oh yea that is poop. She stated that she had not suspected that the substance was feces and had not sensed an odor of feces when cleaning up the resident. She stated had she known that the resident had feces on his hand or face she would have reported to LVN A who was the resident's nurse. She stated that incident would be considered a change in condition and required immediate reporting to the resident's MD and RP. She stated interventions would then be put in place for Resident #2 to be redirected following the infection control policy. She stated that the resident had to be redirected often about notifying staff when he had a soiled brief so he could be changed. She stated she believed she documented the incident in progress notes but could not recall the date or time. on that date but stated that she had not reported the incident to the resident's MD because she was pulled into his room to assist and was sure if that was behavior that required reporting, LVN A would have already had reported. During an interview on 01/07/2026 at 12:06 p.m. PTA stated on or about 12/29/2025 during lunchtime he entered Resident #2's room for therapy services and observed the resident in bed with what appeared to be feces on his hand. He stated that he came closer and could smell the odor of feces from the resident and then noticed a brown tinge in the resident's mustache, beard and chin. He stated then the resident began speaking and he saw more feces in the resident's mouth and teeth and the odor of feces increased. He stated he immediately searched for a nurse finding LVN B who he felt was a reliable nurse to share his finding. He stated LVN B observed the resident and left the room stating she was reporting the incident to LVN A. He stated no one returned to clean the resident and lunch trays were being passed so he put on gloves and used sanitation wipes to clean resident's hands and fingernails. He stated while cleaning, Resident #2 told him that he had reached back into his brief, brought his hand around and had not realized that his hands had gotten soiled with feces. He stated he disposed of the wipes in the resident's bathroom trashcan, washed his hands, and left the resident returning to the rehab department. He stated he informed the Director of Rehabilitation (DOR) of the incident. He stated he had not had an in-service training on infection control since being employed, and felt the facility needed to do better on their infection control monitoring and practices. He stated he had not felt the resident had the mental cognition to inform staff when he soiled his briefs and saw the resident a few times a week for therapy services in the resident's room. He stated that the resident was not compliant with therapy services, and he had to continuously motivate the resident to get him out of bed. He stated that OTA and himself assisted with feeding residents during meals and stated that this was not the first incident where the resident was found with feces on his hand. During an interview on 01/07/2026 at 12:37 p.m. DOR stated that she had not been made aware of Resident #2 digging in his soiled brief by PTA. She stated on (continued on next page)

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	675321	A. Building B. Wing	01/07/2026

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/05/2026 the facility had an interdisciplinary team (IDT) meeting which consisted of DON, ADM, MDS, and herself to discuss Resident #2's issue of digging in his brief. She stated that the facility had set additional monitoring in place as an intervention for Resident #2's behavior. She stated that the resident had not been at the facility long and she had previously observed the resident eating in the dining room with no issues. During an interview on 01/07/2026 at 02:59 p.m. Family A stated that the facility had not informed her of any incidents relating to Resident #2 outside of a recent fall on 01/05/2026. She stated she was not aware of any past or present abnormal behaviors with the resident other than losing his will to walk and take care of himself. She stated that the resident had received psychiatric services in the past and saw a psychiatric physician every 3 months for medications to treat some current diagnosis. During an interview on 01/07/2026 at 03:35 p.m. Assistant Director of Nursing (ADON) stated that on 01/04/2026 ADM and DON informed her that that Resident #2 had smeared his feces, not knowing until 01/07/2026 at 03:35 p.m. feces was in/on his mouth and beard. She stated LVN B had apparently told LVN A that the resident had placed his hand in his mouth after digging in his brief with bowel movement. She stated when LVN B confronted the resident about the behavior, he denied the event. She stated all she knew was LVN B made him clean his nails and face and then MDS care planned that he had smeared feces. She stated as the infection control preventionist (IP) she was informed and began in-service training on 01/04/2026 with the staff on infection control to educate on redirecting the resident the best they could. She stated knowing that occurrence makes the incident a change in condition and required his MD to be notified. She would expect the MD would refer the resident for a psychiatry evaluation. She stated that progress notes would be updated and reflect the behavior, and the resident's RP would be made known and asked if that was a previously known behavior to understand if it had gone on in the past. She stated that interventions were put in place to increase rounds to monitor resident for increased behaviors and assure his brief was changed more frequently to avoid the behavior. She stated it would have been her expectation that staff followed infection control procedures by reporting and documenting the incidents. She stated the risk of not reporting placed Resident #2 and other residents at risk for illness and disease. She stated that the facility had in-service training on infection control monthly and as needed. During an interview on 01/07/2026 at 03:45 p.m. MDS stated on 01/04/2026 she had been made aware that Resident #2 had smeared his feces and updated his care plan to reflect that behavior on 01/04/2026. She stated she had not known that resident had feces in and around his mouth she would have called an IDT care conference meeting with all the department head managers to discuss the behavior and make both the physician and family aware. She stated that Resident #2 would receive education on the importance of infection control, and the IDT will be conducted an all-staff in-service on reporting a residents change in condition infection control. Record review of policy titled Nursing Policies and Procedures with revised date of 06/2019 reflected: Subject: Change in Condition Communication: Policy:To improve communication between physicians and nursing staff to promote optimal patient/resident care, provide nursing staff with guidelines for making decisions regarding appropriate and timely notification of medical staff regarding changes in a patient's/resident's condition, and provide guidance for the notification of patients/residents and their responsible party regarding changes in condition.Procedures:Complete assessment of the patient/resident which may include but is not limited to: A. Patient/resident name, age, primary diagnosis.Notify the physician of the change in medical condition. (The physician notification grid may be used as a reference tool regarding acceptable notification timeframes.} The nurse will document all assessments and changes in the patient's/resident's condition in the medical record.If the physician does not respond within an acceptable time frame, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an infection control program designed to provide a safe, comfortable, and sanitary environment to help prevent the development and transmission of diseases for 1 of 3 Residents (Residents #2) and 3 of 4 staff (LVN B, MA A, and PTA A) reviewed for infection control. LVN B, MA A, and PTA A failed to document and/or report feces found on Resident #2's mouth/teeth, face, beard, hand, fingernails, and pillow sheet to the resident's nurse. These failures could place residents at risk for spread of infection and cross contamination.The findings included: Record review of Resident #2's Facesheet generated on 01/04/2026 reflected a [AGE] year old male who admitted to the facility on [DATE] as his own responsible party (RP) with medical diagnosis of schizoaffective disorder (a mood disorder featuring periods of hallucinations, delusions, and disorganized thinking) depressive type, gastro-esophageal reflux disease (a condition where the stomach acid frequently flows back into the esophagus (canal that connects the throat to the stomach), irritating its lining, causing symptoms like heartburn, regurgitation (food/fluid coming up), bipolar disorder (a serious mental illness causing extreme shifts in mood, energy, and activity levels, ranging from manic highs (euphoria, irritability, high energy) to depressive lows (sadness, hopelessness, low energy). Record review of Resident #2's Minimum Data Set (MDS) dated [DATE] reflected the resident had a Brief Interview for Mental Status (BIMS) of 11 out of 15 reflecting the resident had moderate cognition impairment. (A score of 13-15 would indicate intact cognition.) Resident #2 required assistance with toileting, and was incontinent for bladder and bowel, had social isolation. Resident received a Preadmission Screening and Resident Review (PASRR: in-depth assessment reviews records, interviews individuals/families, and involves mental health/ID professionals to create personalized placement and treatment plans) with a positive level II diagnosis that noted he had serious mental illness. Record review of Resident #2's December 2025 Medical Administration Record (MAR) reflected he was prescribed Ondansetron HCl tablet 4 milligrams (mg) to be taken every 6-hours (hrs) by mouth (PO) as needed (PRN) for nausea and vomiting. Order date of 12/18/2025 at 11:06 a.m. As of 01/07/2026 at 04:45: p.m. Resident #2 had not been administered any Ondansetron. Record review of Resident #2's January 2026 MAR reflected he was prescribed Ondansetron HCl tablet 4mg to be taken every 6 hours by mouth as needed (PRN) for nausea and vomiting. Order date of 12/18/2025 at 11:06 a.m. but had not received any of his doses as of 01/07/2026 at 04:45: p.m. Record review of Resident #2's Care Plan reflected:Focus:Resident #2 had any focused behaviors of eating or smearing feces. Resident #2 had been identified as having a PASRR positive status r/t to a severe mental illness relating to signs and symptoms on admission with a revision date of 12/29/2025.Focus:Resident #2 had a behavior of smearing his feces and was at risk for further increased episodes and injury.Goal: Resident #2 will have decreased behaviors and episodes through behavioral monitoring and interventions, dated 01/04/2026.Interventions/Tasks:Resident to be encouraged to attend social activities of preference, explain procedures using terms/gestures the resident can understand, give medications as ordered, monitor labs, report results to Medical Doctor (MD), monitor and chart behaviors as they occur and report progress/declines to MD, observe for early warning signs of behavior - approach in a calm manner, call by name, remove from unwanted stimuli, and provide psychiatric consult as ordered. Record review of Resident #2's Progress Note dated 01/05/2026 at 08:45 p.m. reflected Nurse Practitioner (NP) A evaluated Resident #2 for a chief complaint of diarrhea with no new orders in place. Record review of Resident #2's Progress Note dated 01/05/2026 at 08:53 p.m. reflected MD noted Resident #2 had reported having loose stools occurring approximately once daily, and resident would be monitored for signs of dehydration and/or electrolyte imbalance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when he returned to the rehab department, he informed the Director of Rehabilitation (DOR) of the resident incident. He stated he had not had an in-service training on infection control since being employed, and felt the facility needed to do better on their infection control practices and monitoring. During an interview on 01/07/2026 at 12:37 p.m. DOR stated she had worked for the facility for 2-years. She stated that DON, ADM, MDS, ADON, and herself had an internal department team meeting on 01/05/2026 to discuss Resident #2's issues with digging in his brief. She stated she had not been made aware of the resident's behavior by PTA for digging in his brief. She stated that the facility had put monitoring in place as an intervention for Resident #2's behavior. She stated that the resident had not been at the facility long and she had previously observed the resident eating in the dining room with no issues. During an interview on 01/07/2026 at 02:59 p.m. Family A stated Resident #2 had received psychiatric services in the past, and saw a psychiatric physician every 3 months for medications for his current diagnosis. She stated that the facility had not informed her of any incidents of the resident outside of a recent fall on 01/05/2025. She was not aware of any past or present abnormal behaviors with the resident other than him losing his will to walk and take care of himself. During an interview on 01/07/2026 at 03:35 p.m. Assistant Director of Nursing (ADON) stated that she was the infection control preventionist (IP) and was informed on 01/04/2026 that Resident #2 had smeared feces, but on 01/07/2026 learned he had placed feces in his mouth and beard. She stated LVN B had told her that Resident #2 had dug in his soiled brief and had BM on his hand. She stated LVN B made him clean his nails and face. She stated on 01/04/2026 the staff were educated on redirecting the resident the best they could and on that same date Resident #2's care plan was updated to reflect that the resident smears feces. She stated knowing the resident's behavior had changed, his MD would be contacted for a psychiatry service evaluation referral, progress notes updated reflecting the incident, the RP contacted and asked whether they were aware of this behavior to understand if it had gone on in the past. She stated that staff would increase rounds to monitor Resident #2 for increased behaviors and check his brief more frequently. She stated it would have been her expectation that staff report such incidents to herself, the DON, and the resident's nurse. She stated that resident's care plan should note the incident. She stated the facility should ensure the resident followed the infection control protocols and ensure Resident #2 was not at risk for illness and disease. She stated that the facility had in-service training on infection control monthly and as needed. During an interview on 01/07/2026 at 03:45 p.m. MDS nurse stated that she had been made aware on 01/04/2026 that Resident #2 had been smearing his feces and she care planned that behavior that same date. She stated had she known he had feces in and around his mouth she would have called an IDT care conference meeting with all the department head managers to make the physician, and family aware and educate Resident #2 on the importance of infection control preventions method. She stated that an IDT meeting will be conducted and staff in-serviced on infection control and reporting a residents change in condition. Record review of policy titled Policies and Procedures Infection Control Program with revised date of 06/2024 reflected: The Facility will establish a comprehensive infection control program encompassing essential elements to safeguard the health and safety of residents, staff, and visitors. The Facility is dedicated to maintaining a safe and healthy environment by implementing an effective infection control program that adheres to state and federal regulations and follows evidence-based practices recommended by the Center of Disease Control (CDC).Program Objectives The program's objectives encompass key infection control ideologies: prevention, identification, reporting, investigation, and control of infections and communicable diseases among residents, employees, and visitors. The Facility promotes awareness and adherence to infection control practices through the (continued on next page)

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