STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675344	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at Sweeny	109 N McKinney Sweeny, TX 77480

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 (CR#1) of 7 residents reviewed. The facility failed to initiate wound preventative measures on [DATE] when CR#1 readmitted to the facility leading to infection and hospitalization. The facility failed to assess and recognize a change in condition and initiate wound preventative measures of [DATE] when the facility became aware that CR#1 had redness on her sacrum area during weekly skin observation leading to infection and hospitalization. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the Administrator on [DATE] at 7:21p.m. While the IJ was removed on [DATE] at 6:20pm, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures placed residents at risk of physical harm.Findings included:Record review of face sheet dated 4.14.26 indicated, CR#1 was a [AGE] year-old female initially admitted to the facility on [DATE], readmitted [DATE] and discharged [DATE] with a diagnosis of metabolic encephalopathy [altered brain function caused by systemic illness].Record review of CR#1's MDS [Admission] dated 3.9.26 revealed CR#1's date of admission to the facility was 2.20.26, with a BIMS score of 12 [moderately impaired cognition]. Section GG [Functional abilities] revealed: CR#1 used a wheelchair as a mobile device, is totally dependent on staff for eating, personal, oral and toileting hygiene, shower/bathing, upper and lower body dressing, putting on /taking off footwear; roll left and right, sit to lying and standing, chair/bed to chair transfer; occasionally urinary incontinent and always bowel incontinent. Section M [Skin Conditions] revealed CR#1 was at risk of developing pressure ulcers/injuries but did not have any unhealed pressure ulcers/injuries.CR#1's MDS [discharge] dated 4.13.26 revealed CR#1 was dependent in all functional abilities' areas. Section C [Cognitive Patterns] revealed CR#1 had a memory problem and was severely impaired (never/rarely made decisions). Section J [Health Conditions] revealed CR#1 had an Injury (except major) which involves skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain. Section M [Skin Conditions] revealed CR#1 did not have one or more unhealed pressure ulcer/injuries.Record review of CR#1's Care Plan dated reveal revealed the following:Focus: CR#1 has ADL self-care deficits and is at risk for further decline in ADL functioning and injury. Date initiated 3.17.26 Revision on 3.17.26Goal: CR#1 will be well dressed, groomed, clean, dignity will be maintained and will have no further decline in ADL functioning or injury over the next 90 days. Date initiated: 3.17.26, Revision on 3.17.26; Target Date: 9.3.2026.Interventions: Anticipate needs-Provide prompt assistance; requires supervision/limited assist for bathing, bed mobility, mobility, and transfers (date initiated 3.17.26); Encourage independent function as able (dated initiated 3.17.26); keep daily preferred routine unchanged (date initiated 3.17.26); requires supervision/limited assist for bathing (date initiated 3.17.26); requires supervision/limited assist for bed mobility (date initiated 3.17.26); requires supervision/limited assist for mobility (date initiated (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	3.17.26); requires supervision/limited assist for transfers (date initiated 3.17.26).Focus: CR#1 requires Enhanced Barrier Precautions AEB, Open Wound(s): 6/3 r heel PU deep tissue, l heel PU deep tissue, sacra PU unstageable (date initiated 4.15.26; Revision 6.10.26)Goal: CR#1 will experience no adverse effects related to the requirements of Enhanced Barrier Precautions through the review date. (date initiated and revision 4.15.26; Target date 9.3.26)Interventions: Administer medications as ordered (date initiated 4.15.26); complete treatment as ordered (date initiated 4.15.26); Monitor resident for s/s of infection (date initiated 4.15.26); Other orders cleanse with Normal Saline/House Wound Cleanser Topical Treatment, Betadine-Apply Betadine to non-open wounds, leave open to air after application Schedule Daily and PRN (and as needed), Wound #2 Left Heel other orders-Cleanse wound with Normal Saline/House Wound Cleanser Topical Treatment, Betadine-Apply Betadine to non-open wounds Leave open to air after application Schedule Daily and PRN (and as needed); Wound #3 Sacral Other orders, cleanse wound with Normal Saline/House Wound Cleanser-Cleanse wound with NS Topical Treatment, Santyl (Nickel Thick_-Apply a nickel thick layer to wound bed with ca alginate, primary dressing, Calcium alginate, Secondary dressing, bordered Gauze, Schedule, Daily and PRN (and as needed)_Date initiated 6.10.26.Focus: CR#1 requires Palliative care as evidenced by decline in health (date initiated 4.15.26)Goals: Dignity will be maintained and the CR#1 will be kept comfortable and pain free with in one hour or intervention thru next review (date initiated 4.15.26; Target date 9.3.26)Interventions: Monitor for S/S of increased pain, discomfort-give meds/tx.s monitor for relief (date initiated 4.15.26; Revision on 6.10.26); Assist with Adl's and provide comfort measures as needed (date initiated 4.15.26; Revision on 6.10.26); Comfort CR#1 and family as needed (date initiated 4.15.26; Revision on 6.10.26); Monitor for decreased appetite, weight loss, skin breakdown nv, etic and notify md (date initiated 4.15.26; Revision on 6.10.26), O2 as needed (date initiated 4.15.26; Revision on 6.10.26); Provide quiet environment for care measures (date initiated 4.15.26)Focus: GERD: (CR#1 has a history of GERD and is at Risk for increased abdominal distress, weight loss, and G.I. bleed (Date Initiated: 6.10.26)Goals: CR#1 will maintain levels of ADL's and any abdominal distress will be relieved within one hour of intervention over the next 90 days (Date Initiated and Revision: 6.10.26; Target Date:9.3.26)Interventions: Encourage CR#1 to sit up for at least 30 min. after meals (Date Initiated: 6.10.26), Give medications per order-monitor for effectiveness-report to MD if resident c/o increased abdominal distress (Date Initiated: 6.10.26); Monitor appetite, weight, and encourage appropriate p.o. and fluid intake, serve diet per order, Offer snacks with the diet (Date Initiated: 6.10.26); Monitor for proper body alignment, to assure CR#1 is setting/lying correctly (Date Initiated: 6.10.26); Monitor labs as ordered (Date Initiated: 6.10.26).Focus: Urinary Incontinence: CR#1 has bladder incontinence related to: overactive bladder and is at risk for breakdown (Date Initiated and revision: 6.10.26)Goal: CR#1 will Have no alterations in skin integrity related to incontinence or brief use through the review date (Date Initiated and Revision: 6.10.26. Target Date: 9.3.26)Interventions: Apply house moisture barrier cream after each episode of incontinence (Date Initiated: 6.10.26); Educate the resident and responsible party/family a proper perineal hygiene practices (Date Initiated: 6.10.26); Perform routine rounding to include incontinence care and brief changes (Date Initiated: 6.10.26); Remind and assist the resident to use the toilet regularly as indicated/able (Date Initiated: 6.10.26); Report any changes in skin integrity to the charge nurse(Date Initiated: 6.10.26).Focus: CR#1 Has a skin tear/potential for skin tear of the (posterior LLE) left forearm (Date Initiated and revision: 6.10.26)Goal: CR#1 will be free from skin tears through the review date (date Initiated and revision: 6.10.26, Target date: 9.3.26)Interventions: Encourage good nutrition and hydration in order to promote healthier skin (Date Initiated: 6.10.26), Identify potential causative factors and eliminate/ resolve when possible skin (Date Initiated: 6.10.26), If skin tear occurs, treat her facility protocol and notify MD, family skin (Date Initiated: 6.10.26), Inform/instruct staff of causative factors and measures to prevent skin tears skin (Date Initiated: 6.10.26), Keep skin clean and dry period use lotion on dry scaly skin (Date Initiated: 6.10.26), Monitor/ document location, size and treatment of skin tear. Report abnormalities, failure to heal, (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	s/sx of infection, maceration etc.to MD skin (Date Initiated: 6.10.26), The residents need their nails kept short to reduce risk of scratching or injury from picking at skin (Date Initiated: 6.10.26). Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface (Date Initiated: 6.10.26).Record review of care plan dated 4.14.26, CR#1 was not care planned for linens being changed every shift per Braden Scale.CR#1's June orders dated [DATE]-[DATE] revealed the following:-Zinc Sulfated Oral Capsule 220 (50Zn) MG (Zinc Sulfate) Give 1 tablet by mouth one time a day for Wound infection for 30 days-Start date-6.3.26 8:00am-D/C Date:6.4.26 3:15pm; -Ascorbic Acid Tablet 500 MG Give 1 tablet by mouth two times a day for Wound infection for 30 Days-Start Date-6.2.26 at 4:00pm-D/C Date-6.4.26 3:15pm;-Doxycycline Hyclate (antibiotic) Tablet 100 MG Give 1 tablet by mouth two times a day for infection for 14 days-Start Date-6.1.26 4:00pm-D/C Date-6.4.26 3:15pm;-Pro-Stat Oral Liquid (Amino Acids-Protein Hydrolysate) Give 30 ML by mouth two times a day for Wound infection for 30 Days-Start Date 6.2.26 4:00ppm-D/C Date-6.4.26 3:15pm;-Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 1 tablet by mouth three times a day for pain-Start Date-6.1.26 1:00pm-D/C Date 6.4.26 3:15pm;-Conduct Weekly Skin Evaluation, Document UDA under Assessments-Skin Observations, Notify MD of New Skin Conditions, every day shift every Tue for skin evaluation-Order Date-3.3.26 5:05pm-D/C Date 6.4.26 3:15pm;-Every day shift for wound-Order date-4.20.26 3:11pm-D/C Date-6.4.26 3:15pm; Cleanse skin tear to posterior LLE with wound cleaner, pat dry, and LOTA every shift until resolved every shift for Skin tear-Order Date 4.21.26 9:37am-D/C Date-6.4.26 3:15pm;-Cleanse skin tear to posterior LLE with wound cleanser, pat dry, and LOTA every shift for wound-Order date 4.20.26 3:11pm-D/C Date-6.4.26 3:15pm;enhance Barrier Precautions-PPE; Gloves/Gown during high-contact resident care activities every shift-Order Date 4.20.26 2:31pm-D/C Date-6.3.26 11:24am;-Turn and reposition frequently every shift-Order Date-5.27.26 10:34am-D/C date-6.4.26 3:15pm;-Ertapenem Sodium Solution Reconstituted 1 GM Use 1 gram intravenously every 24 hours for infection for 14 Days-Order Date-6.2.26 11:34am-D/C Date-6.4.26 3:15pm;-Cleanse Wound to Sacrum with Dakins 0.25% pat dry, Apply dakins soaked gauze to wound bed, Bordered gauze daily and PRN ever day shift for Wound care-Order Date-5.29.26 9:59am-D/C Date 6.1.26 12:46pm;-Cleanse Wound to Sacrum with Normal Saline, pat dry, Apply Normal Saline wett to moist soaked gauze to wound bed, Bordered gauze daily and PRN every day shift for Wound care-Order Date-6.1.26 12:46pm-D/C Date-6.2.26 12:38pm;-Collagenase Ointment (250 Unit/GM apply to Sacrum topically every day shift for Wound care-Order Date-6.4.26 11:07am-D/C Date-6.4.26 3:15pm;-Conduct Weekly Skin Evaluation, Document UDA under Assessments-Skin Observations, Notify MD of New Skin Conditions, one time a day every Thu-Order Date-4.15.26 10:51am-D/C Date 6.4.26 3:15pm;-Dakins (1/4 strength) External Solution 0.125% (Sodium Hypochlorite) Apply to sacrum topically every day shift for Wound Care-Order Date-6.1.26 10:51am-D/C Date-6.4.3:15pm;-Sacrum-Soak Unstageable Pressure Ulcer wound for 30 seconds with Dakins 0.125% soaked gauze to wound bed, then cover with a bordered gauze daily and PRN until healed every day shift for Wound care-Order Date-6.2.26 12:33pm-D/C Date 6.4.26 3:15pm.Record review of Skin Observation dated 4.14.26 at 7:39 a.m. and locked 6.11.26 at 10:51am revealed CR#1 had new areas identified; had no pressure injuries; does not have non-pressure areas (Surgical/Diabetic/Friction/MASD); and the identifiable sites were Face, Right hand (back), Left Elbow, Left lower leg (rear), and left ankle (outer). There were no measurements of the wound and the description of the wounds were in this report. Record review of Unavoidable pressure ulcer dated [DATE] by PCP revealed due to altered mental status, immobility-secondary to underlying disease, bowel/bladder incontinence, muscle wasting syndrome. Facility interventions to be put in place were, weekly skin evaluation, turn/reposition as indicated, use of barrier ointments/creams, administer treatment as ordered. The results of findings were patient was not eating, poor protein intake, is on palliative care. Wound prognosis poor.Record review of CR#1's Skin Observation dated 4.20.26 at 11:55 a.m., and locked 4.27.26 at 11:58 a.m., revealed CR#1 did not refuse skin checks, CR#1 skin was not intact, and CR#1's skin issues were identified as Multiple skin tears to all extremities, Barrier (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	cream to peri area, and facility bruising.Record review of CR#1's Braden Scale-Predicting Pressure Score Risk dated [DATE] at 3:19 p.m., with a score of 14.0 [Moderate Risk] revealed, CR#1 was slightly limited to respond to meaning pressure related discomfort (She made frequent slight change in body or extremity position independently); CR#1's skin was very moist (but not always. Linen was to be changed at least once a shift); CR#1 was Bedfast (confined to bed); CR#1 ate over half of most meals; and CR#1 had a presence of specific factors involving skin, that was a potential problem.Record review of nursing notes dated [DATE] created 9:57 a.m., for effective dated [DATE] by LVN C revealed, Change of Condition Identified: Open area to Sacrum. Vital Signs: BP 122/75-5.27.26 9:30 am Position: Lying l (left)/arm, P 80- 5.27.26 9:30am Pulse Type: Regular, R16-5.27.26 9:30am, 02 98%-5.27.26 9:30am Method: Room Air. CR#1 noted with small opening and necrotic eschar to sacrum (7x7). No drainage noted. Wound cleansed Normal Saline pat dry and covered with dry bordered dressing. CR#1 with no s/s of pain or discomfort at this time. CR#1 referred to Wound Care NP. Resident monitored for pain/discomfort Q 2hr and PRN. PCP notified [DATE] 10:15 AM and FM A notified [DATE] 10:20 AM.Record review of Braden Scale -Predicting Pressure Score Risk dated 5.27.26 at 12:04 p.m. and lock date 5.27.26 at 12:06 p.m. revealed CR#1 is high risk with a score of 10.0. CR#1's Sensory Perception category indicated she responded only to painful stimuli; CR#1"s skin was very moist and linen must be changed at least once a shift; CR#1 was confined to a bed; CR#1 was unable to communicate discomfort except by moaning or restlessness or she had sensory impairment which limited her ability to feel pain or discomfort over 1/2 of her body; CR#1 rarely ate; CR#1 required moderate to maximum assistance in moving.Record review of CR#1's skin observation dated 5.28.26 at 10:08 a.m. ad locked 5.28.26 at 10:19 a.m. revealed CR#1 did not refuse skin check, CR#1 skin was not intact, and CR#1 had the following skin issues: Multiple fading bruising to all extremities, fading bruising to face and neck, Multiple healing skin tears to (BUE) and (BLE), Unstageable Pressure Ulcer to Sacrum, and DTI to bilateral heels, Betadine applied.Record review of Labs ordered by FNP-C on 5.28.26 at 9:16 a.m. and received on 6.1.26 at 9:53 a.m. and reported date (to facility) on 6.1.26 at 12:15 p.m. revealed CR#1 had the following Pathogens (Infections): Bacteroides, Enterococcus Faecalis, Escherichia Coli, Morganelia morganii, and Proteus Mirabilis. The final result of the Antibiotic Resistnce Genes were: Tetracycline resistance gene M (tetM); and Vancomycin Resistance [NAME] A/B ([NAME]/vanB)Record review of Task List Report dated 4.14.26 and cancelled 6.4.26 revealed, the CR#1's care schedule showed the task schedule for bathing and other ADL's; however, did not confirm if the CNA/Resident Care Specialist performed the duties or if CR#1 denied care.Record review of Labs show UTI Panel Final report collection dated 3.26.26 at 10:00pm and reported 3.30.26 10:30pm.Record review of labs revealed there was no Lab or CBC ordered.Record review of labs, assessments did not reveal and documentation of CR#1's sacral wound debrided.Record review of nursing notes dated 6.1.26 by WCN revealed, at 10:00 a.m. WCN accompanied by ADON, Unit Manager, GERI Charged nurse and CNA to patient room regarding patient status of wound to sacrum was noted with severe deterioration from prior SBAR on [DATE]. FNP-C initial exam of patient on [DATE] noted as Unstageable Pressure Ulcer with moderate amount of sero-sanguineous drainage (a thin, watery wound discharge with a pink or light-red tint) and 91-100% Slough. WCN noted wound deterioration to be covered in necrotic eschar, eruthema and very foul odor with small amount of sero-sanguineous drainage. Wound was cleaned with Normal Saline, pat dry and clean borderd gauze applied at 12:30pm WCN contacted Wound Care NP and received results of culture. Culture sent to NP. Wound order updated to Cleanse Unstageable pressure ulcer to sacrum with Normal Saline, pat dry, apply wet to moist gauze then bordered gauze daily and PRN.covered in necrotic eschar, BRYTHEM and verify order with small amount of cirrus SANGU INEOUS drench. Moon was cleansed with normal sagging, packed dry and clean bordered galls applied. At 12:30 PM WCN contacted wound care NP and received results of culture. Culture sent to in peak period moon order updated to cleanse unstageable pressure ulcer to sacrum with normal saline, pat dry, apply wet to most galls then border galls daily and PRN.Record review of nursing notes dated 6.1.26 at 10:30am (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	revealed, nursing staff spoke with Resident #1, for CR #1 in regard to sacral wounds. Per Resident #1 wants to continue palliative care in house and does not want residents to be sent out to hospital. NP made aware of odor from sacral wound and resident number one's request to keep resident in house. N/O for doxycline 100mg bid x 14 days and Tylenol 500 mg po tid (pt allergic to codeine and tramadol). New orders transcribed and initial dose retrieved from Nexus System. Resident #1 aware of new orders.Record review of nursing notes dated 6.2.26 at 2:09 p.m., by LVN C revealed the NP's new orders received PICC line order placement. Ertapenem IV (antibiotic) every 24 hours; Vitamin C 500 MG PO. BID for 30 days, will be I'd today at 4PM-will complete 7.3.26; Zinc 220 MG one P.O. daily for 30 days will be I'd 6.3.26 will complete 7.4.26 and Pro-Stat 30cc BID for 30 days I'd 6.2.26 and complete 7.3.26. NP viewed this resident buttock wound this shift with the charge nurse; wound nurse and a RCS. Resident being turned every two hours. Resident's bed in low position and the call light within reach. Record review of nursing note dated 6.3.26 at 1:25 p.m., by LVN D revealed CR#1 continue on two ABX for diagnosis of buttock wound infection. Today is 3/14 CR#1 started doxycycline 100 mg PO 2 times daily, and ertapenem IV solution every 24 hours for 14 days. PICC line on left arm. Midline flushed with 10 cc of N/S as order. CR#1 tolerating well with both ABX. V/S.Record review of Skin Observation 6.4.26 at 12:52 p.m. and locked 6.4.26 at 1:06pm revealed resident skin was not intact and she had the following skin issues identified: Multiple fading bruising to all extremities, fainting bruising to face and neck, multiple healing skin tears to (BUE) and (BLE), Unstageable Pressure Ulcer (7x8x1) to sacrum, DTI to bilateral heels. Betadine applied. Left heel DTI (3x6x0) Right heel (2x4.2x0), and small scattered scabs to all extremities.Record review of ER admitting diagnosis dated [DATE] revealed Acute Cystitis (inflammation of urinary bladder caused by a bacterial infection), Acute Delirium (change in mental function), Altered mental state (change in cognition), Atrial fibrillation with tachycardic ventricular rate (highly serious and considered a medical emergency that occurs when upper heart chambers cause lower chambers to beat too quickly), Decubitus ulcer (bed sore or pressure ulcer), stage 4 with infection (a life threatening medical emergency the wound extends into the muscle and can extend as far down as the bone), local infection of the skin and subcutaneous tissue (occurs when pathogens (such as bacteria, fungi, or viruses) enter through a break in the skin's barrier), unspecified, sacral decubitus ulcer, stage IV, transient alteration of awareness, complaint of UC-Altered Mental Status.Record review of the EMS report dated [DATE], arrived at the facility 1:00 p.m Upon arrival, the nursing staff reported resident is normally awake and talking and now she is not. It was also reported resident had DNR and had bed sore on her back/bottom. Staff was unable to report the last time resident was normal or any other information. EMS requested resident info. EMS assessment revealed signs of stroke with eyes rolled back looking to the left. After resident was in the ambulance, EMS discovered resident had a PICC line, so no IV access attempted.Record review of the initial tracking and trending wounds for the timeline of [DATE]-[DATE] or on the [DATE]-[DATE] list [copied by facility on 6.27.26 at 11:00am] did not list CR#1 has having wounds. CR#1's acquired wounds that were first observed on [DATE] for sacrum, right heel, and left heel.In an interview on 6.27.26 at 4:16 p.m. with LVN D she stated she observed CR#1 had a sacrum wound on 6.2.26. LVN D stated CR#1 was turned every two hours. LVN D stated CR#1 wound happened very quickly. She stated CR#1 went to hospital due to wound infection. LVN D stated Resident #1 insisted that the facility send CR#1 out to hospital when she was unresponsive on 6.4.26.In an interview on 6.28.26 at 8:45 a.m., Resident#1 stated he was informed about CR#1's bedsore; however, he stated he was never informed how severe it was. Resident #1 stated nursing home staff never came in to provide care or turn CR#1 every 2 hours. He stated he can't remember observing CR#1 getting a bed bath. Resident #1 stated he believed CR#1 was neglected by staff. Does not believe CR#1 was treated right by nursing staff.In an interview on 6/28.26 at 1:00 .p.m., the MPOA stated CR#1 was not in her right mind because of her altered mental state. She stated CR#1 died 6.16.26. The MPOA stated she believed CR#1's sacrum wound did not occur overnight. MPOA stated she is employed with a facility that cares for wound patients. The (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	MPOA stated, based on CR#1's wounds which she seen from photos in the local hospital, she believed CR#1 was continously allowed to sit in saturated urine and not being turned frequently. The MPOA stated when she asked Resident #1 about CR#1 and if staff were turning her he said no. Resident #1 told her this is why he wanted MPOA to assist him in getting a transfer. She went to see CR#1 on [DATE] at the local hospital.Arrived at the local hospital 6.29.26 at 2:20 p.m. an interviewed MD who stated she treated CR#1 when she arrived at the ER with a Stage IV decubitus pressure ulcer. She stated CR#1's bone was exposed on her sacrum. She stated there has never been any medical attention paid to CR#1's wounds.MD stated nothing, and she reiterated nothing had been done to this wound. She stated the wound was 14X10L in size at least based on her professional knowledge. She stated this wound could have been avoided. She stated CR#1 had no foley bag. She stated this wound was never debrided and a wound of this size was present long before 5/27.26. She stated the wound had a horrible odor and was draining. She stated it appeared someone just slapped a bandage over it and sent CR#1 to the hospital. She stated she placed a call to the facility because she stated in CR#1's notes it stated there was Dakins solution ordered. She stated the nursing facility staff stated it was applied and MD stated it was not. She stated CR#1's WBC was 14.20 when she arrived in the ER, which explains her altered mental status. She stated once CR#1 was transferred upstairs to the wound care floor of the ER, while cleaning the wound her facial expressions was grimacing while receiving treatment, which is a reaction she was in a lot of pain.In an Interview on 6.29.26 at 5:39 p.m., LVN C stated she took care of CR#1 when she was in the memory care unit (Dementia) until Resident #1 was admitted to the facility, then CR#1 transferred out of the memory care unit and roomed with Resident #1. LVN C stated CR#1 did not have any sacrum wounds while in the memory care unit and if she did it is an expectation that the CNA's report it during their ADL's with her. LVN C stated the last time she seen CR#1 was on [DATE] and she appeared to have an altered mental status and was non-verbal.In a telephone interview on 6.29.26 at 6:06 p.m., FNP-C who identified herself as the Wound Care NP stated she became aware of the wound [DATE] and began the process of treating the wounds. Stated she ordered labs on [DATE], which returned with organisms related to the wound infection. This was the first time seeing resident. Ordered additional wound CBC/CMP concerned about infection. She stated the wound was infected. She stated the wound was unstageable because she was unable to see wound bed. She stated she did not debride the wound on her initial visit but believes she did on the second visit. Stated the wound could have been avoided through frequency of incontinence care and repositioning of patient. She stated she is unable to say how long the wound was there.In a telephone interview on 6.30.26 at 9:24 a.m., the WCN stated she completed a head-to-toe skin assessment on Thursday, [DATE] and CR#1 had a redness on her sacrum area. WCN stated she ordered barrier cream to be put on peri area. She stated pressure points are typically on sacrum and heel area of residents who are always in the bed. The WCN stated once she completes the skin assessments/evaluations and recommends tuning and repositioned, she places it in the MAR, then when the nurse open up her MAR the updated order for all residents populates, then the Charge Nurse is responsible for placing the information on the 24-hour report. All follow ups are completed by floor charge nurses. WCN stated she expressed to staff that CR#1 should be up out of bed daily; however, this was not in nursing notes. She stated CR#1's orders stated to keep resident heels elevated. WCN stated CR#1 was able to move but not turn herself much and staff should have been turning resident every two hours. WCN stated she is off on weekends and when she returned, she observed CR#1 on [DATE] and CR#1 had a small open area to her sacrum. WCN stated she called the DON who sent the Unit Manager and ADON to see CR#1. WCN stated the Unit Manager said CR#1 was on Palliative Care, but she informed the Unit Manager CR#1 should have been sent out to local hospital. WCN stated the Unit Manager told her that Resident #1 needed to be consulted first to make the decision, which she stated the Unit Manage told her Resident #1 said treat CR#1 in-house and not send her out to the local hospital. WCN stated she was informed by the nurse that the area began to change that Sunday prior, which was on [DATE], but was not relayed on an SBAR (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675344	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at Sweeny	109 N McKinney Sweeny, TX 77480

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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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	(standardized communication used among healthcare professionals) or the 24-hour report. WCN stated CR#1's PCP ordered labs on [DATE] or [DATE] and it returned with 5 different blood infections. She stated CR#1 was placed on contact isolation after the labs returned. She stated on [DATE] CR#1 received antibiotics. WCN stated on [DATE] a CNA came and told her that CR#1 wasn't acting right. The WCN stated CR#1's wounds could have been prevented by frequent turning and peri care. She stated most likely the CR#1 was septic at the point when the CNA told her CR#1 wasn't acting right. She stated she spoke with Resident #1 who stated he wanted CR#1 to go to the hospital. WCN stated CR#1 was placed on palliative care but still needed to receive wound care. When asked the difference between Palliative care versus Hospice and she stated Palliative care is when you make them comfortable but understand the end is near. She stated if a resident needs to go out to the hospital, then they should be sent out; however, for Hospice, all treatment is completed in the facility.In an interview on 6.30.26 at 6:10 p.m., LVN E stated when any resident have a change of condition, even with wound care, she is informed by 24-hour report of shift change. She stated she can find the changes under the treatment monitoring for changes. She stated she was unaware of CR#1's wounds until she heard everyone talking about it and she went into the resident room to view her wound area. She stated she has spoken with CR#1 in the past and did not get the impression that she had altered mindset.An Immediate Jeopardy (IJ) was identified on 6.30.2026. The IJ template was provided to the Administrator on 6.30.2026 at 7:21p.m. While the IJ was removed on 7.1.25 at 6:20pm, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not an immediate jeopardy and a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems.The following Plan of Removal submitted by the facility was accepted on 7.1.26 at 12:49PM.PLAN OF REMOVALName of facility:Date: 7.1.26F686- Quality of CareProblem: According to the IJ Template, F686 Quality of Care. The facility failed to initiate wound preventative measures on [DATE] when CR#1 readmitted to the facility who was identified as high risk for wounds who had change in condition on [DATE] of redness to sacrum area. CR#1 was diagnosed with stage IV decubitus wound on her sacrum area with infection in her blood that led to altered mental status and discharged from the facility to ER on 6.4.26.Corrective Actions Taken:The Administrator and Director of Nursing (DON) notified the Medical Director of the Immediate Jeopardy on [DATE] during an ad hoc QAPI meeting.CR#1 was discharged to the hospital on [DATE] and did not return to the facilityOn [DATE], the Director of Nursing, Assistant Director of Nursing, Wound Care Nurse, and Unit Manger conducted a 100% head to toe skin assessment of all current residents to identify any areas of skin impairments or signs of skin breakdown. Will be completed on [DATE]. Any new areas or concerns will be immediately reported to the physician, documented, obtain treatment order and care plan updated accordingly.On [DATE] the Director of Nursing/Designee assessed all residents with current pressure ulcers to evaluate for signs and symptoms of infection. Assessments will be updated and completed on [DATE]. Director of Nursing/Designee will complete 100% Braden scales, followed by updating care plans and interventions for residents at risk for pressure ulcers will be completed on [DATE].On [DATE], the Regional Nurse Consultant provided education to the Administrator and DON regarding:Change of condition focusing on skin and wound infectionFollowing residents identified at risk care plans and interventionThe DON initiated education on [DATE] for licensed nursing staff (the facility currently does not use agency) on:Completing skin assessments upon admission, readmission, weekly, and with any change in conditionChange in condition focusing on signs and symptoms of skin and wound infectionCompletion and accuracy of Braden Scale Assessments.Education will be completed by [DATE].Staff will not be able to provide direct resident care until training has been completed. Education for new