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	07/04/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the notices to residents was provided when changes in coverage were made to services covered by Medicare/Medicaid for 3 of 3 residents (Resident #1, Resident #6, and Resident #43) reviewed for resident rights. -The facility failed to ensure Resident #1, Resident #6 and Resident #43 was given a Notice of Medicare NON-Coverage (resident who is not covered on a Medicare Part A skilled nursing stay) and or Beneficiary Notice CMS form 10055 (Notice of Medicare Non-Coverage). This failure could place residents, or their representatives at risk for not being fully informed about services covered by Medicare Part A and not being aware of changes to provided services. Findings include: Resident #1 Record review of Resident #1's face sheet dated 05/29/25, revealed he was admitted to the facility on [DATE] with diagnoses of aftercare following Joint replacement surgery (aftercare refers to the medical and supportive care provided after the surgery to help ensure proper recovery, prevent complications, and restore mobility and function), diffuse (injury affects widespread areas of the brain) traumatic brain injury(brain damage caused by an external force) without loss of consciousness (the person did not pass out) sequela (mean the person is experiencing ongoing symptoms), unspecified convulsions (identified that convulsions are occurring, but they haven't determined the exact type), Hallucinations (perception of having seen, heard, touched, tasted or smell something that wasn't actually there). discharge date revealed 05/06/2025 at 1516 (4:16pm), length of stay 39 days, discharge to private home with home health services. Record review of Resident #1's Progress Notes, revealed effective date of discharge 05/06/2025, discharge transportation method home: RP picked up Resident #1 from the facility and transported resident home, referrals required/setup: referral sent to Home Health for continued services of PT. Follow up appointments: with PCP. Record review of Resident #1's revealed form CMS 1055 was not provided to Resident #1. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/2025 at 6:55 pm with the Social Worker, she said for Resident #1 he was not issued a NONMC. She said she called Resident #1's RP to inform her 20 percent of the total cost was due. She said Resident #1's RP was upset, and RP voluntary came to remove Resident #1 from the LTC Facility. Resident #6 Record review of Resident #6's face sheet dated 05/29/25, revealed she was admitted to the facility on [DATE] with diagnoses of unspecified dementia (progressive decline in mental abilities), contracture right knee (a condition where the knee cannot fully straighten), schizoaffective disorder (disorder that affects a person's ability to think, feel, and behave clearly) legal blindness, anemia in chronic kidney disease (is a complication where the body doesn't have enough red blood cells to carry oxygen throughout the body). Resident #6 is still in the LTC facility. Record review of Resident #6's revealed form CMS 1055 was not provided to Resident #6. Resident #43 Record review of Resident #43's face sheet dated 05/29/25, revealed he was admitted to the facility on [DATE] with diagnoses of esophageal obstruction (the tube that carries food from your mouth to your stomach becomes blocked making it difficult to swallow), pressure ulcer of right buttock stage 3 (involves full thickness skin loss with damage to underlying tissue but not exposing bone, muscle, or tendon), pressure ulcer of left buttock stage 3 (involves full thickness skin loss with damage to underlying tissue but not exposing bone, muscle, or tendon), down syndrome (genetic condition with an extra copy of chromosome 21. extra genetic affects the person's physical features, development, and cognitive abilities). Resident #43 is still in the LTC facility. Record review of Resident #43's revealed form CMS 1055 was not provided to Resident #43. During an interview on 5/29/2025 at 6:32 pm with the Administrator, he said the team members responsible for the beneficiary notices was the business office manager and social worker, with the social worker leading and managing the effort. He said the residents on the beneficiary Notification Review was not given a NONMC nor the CMS 10055. He said If the resident receives the NONMC, then they have a chance to appeal, Record review of the policy, Notice of Medicare Non-Coverage dated 5/2025 revealed the following: 2. Timing of Notice of Medicare Non-Coverage Delivery, The NOMNC must be delivered no later than two calendar days before the end of skilled services. 3. Issuance of Notice of Medicare Non-Coverage, the designated staff member (appointed by the administrator) will: Provide the resident and/or their representative confirming receipt. Documentation: a copy must be given to the resident /representative.

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure two residents (Resident #59 and Resident #60) of five residents reviewed for abuse and neglect were free from abuse.The facility failed to address inappropriate sexual behavior between Resident #59 and Resident #60. Resident #59 had a diagnosis which included Dementia and Resident #60 had a diagnosis which included Alzheimers.The facility failed to immediately implement the Psychology NP's recommendation to move Resident #60 off of the unit. An Immediate Jeopardy (IJ) was identified on 6/14/2025. The IJ template was provided to the facility on 6/14/2025 at 3:35 p.m. While the IJ was removed on 6/17/2025, the facility remained out of compliance at a scope of pattern with the severity level at a potential for more than minimal harm that is not immediate jeopardy, because all staff had not been trained. This failure placed residents at risk of abuse/neglect. Findings included:Record review of the admission Record for Resident #59 revealed she did not have a person other than herself listed as Responsible Party (RP). Diagnoses included dementia (a group of symptoms that affect thinking, memory, and social abilities), schizoaffective disorder (a mix of hallucinations, delusions, and mood disorder), and generalized anxiety disorder. Her admission rate was 11/17/2023. She was [AGE] years old.Record review of the Minimum Data Set (MDS) assessment dated [DATE] for Resident #59 reflected she scored 10 of 15 on the Brief Interview for Mental Status (BIMS), indicative of moderately impaired cognition. The MDS reflected Resident #59 exhibited delusions and wandering. Record review of the admission Record for Resident #60 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease (progressive disease characterized by memory loss), dementia (a group of symptoms that affect thinking, memory, and social abilities), and unspecified psychosis (a mental state marked by loss of contact with reality). The admission Record reflected he was his own RP. Record review of the Quarterly MDS assessment for Resident #60 dated 05/07/25 revealed he scored 10 of 15 on the BIMS, indicative of moderate cognitive impairment. Record review of a Nurse's Note (NN) in Resident #59's electronic record, dated 03/25/25 at 12:15 p.m., reflected Resident #59 and Resident #60 were in Resident #59's room. They were both unclothed and in her bed. The NN reflected Resident #59 believed Resident #60 was her husband. Record review of a Social Services Note for Resident #60, dated 03/25/25 at 1:00 p.m., reflected the Social Worker and a clinical specialist from another service observed Resident #60 in Resident #59's room. The residents were engaged in sexual activity. Resident #60 was redirected. Record review of a Behavior Note for Resident #59, dated 03/29/25 at 9:40 p.m., reflected Resident #59 attempted to go to the men's side of the secured unit. She became combative with staff. She was redirected but attempted to return after ten minutes. She again said Resident #60 was her husband. Record review of an Orders-Administration Note for Resident #59, dated 04/05/25 at 6:34 p.m., reflected Resident #59 had her hand down a male resident's shirt. The nurse asked Resident #59 several times to stop. The male resident told the nurse 'You can't tell us what to do' and stuck his middle finger at the nurse. Resident #59 then stuck her middle finger up at the nurse. Both residents became aggressive with staff.In an interview on 05/28/25 at 3:15 p.m., the DON said Resident #59 and Resident #60 sat together in activities but were not allowed to go to each other's rooms. She said Resident #59 had delusions that she and Resident #60 were married. The DON said Resident #59 was not able to make consensual decisions. In an interview on 05/28/25 at 4:09 p.m., the MDS Coordinator said on 03/25/25 Resident #59 was found in bed with Resident #60. She confirmed there was no Care Plan to address sexual activity. She said the Care Plans should have been updated. She said the interventions needed to be changed.Record review of a Behavior Note for Resident #59, dated 06/03/25 at 5:43 p.m., reflected Resident #59 was in Resident #60's room, sitting next to Resident #60 on his bed. Resident #60 was lying on his back with his shirt raised. No sexual activity was noted. Resident #59 was redirected to her room.In an interview on 06/13/25 at 2:32 p.m., the Psychology Services NP said he was made aware of the incident soon after it occurred. He said he recommended separating the residents by moving Resident #60 out of the secure unit. He said both had dementia.In an interview on 06/13/25 at 1:05 p.m. with the DON, when asked what could the facility have done differently, the DON said the facility could have moved Resident #60 from the secured unit sooner.In an interview on 06/13/25 at 1:20 p.m. the Administrator said he wished both residents were not their own RP. He said that in hindsight, they should have moved Resident #60 out of the secured unit in March of 2025.An IJ was identified on 06/14/2025 at 3:35 p.m. The IJ Template and Plan of Removal guidance were provided

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide and document sufficient preparation and orientation of resident representative to ensure safe and orderly transfer or discharge from the facility for 1 of 1 resident (Resident #1) reviewed for transfer and discharge rights.-The facility failed to notify the resident representative (Office of the State Long-Term Care Ombudsman) of the transfer or discharge with the reasons for the move in writing in a language and manner they understand. -The facility failed to send a copy of the notice of transfer or discharge to the representative of the Office of the State LTC Ombudsman involving Resident #1.-This failure placed residents at risk of not receiving an advocate who can inform them of their options, rights, and the added protection from being inappropriately transferred or discharged . Findings include: Record review of Resident #1's face sheet dated 05/29/25, revealed he was admitted to the facility on [DATE] with diagnoses of aftercare following Joint replacement surgery (aftercare refers to the medical and supportive care provided after the surgery to help ensure proper recovery, prevent complications, and restore mobility and function), diffuse (injury affects widespread areas of the brain) traumatic brain injury(brain damage caused by an external force) without loss of consciousness (the person did not pass out) sequela (mean the person is experiencing ongoing symptoms), unspecified convulsions (identified that convulsions are occurring, but they haven't determined the exact type), Hallucinations (perception of having seen, heard, touched, tasted or smell something that wasn't actually there). discharge date revealed 05/06/2025 at 1516 (4:16pm), length of stay 39 days, discharge to private home with home health services. Record review of Resident #1's Progress Notes revealed effective date of discharge 05/06/2025, discharge transportation method home: RP picked up Resident #1 from the facility and transported resident home, referrals required/setup: referral sent to Home Health for continued services of PT. Follow up appointments: with PCP. An attempted telephone interview with Ombudsman on 5/27/2025 at 11:52 am was unsuccessful.During an interview on 5/29/2025 at 6:32 pm with the Administrator, he said the team members responsible for the beneficiary notices was the business office manager and social worker, with the social worker leading and managing the effort. He said the ombudsman was not notified.During an interview on 5/29/2025 at 6:55 pm with the Social Worker, she said she only work with the skilled residents and not the long-term residents. Record review of the policy, Transfer or Discharge Notice dated 6/2024 revealed the following:1. The resident, the resident representative (if applicable), and the Long-Term Care Ombudsman Program will receive written notice of discharge at least 30 days before the planned discharge date in a language and manner the resident can understand

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care that included measurable objectives and timeframes to meet the residents' medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment for 3 residents (Resident #31, Resident #59, and Resident #60) of 8 residents reviewed for care plans. -Resident #31's Care Plan did not include interventions and services to appropriately address the resident's behavior of placing inedible objects in her mouth.-Resident #59's Care Plan was not updated to include interventions and services to appropriately address inappropriate sexual behavior.-Resident #59 had delusional thoughts that Resident #60 was her husband.-Resident #60's Care Plan was not updated to include interventions and services to appropriately address inappropriate sexual behavior. An Immediate Jeopardy (IJ) was identified on 6/16/2025 The IJ template was provided to the facility on 8/16/2025 at 3:45 p.m. While the IJ was removed on 6/17/2025, the facility remained out of compliance at a scope of pattern with the severity level at a potential for more than minimal harm that is not immediate jeopardy, because all staff had not been trained. This failure placed residents at risk of not receiving the necessary care and services to meet their needs resulting in a decline in health or harm.Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care that included measurable objectives and timeframes to meet the residents' medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment for 3 residents (Resident #31, Resident #59, and Resident #60) of 8 residents reviewed for care plans.-Resident #31's Care Plan did not include interventions and services to appropriately address the resident's behavior of placing inedible objects in her mouth.-Resident #59's Care Plan was not updated to include interventions and services to appropriately address inappropriate sexual behavior.-Resident #59 had delusional thoughts that Resident #60 was her husband.-Resident #60's Care Plan was not updated to include interventions and services to appropriately address inappropriate sexual behavior.An Immediate Jeopardy (IJ) was identified on 6/16/2025 The IJ template was provided to the facility on 8/16/2025 at 3:45 p.m. While the IJ was removed on 6/17/2025, the facility remained out of compliance at a scope of isolated with the severity level at a potential for more than minimal harm that is not immediate jeopardy, because all staff had not been trained. This failure placed residents at risk of not receiving the necessary care and services to meet their needs resulting in a decline in health or harm. Resident #31Review of Resident #31's face sheet revealed, the resident was a [AGE] year-old female admitted to the facility on [DATE] with a history of Dementia (group of symptoms affecting memory, thinking or language) anxiety (intense, excessive, and persistent worry and fear about everyday situations), altered mental status, and intellectual disabilities (condition that involves limitation on intelligence). Review of Resident #31's Quarterly MDS Assessment, dated 05/07/25, indicated the resident's cognitive skills for daily decision making was severely impaired. Review of progress notes, entered by RN C and dated 05/25/25 at 5:57 PM, indicated the following: Resident ingested plastic saran wrap from desert cup. Resident @ baseline; no signs of distress, breathing even and unlabored. Behavior @ baseline; BP:132/88 HR 55 RR 18 O2: 97 T: 97.3. NP B notified; no n/o. Will continue to monitor.Review of progress notes, entered by the DON and dated 05/28/25, indicated the resident had an IDT review due to swallowing plastic wrap. Recommendations were to continue to monitor for adverse effects, KUB (Kidney, Ureter and Bladder imaging), dietary evaluation, and in-service on meal setup. IDT members were Administrator, DON, ADON, Unit Manager, MDS nurse and Social Worker.Telephone interview with CMA H on 05/29/25 at 11:52 AM, who said on 05/25/25 during lunch, Resident #31 took the plastic wrapping off the applesauce and swallowed it. She denied knowledge of the resident putting other inedible items in her mouth. She said she assisted the resident with eating lunch but could not get to her quickly enough before she swallowed the plastic. She said the resident never appeared to be in distress, did not have difficulty breathing, and did not choke after swallowing the plastic wrap. She said the resident continued to eat her meal after swallowing the plastic wrap. She said the resident was supposed to be closely monitored during meals. She said the resident was not on 1:1 supervision. She said she notified the nurse immediately after the incident, and the nurse performed a head-to-toe assessment on the resident. Review of Resident #31's care plan, updated 05/01/25, indicated the resident had a history of putting inedible things in her mouth, and was noted to have eaten paint off walls, Styrofoam cups, etc. The resident's goal was not to have adverse effects related to

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Findings included: Resident #31 Review of Resident #31's face sheet revealed, the resident was a [AGE] year-old female admitted to the facility on [DATE] with a history of Dementia (group of symptoms affecting memory, thinking or language) anxiety (intense, excessive, and persistent worry and fear about everyday situations), altered mental status, and intellectual disabilities (condition that involves limitation on intelligence). Review of Resident #31's Quarterly MDS Assessment, dated 05/07/25, indicated the resident's cognitive skills for daily decision making was severely impaired. Review of progress notes, entered by RN C and dated 05/25/25 at 5:57 PM, indicated the following: Resident ingested plastic saran wrap from desert cup. Resident @ baseline; no signs of distress, breathing even and unlabored. Behavior @ baseline; BP:132/88 HR 55 RR 18 O2: 97 T: 97.3. NP B notified; no n/o. Will continue to monitor. Review of progress notes, entered by the DON and dated 05/28/25, indicated the resident had an IDT review due to swallowing plastic wrap. Recommendations were to continue to monitor for adverse effects, KUB (Kidney, Ureter and Bladder imaging), dietary evaluation, and in-service on meal setup. IDT members were Administrator, DON, ADON, Unit Manager, MDS nurse and Social Worker. Telephone interview with CMA H on 05/29/25 at 11:52 AM, who said on 05/25/25 during lunch, Resident #31 took the plastic wrapping off the applesauce and swallowed it. She denied knowledge of the resident putting other inedible items in her mouth. She said she assisted the resident with eating lunch but could not get to her quickly enough before she swallowed the plastic. She said the resident never appeared to be in distress, did not have difficulty breathing, and did not choke after swallowing the plastic wrap. She said the resident continued to eat her meal after swallowing the plastic wrap. She said the resident was supposed to be closely monitored during meals. She said the resident was not on 1:1 supervision. She said she notified the nurse immediately after the incident, and the nurse performed a head-to-toe assessment on the resident. Review of Resident #31's care plan, updated 05/01/25, indicated the resident had a history of putting inedible things in her mouth, and was noted to have eaten paint off walls, Styrofoam cups, etc. The resident's goal was not to have adverse effects related to putting inedible things in her mouth. Interventions included observing the resident closely for presence of foreign matter in mouth. Providing limited assistance of one staff member with dining. Remove any foreign matter from mouth. Observe for presence during crafts or activities where she could pick up items and put them in her mouth. Further review of Resident #31's care plan revealed documentation of past incidents of the putting inedible things in her mouth or ingesting inedible items and the incident on 05/25/25 was not addressed in the care plan. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with DON on 05/29/25 at 12:28 PM, who said the facility updated Resident #31's care plan on 05/28/25 to include 1:1 supervision/care at all times. She said she also emailed the dietitian to discuss interventions. She said the facility obtained a referral for an inpatient psychiatric evaluation for the resident. She said the facility also held an ad hoc QAPI meeting with the NP to provide additional interventions for the resident. She said the resident was at risk of an incident similar to ingesting plastic wrap reoccur. In an interview on 05/29/25 at 2:21 p.m. the Administrator said the facility tailored the resident's care plan to meet her needs. In an interview on 05/29/25 at 4:21 p.m. the MDS Coordinator said care plans were updated daily, or sometimes multiple times a day, to provide an accurate reflection of the care or services a resident required. She said the risk of not updating a care plan was resident's care needs not being met by facility staff. In an interview on 05/29/25 at 4:26 p.m. the DON said the MDS was supposed to update resident care plans as needed. She said a care plan should reflect goals and interventions based on a resident's specific needs to outline care to be provided to residents by facility staff. She said the risk of not updating the care plan to meet a resident's specific needs was failure to provide appropriate care to the resident. In an interview on 05/29/25 at 4:33 p.m., the Administrator said the MDS nurse was responsible developing care plans. He said the IDT team was also involved in developing comprehensive care plans. He said the risk associated with a resident not having an individualized care plan was facility staff may not have been meeting the resident's needs or may not have been aware of the resident's needs. Resident #59 Record review of the admission Record (dated 05/28/25) for Resident #59 revealed she was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included dementia (a group of symptoms that affect thinking, memory, and social abilities), schizoaffective disorder (a mix of hallucinations, delusions, and mood disorder), and generalized anxiety disorder. The document did not have a RP listed. Record review of the Quarterly MDS assessment for Resident #59, dated 05/06/25, revealed she scored 11/15 on the BIMS, indicative of moderate cognitive impairment. Record review of a Psychosocial Evaluation dated 02/25/25 revealed Resident #59 scored 14/15 on the BIMS, indicative of intact cognition. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #59 reflected she scored 10 of 15 on the Brief Interview for Mental Status (BIMS), indicative of moderately impaired cognition. The MDS also reflected Resident #59 exhibited delusions and wandering. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #59's Care Plan, updated on 03/07/25, revealed she was found in her bed, naked with a male peer on 03/25/25. Resident #59 believed the male resident was her husband. Interventions included monitoring and charting behaviors as they occurred and reporting progress/declines to MD. Review of the care plan did not reveal goals or interventions to address the behavior of physical contact with peers. Record review of a Behavior Note for Resident #59, dated 03/29/25 at 9:40 p.m., reflected Resident #59 attempted to go to the men's side of the secured unit. She became combative with staff. She was redirected but attempted to return after ten minutes. She again said Resident #60 was her husband. Record review of an Orders-Administration Note for Resident #59, dated 04/05/25 at 6:34 p.m., reflected Resident #59 had her hand down a male resident's shirt. The nurse asked Resident #59 several times to stop. The male resident told the nurse 'You can't tell us what to do' and stuck his middle finger at the nurse. Resident #59 then stuck his middle finger up at the nurse. Both residents became aggressive with staff. Resident #60 Record review of the admission Record for Resident #60 revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease (progressive disease characterized by memory loss), dementia (a group of symptoms that affect thinking, memory, and social abilities), and unspecified psychosis (a mental state marked by loss of contact with reality). The admission Record reflected he was his own RP. Record review of Resident #60's Quarterly MDS assessment dated [DATE] revealed he scored 10/15 on the BIMS, indicative of moderate cognitive impairment. He was able to walk independently. The resident did not exhibit physical or verbal adverse behaviors during the seven-day lookback period. Record review of Resident #60's Care Plan, initiated 07/18/24, reflected he was found naked in bed in a female peer's room on 03/25/25. Review of the care plan did not reveal goals or interventions to address the behavior of physical contact with peers. In an interview on 05/28/25 at 3:15 p.m., the DON said Resident #59 and Resident #60 may sit together in activities but were not allowed to go to each other's rooms. She said Resident #59 had delusions that she and Resident #60 were married, she was not able to make consensual decisions. In an interview on 05/28/25 at 4:09 p.m., the MDS Coordinator said on 03/25/25 Resident #59 was found in bed with Resident #60. She confirmed there was no Care Plan to address sexual activity. She said the Care Plans should have been updated. She said the interventions needed to be changed. The facility policy Care plan Revisions (revised May 2022) read, in part, .1. The comprehensive care plan will be reviewed and revised every quarter, when a resident experiences a status change and as deemed necessary .c. The care plan will be updated with the new or modified interventions. An IJ was identified on 6/16/2025 at 3:45 p.m. The IJ template was provided to the Administrator via email at 3:45 p.m and a Plan of Removal was requested. (continued on next page)

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	675344	A. Building B. Wing	07/04/2025

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Paradigm at Sweeny	109 N McKinney Sweeny, TX 77480

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following Plan of Removal was submitted by the facility and was accepted on 6/16/2025 at 10:08 p.m. and indicated the following: Plan of Removal Name of facility: _____ Date: 06/16/2025 According to the IJ Template, the facility failed to update care plans for Resident #59 and Resident #60 with measurable objectives and timeframes following a possible sexual encounter involving both residents. -Resident #31's care plan did not include interventions and services to appropriately address the resident's behavior of putting inedible items in her mouth. -Resident #59's Care Plan was not updated to include interventions and services to appropriately address inappropriate sexual behavior. -Resident #60's Care Plan was not updated to include interventions and services to appropriately address inappropriate sexual behavior. Immediate Action June 16, 2025 - 30-Day Incident Review Action: Regional Clinical Reimbursement Specialist will conduct full review of behavioral incidents from the past 30 days to ensure all related care plans were properly updated with measurable goals and appropriate interventions. There were not any negative findings. Responsible: Regional Clinical Reimbursement Specialist Completion Date: June 16, 2025 June 16, 2025 - MDS Nurse Education Action: Regional MDS Nurse will provide an in-service education to the facility's MDS Nurse on timely, individualized care plan updates in response to behavioral incidents. Responsible: Regional MDS Nurse/designee Completion Date: June 16, 2025 June 16, 2025 - Facility Medical Director Notified Action: The facility's Medical Director was formally notified of the F-0656 deficiency. Responsible: Administrator Completion Date: June 16, 2025 (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	June 16, 2025 - Ad Hoc QAPI Meeting Held Action: Meeting conducted with Medical Director, DON, MDS Nurse, Regional MDS Nurse, Regional Director of Operations, and Regional Nurse Consultant to review recent incidents and care planning deficiencies. Performance Improvement Plan created. Responsible: Administrator Completion Date: June 16, 2025 June 16, 2025 - Daily Behavior Review and Care Plan Update Monitoring Action: The IDT team will review progress notes daily during the clinical morning meeting to identify behaviors, ensuring the care plans are updated with appropriate interventions. Responsible: DON June 16, 2025 - Care Plan Revision Policy Action: The Administrator reviewed the care plan revision policy. Upon review, no changes were noted. Responsible: Administrator Completion Date: June 16, 2025 Monitoring of the plan of removal included the following: In an interview on 06/15/2025 at 11:15 a.m. the Administrator said Resident #59 had been transferred from the facility. Observation on 06/15/2025 at 11:55 a.m. revealed Resident #60 had been relocated off of the secured unit. He was asleep when observed at that time. In an interview on 06/15/2025 at 12:06 p.m. the DON said she was reviewing the behaviors of the 24 residents on the secure unit. She said she would complete the audit that day. Record review on 06/16/2025 at 09:30 a.m. revealed all of the secured unit resident audits have been completed. The following interviews occurred on the Secured Unit: Observation on 06/17/2025 at 11:50 a.m. revealed Resident #70 relocated back to the Secured Unit. In an interview on 06/17/2025 at 1:55 p.m., The MDS Coordinator said the facility implemented the following changes: All incident/accident reports were reviewed in the morning meeting. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Internal messaging for daily events were done via telephone or e-mail. There was a Standards of Care meeting conducted every Tuesday. She was reading Progress Notes every morning. She said she had received counselling from the Regional MDS Coordinator on 06/16/2025. In an interview on 06/17/2025 at 2:10 p.m. RN M (ADON) said information regarding care plans was discussed in the stand-up meeting in the mornings. She said the nurses could communicate concerns via email or telephone to the MDS Coordinator. In an interview on 06/17/2025 at 2:25 p.m. RN C said if there were incidents, accidents or changes in condition requiring Care Plan updates, she would notify the MDS Coordinator and DON via email or phone. The Administrator was informed the Immediate Jeopardy was removed on 06/17/2025 at 2:30 p.m. The facility remained out of compliance at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure each resident's environment remained free of accident hazards for 1 of 6 residents (Resident #31) reviewed for accident hazards.The facility failed to adequately supervise Resident #31 when she ingested plastic wrap from a container while being monitored by CMA H during dining.An IJ was identified on 07/03/35 at 1:22 PM. The IJ template was provided to the facility on [DATE] at 1:22 PM. While the IJ was removed on 07/04/25, the facility remained out of compliance at a scope of isolated and a severity of no actual harm with potential for more than minimal harm because all staff had not been trained on accidents and supervision.This failure could place residents at risk for injury, harm, and impairment. Findings included: Record review of Resident #1's face sheet revealed, the resident was a [AGE] year-old female admitted to the facility on [DATE] with a history of Dementia (group of symptoms affecting memory, thinking or language) anxiety (intense, excessive, and persistent worry and fear about everyday situations), altered mental status, and intellectual disabilities (condition that involves limitation on intelligence). Record review of Resident #31's Quarterly MDS Assessment, dated 05/07/25, indicated the resident's cognitive skills for daily decision making was severely impaired and required supervision when eating. Record review of Resident #31's care plan, updated 05/01/25, indicated the resident had a history of putting inedible things in her mouth, and was noted to have eaten paint off walls, Styrofoam cups, etc. The resident's goal was not to have adverse effects related to putting inedible things in her mouth. Interventions included observing the resident closely for presence of foreign matter in mouth. Providing limited assistance of one staff member with dining. Remove any foreign matter from mouth. Observe for presence during crafts or activities where she could pick up items and put them in her mouth. On 05/28/25 the care plan indicated Resident #31 was placed on 1:1 observation pending inpatient psych eval. The resident's goal was to not consume any plastic wrap through next review. Interventions included monitoring resident at meal times, staff to setup tray with each meal, and removing plastic wrap before meals were served. Record review of progress note entered by RN C and dated 05/25/25 at 5:57 PM, indicated the Resident ingested plastic wrap from desert cup. Resident @ baseline; no signs of distress, breathing even and unlabored. Behavior @ baseline; BP:132/88 HR 55 RR 18 O2: 97 T: 97.3. NP B notified; no n/o. Will continue to monitor.Record review of progress notes entered by the DON indicated the following: 05/28/25 at 5:43 PM, indicated the resident had an IDT review due to swallowing plastic wrap. Recommendations were to continue to monitor for adverse effects, KUB (Kidney, Ureter and Bladder imaging), dietary evaluation, and in-service on meal setup. IDT members were Administrator, DON, ADON, Unit Manager, MDS nurse and Social Worker.Further review of progress notes on 5/28/25 at 6:14 PM, indicated the resident's NP ordered follow up chest x-rays to rule out aspiration. Further review revealed the resident was sent for imaging.Further review of progress notes on 5/29/25 at 1:47 PM, indicated the resident's MD was notified of negative x-ray results. MD did not give new orders.During a telephone interview on 05/29/25 at 11:52 AM, CMA H said on 05/25/25 during lunch, Resident #31 took the plastic wrapping off the applesauce and swallowed it. She denied knowledge of the resident putting other inedible items in her mouth. She said she assisted the resident with eating lunch but could not get to her quickly enough before she swallowed the plastic. She said the resident never appeared to be in distress, did not have difficulty breathing, and did not choke after swallowing the wrap. She said the resident continued to eat her meal after swallowing the wrap. She said the resident was supposed to be closely monitored during meals. She said the resident was not on 1:1 supervision. She said she notified the nurse immediately after the incident, and the nurse performed a head-to-toe assessment on the resident. During an interview on 05/28/25 at 12:28 PM, RN C said on 05/25/25 a CNA informed her that Resident #31 ingested the plastic wrap from her dinner cup after the incident had occurred. RN C said she notified the NP and performed a head-to-toe assessment on the resident, who had normal vital signs and no changes in baseline. She said the NP did not give any new orders at that time. She said the facility continued to monitor the resident for adverse effects. She said the risk associated with the resident swallowing wrap was aspiration, choking, and/or bowel obstruction. During a telephone interview on 05/28/25 at 12:49 PM, NP B said the nurse had contacted him regarding the resident swallowing plastic wrap. He informed the staff to monitor the resident because her vital signs were stable and displayed no signs or symptoms of distress. He said Resident #31 was not having any issues, so no new orders were given. He said there was only risk to the resident if the resident could not pass the

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for storage, preparation and sanitation. -The facility failed to label and date gravy and milk stored in the walk-in refrigerator. -The facility failed to label and date Gelatin stored in the dry storage. -The facility failed to discard expired cooked food from the walk-in refrigerator. -The facility failed to discard juice thickener, with a best used by date of 04/16/25, from the dry storage. These failures could place residents who received meals and/or snacks from the kitchen at risk for food-borne illness and food contamination if consumed. Findings included: Kitchen Observation on 05/27/25 at 10:12 AM revealed the following: *Chicken gravy and two glasses of milk in refrigerator were not labeled or dated. *Cherry Gelatin in the dry storage was not labeled or dated. *Cooked beef chili in the walk-in refrigerator was not labeled with an expiration of 05/25/25. *1 bottle of Apple Juice Thickener (46 fl oz) was in the dry storage and had not been discarded after best used by date of 04/16/25 was noted. During an interview on 05/29/25 at 3:39 PM, the Dietary Manager said the expectation was for all foods placed in the refrigerator, that had been opened or cooked, to be labeled with the date the item was placed in the refrigerator. He said open food or beverages placed in the dry storage area also needed to be labeled with the date the item was opened. He said the cooks, tray aides, and himself were responsible for appropriate food storage, including labeling and dating foods. He said the risk of storing unlabeled and expired items could have led to food-borne illnesses in residents. During an interview on 05/29/25 at 3:59 PM, Tray Aid A said he usually prepared daily desserts and drinks served to residents. He said he also labeled and dated desserts and drinks before they were placed in the refrigerator or dry storage. He said all food items and drinks in the kitchen should be labeled and dated on the date the items were opened. The risk of not labeling and dating items could have led to staff to giving expired food to residents, and the residents could have gotten sick. During an interview on 05/29/25 at 4:33 PM, the administrator said the risks associated with unlabeled and undated food items in the refrigerator or the dry storage area could have led to infection and illness in residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Nutrition Services policy and procedure, dated 08/12/19, reflected, . Food Safety in Receiving and Storage It is the policy of this facility that food will be received and stored by methods to minimize contamination and bacterial growth. Procedures: Receiving Guidelines: 7. Check expiration dates and use-by dates to assure the dates are within acceptable parameters. General food: Place food that is repackaged in a leak-proof, pest-proof, non-absorbent, sanitary container with a tight-fitting lid. Label both the container and its lid with the common name of the contents and the date it was transferred to the new container. It is recommended that food stored in bins (e.g. flour or sugar) be removed from its original packaging . Record review of the Food and Drug Administration Food Code, dated 2022, reflected, 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety