STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675612	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at Westbury	5201 S Willow Dr Houston, TX 77035

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37059 Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 1 resident reviewed for resident rights. (Resident #1) The facility failed to place a privacy cover over Resident #1's urinary catheter bag. This failure could place residents with urinary catheters at risk for decreased quality of life and self-esteem. Findings included: Record review of Resident #1's Face sheet dated 4/30/24 revealed a [AGE] year-old male, admitted on [DATE]. Diagnoses were not listed. Record review of the physician orders dated 4/30/24 indicated Resident #1 was [AGE] years old and admitted to the facility on [DATE] with diagnoses of incontinence (foley catheter). Record review of Resident #1's progress notes dated 4/29/24 at 4:56 pm revealed the following in part: Patient is transferred into facility via stretcher and has to be total care . Foley catheter intact, Record review on 4/30/24 at 2:20 pm of Resident #1's MDS section of the electronic health record revealed an admission MDS had not been started or completed. Record review 4/30/24 at 2:24 pm of Resident #1's electronic health record revealed a care plan was not completed. During an observation on 4/30/24 at 1:10 pm, Resident #1 was lying in his bed with eyes open. His catheter drainage bag did not have a privacy bag and was hanging on the frame of the bed, approximately half filled with yellow urine. In an attempted interview on 4/30/24 at 1:11 pm, Resident #1 did not respond to questions. Resident #1 stared and had random eye movement. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/30/24 at 1:13 pm, ADON said Resident #1 should have had a privacy bag to honor his dignity and privacy. The ADON said Resident #1 was admitted late yesterday evening and the was the reason he did not have a privacy cover. The ADON said the privacy cover should have been placed over the catheter bag at admission. The ADON said it was the responsibility of the admitting Nurse and or the CNA. She said the charge nurse would have been responsible for ensuring the cover was in place. In an interview on 4/30/24 at 1:15 pm, CNA #1 said she had seen Resident #1's catheter bag on the floor earlier, picked it up but did not place a cover over the catheter bag. She said there should be a cover over the bag to maintain dignity. She stated Resident #1 was a new admit and that could have been why the privacy cover was not in place. She said she had been trained during orientation related resident rights and catheter care . Interview on 4/30/24 at 3:00 p.m., the Administrator said a privacy bag should be used with all foley catheter bags. He said Resident #1's privacy and dignity were not honored. He expected drainage bags to be covered at all times to protect resident's dignity. He said he thought all nursing should have been responsible for this task or ensuring it was in place. Administrator said because the resident had not been admitted for 24 hours that is why the privacy bag was not in place. Record review of the facility policy Nursing Policies and Procedures (revised date 5/19), revealed the following in part: .Subject: Catheter Care . Procedures: 1. Provide for privacy and educate resident . Record review of the facility policy Resident Dignity and Privacy (revised date 04/24, revealed . Policy: The facility provides care for residents in a manner that respects and enhances each resident's dignity, . and right to personal privacy.Definition : Dignity - Treating resident with the utmost respect, recognizing their inherent worth and value as individual. It involves honoring their .privacy .while also ensuring their physical and emotional well-being is maintained. Maintain resident privacy during toileting . and other activities of personal hygiene.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37059 Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 1 (Resident #7) of 10 resident rooms reviewed for environment. The facility failed to ensure the window blinds in Resident #7-room [ROOM NUMBER] (bed B next to window) were in good repair. The facility failed to ensure Resident #7 plastic handrail on the bed was in good repair. The failure placed residents at risk of possible injury due to an unsafe environment. Findings included: Record review of Resident #7's face sheet dated 4/30/2024 revealed a [AGE] year-old female admitted on [DATE] (originally 1/13/22) with the following diagnoses legal blindness and unspecified glaucoma (group of eye conditions that damage the optic nerve and can cause vision loss). Resident #7 room was on Unit B. Record review of Resident #7's care plan dated 3/27/24 revealed the following in part: Focus: Resident #7 is at risk for injury related to grabbing/pulling her window curtains (blinds). Interventions: Monitor/record occurrence of for target behavior symptoms (Depression, hallucinations, loose thinking) and document per facility protocol. Date initiated 10/19/22. Review of Resident #7's MDS, dated [DATE], revealed the resident had a BIMS of 7 which indicated severe cognitive impairment. Observation on 4/30/24 at 9:20 a.m. of Resident #7 room revealed broken blinds, within reach of Resident #7, that had sharp jagged edges. Resident #7 was reaching with her right hand towards the window blinds while holding onto the handrail of the bed. Her bed was pushed against the wall and the window. Resident #7's handrail had plastic peeled upward away from the metal frame. The handrail plastic had pointy sharp edges. Interview on 4/30/24 at 9:21 a.m. Resident #7 said she was blind, and she was not sure what has happened to the window blinds or the plastic handrail to her bed . Observation on 4/30/24 at 2:10 p.m. of Resident #7's room, with the Administrator, revealed the bed handrail and window blinds in the same damaged condition as observed in the morning during general observation rounds. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/30/24 at 2:11 p.m. with, the Administrator said the damaged window blinds and bed handrails could cause injury to Resident #7. He said all staff that entered the room were responsible and should have made a maintence request. He said when the staff completed the Angle Rounds throughout the week they should have looked at the residents room for repairs needed. Interview on 4/30/24 at 4:26 p.m. with Director of Support Services said there are Angel Rounds (rounds made by facility staff to engage with resident and document any concerns or repairs needed) done to check the rooms and with the residents on any need that are not met, which included environmental . He said he has not received a work order to repair Resident #7's handrail to her bed or the window blinds. He said an order should have been placed in the maintenance log that is kept at each nurses' station. He said he does frequent round but did not notice the needed repairs in Resident #7's room. He was not sure who completed the Angle Round last for Resident #7 because it varies. Record review of the maintenance log for Unit B revealed there had not been a request for Resident #7 handrail or window blinds. The last maintenance request was 10/2023 which was prior to Resident #7's admission. Director of Support Services reviewed the log.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37059 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program for 4 (301,407,416, 417) of 10 rooms on halls (300 and 400 halls) reviewed for pests, in that: 1. Numerous gnats were observed in a resident room on Hall 300 (Resident #6-room [ROOM NUMBER]-B). 2. Numerous gnats were observed in a resident room on Hall 400 (Resident #2-room [ROOM NUMBER]-A, Resident #3-417-A, Resident #4 - 407-B and Resident #5 - 407-A). This deficient practice could place residents at risk of residing in an environment with pests. The findings were: Observation on 4/30/24 at 10:06 a.m. in Resident #2's room revealed the presence of numerous gnats in Resident #2's room on Hall 400. There were numerous gnats on two of Resident #2's training cup spouts. Resident #2 had one cup in her hand that was being used and one sitting on tray the tray table. Interview attempt on 4/30/24 at 10:07 a.m. with Resident #2 did not respond to questions related to gnats in the room. Observation on 4/30/24 at 10:15 a.m. in Resident #3's room revealed gnats around the resident. Interview on 4/30/24 at 10:17 a.m. with Resident #3 said she waves the gnats away. She said she thought pest control would take care of the gnats. She said it was aggravating when she ate, and she normally eats in her room. Observation on 4/30/24 at 11:22 p.m. revealed the presence of gnats in Resident #4's and Resident #5's room. Interview on 4/30/24 at 11:23 p.m. with Resident #4 said he does the best he can with the gnats. He said the gnats have been more obvious in the past couple of months since the temperature has been warmer. He said he has learned to deal with the gnats. Observation on 4/30/24 at 12:35 p.m. with Resident #6 revealed gnats on her food tray of food. Interview on 4/30/24 at 12:36 p.m., Resident #6 said she had to swat the gnats away while she ate her food. She said the gnats annoyed her. Interview on 4/30/24 at 1:46 p.m., Administrator said he had not seen gnats. He said facility staff complete Angel Round daily, which done to check in with residents and address concerns. He said he had not been told about gnats. He said he assumed pest control treats the building once a month and would eliminate any pest. He said a outside contracted service was responsible for the pest control. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 4/30/24 at 2:06 p.m. the Administrator stated he was not sure why the gnats were in the residents' rooms but that pest control came monthly or when needed. Record review of the maintenance log for Unit B revealed there had not been a request for pest controls related to gnats. The last maintenance request was 10/2023 . Record review of the facility policy, Pest Control, revised 8/12/09, revealed, It is the policy of this facility that the facility will maintain an effective pest control program to prevent or eliminate infestation of pest and rodents. Report sighting of live pest immediately to the Pest Management Coordinator to request emergency service to provide additional, unscheduled treatment as necessary.