STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024

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 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 15976

47277

Based on observation, interview and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for 5 (Resident #5, #6, #7, #8, and #9) of thirty-one residents reviewed for ADL care.

The facility failed to ensure Residents #5, #6, #7, #8 and #9 received bath/showers three times a week as per their shower schedule.

This failure could place residents at risk of skin breakdown, infection and loss of self-esteem.

Findings Included:

Resident #5

Record review of Resident #5's face sheet undated revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included primary pulmonary hypertension (high blood pressure that affects the arteries in the lungs), shortness of breath (difficulty breathing), dependence on supplemental oxygen (the need for oxygen when the O2 saturation is low), paroxysmal atrial fibrillation (irregular or rapid heartbeat), bradycardia (slow heart beat), chronic systolic congestive heart failure (when the heart does not pump blood effectively), chronic cough (cough lasting more than eight weeks), chronic obstructive pulmonary disease (difficulty breathing) and pleural effusion (fluid around the lungs).

Record review of Resident #5's quarterly MDS assessment, dated 05/20/2024, reflected a BIMS score of 13, which indicated she was cognitively intact. Section GG- Functional Abilities and Goals, question GG0130 indicated Resident #5 needed supervision for ADLs of toileting, showers, and dressing.

Record review of Resident #5's care plan dated 10/20/2022 revealed resident has ADL care deficit related to muscle weakness and risk pain, resident at risk for further decline and injury.

Goal was to ensure was dress, groomed and clean. Dignity will be maintained and there will be no further decline in ADL functioning or injury over the next 90 days.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Intervention: Anticipate needs. Encourage independent functioning as able. Encourage resident to asked for assistance as needed. Ensure call light in reach and answered within a timel manner. Observation on 6/04/2024 at 12:50pm revealed Resident #5 in her wheelchair. The resident was clean and groomed, alert and oriented and could make her needs known. In an interview on 06/04/2024 at 12:50pm with Resident #5 revealed that they have not being getting showers on the weekend. She said her shower days were Tuesdays and Thursday. She said the last time she had a shower was on 5/30/2024. She said they did not get showers on Saturdays because they did not have a shower tech on the weekend. Record review of Resident #5's electronic health record, showering/bathing for May 2024 and June 2024 revealed the last documented shower was 05/30/2024. There was no documentation of shower given for 6/01/2024 and 6/4/2024. Resident #6 Record review of Resident #6's face sheet undated revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included hypertension (high blood pressure), hyperlipidemia (high levels of fat in the blood), type 2 diabetes (high blood sugar), Coronary heart disease (build-up of fatty deposits on the walls of the arteries), and constipation (difficulty passing stool). Record review of Resident #6's quarterly MDS assessment, dated 05/18/2024, reflected Resident #6 had a BIMS score of 11, which indicated she was moderately cognitively impaired. Section GG- Functional Abilities and Goals, question GG0130 indicated Resident #6 needed supervision for ADLs of toileting, showers, and dressing. Record review of Resident #6's care plan dated 12/14/2022 revealed: Focus: Self-care deficit, Resident #6 has self-care deficit regard to lumbar facture history. Goal: Resident will be dressed groomed and clean, and dignity will be maintained. No further decline in ADL's in the next 90 days. Intervention: Anticipate needs - provide prompt assistance, Encourage independent function as able. Encourage resident to ask for assistance for ADL care. Ensure call light is within reach and answer in a timely manner. Provide assistance for ambulation per therapy orders. Provide encouragement and cueing as needed to perform ADL. Provide extensive assistance x1 for bed mobility. Provide extensive assistance x1 for person. Observation on 6/04/2024 at 12:53pm revealed Resident #6 in her wheelchair. She was clean and groomed, alert and oriented and could make her needs known. (continued on next page)

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

In an interview on 06/04/2024 at 12:54pm with Resident #6 she said she was not getting showers on the weekend. She said her shower days were Tuesdays and Thursday. She said the last time she had a shower was on Thursday, 5/30/2024. She said they did not get showers on Saturday, and she was waiting to get a shower on Tuesday. She said she did not get a shower on Saturday because they did not have shower techs on the weekend. Further interview on 6/5/2024 at 9:30am with Resident #6 she said she did not get a shower on Tuesday 6/4/2024. Asked at that point if she wanted a shower, she said no because she was cleaned up for the day. She said since Thursday was her shower day she would wait until Thursday.

Record review of Resident #6's electronic health record, showering/bathing for May 2024 and June 2024 revealed the last documented shower was 05/30/2024. There was no documentation of shower given for 6/01/2024 and 6/4/2024.

Resident #7

Record review of Resident 7's face sheet dated 6/45/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included primary pulmonary hypertension (high blood pressure), atrial fibrillation (irregular or rapid heartbeat), vascular dementia (memory loss), bipolar disorder (episodes of mood swing) and chronic obstructive pulmonary disease (difficulty breathing).

Record review of Resident #7's quarterly MDS assessment, dated 05/20/2024, reflected Resident #7 had a BIMS score of 05, which indicated she was severely cognitively impaired. Section GG- Functional Abilities and Goals, question GG0130 indicated Resident #7 was total care for ADLs of toileting, showers, and dressing.

Record review of Resident #7's care plan dated 1/12/2024 revealed:

Focus: Resident #7 has ADL self-care deficits related to muscle weakness and impaired cognition and is at risk for further decline in ADL functioning and injury.

Goal: Resident #7 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.

Intervention: Anticipate needs - provide prompt assistance.

Encourage independent function as able.

Encourage resident to ask for assistance for ADL cares as needed.

Ensure call light is within reach and answer in a timely manner.

Provide encouragement and cueing as needed to performed ADL cares.

Provide privacy and maintain dignity.

Observation on 6/04/2024 at 3:50pm revealed Resident #7 was in her wheelchair. The resident was clean and groomed, alert and oriented and could make her needs known.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/04/2024 at 3:50pm with Resident #7 she said she was not being showered on the weekend. She said her shower days were Tuesdays and Thursday. She said the last time she had a shower was on 5/30/2024. She said they did not get showers on Saturday because they did not have a shower tech on the weekend. Record review of Resident #7's electronic health record, showering/bathing for May 2024 and June 2024 revealed the last documented shower was 05/30/2024. There was no documentation of shower given for 6/01/2024 and 6/4/2024. Resident #8 Record review of Resident #8's face sheet undated revealed he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included hypertension (high blood pressure), acute kidney failure (a condition where the kidneys fail to filter waste from the blood), pressure ulcer, disease of the gall bladder (an organ that stores and releases bile). Record review of Resident #8's quarterly MDS assessment, dated 05/20/2024, revealed a BIMS score of 08, which indicated moderate cognitive impairment. Section GG- Functional Abilities and Goals, question GG0130 indicated Resident #8 needed supervision for ADLs of toileting, showers, and dressing. Record review of Resident #8's care plan dated 09/08/2023 for ADL's revealed for: Focus: Resident #8 ADL Self-care deficits regard to muscle weakness and is at risk for further decline in ADL functioning and injury. Goal: Groomed, clean, dignity will be maintained and will have no further decline in ADL functioning or injury over the next 90 days. Encourage independent function as able. Encourage resident to ask for assistance for ADL cares as needed. Intervention: Ensure call light is within reach and answer in a timely manner. Provide encouragement and cueing as needed to perform ADL cares. Provide privacy and maintain dignity. Observation on 6/04/2024 at 12:53pm revealed Resident #8 on his bed. He was clean and groomed, alert and oriented and could make his needs known. In an interview on 06/04/2024 at 12:54pm with Resident #8 he said he was not getting showers on the weekend. He said his shower days were Tuesdays and Thursday and the last time he had a shower was on Thursday, 5/30/2024. He said they did not get showers on Saturdays because they did not have shower techs on Saturdays. Resident #9 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #9's face sheet undated revealed he was a 63 -year-old male who was admitted to the facility on [DATE]. His diagnoses included hypertension (high blood pressure), pressure ulcer, hyperlipidemia, neurogenic bowel (inability to control defecation due to injury), musculoskeletal system, anemia (inadequate healthy blood cells) , atrial fibrillation (rapid heart rate that causes poor blood flow), atherosclerotic heart disease (damage in the heart major blood vessels), dysphagia (difficulty swallowing), severe sepsis (is the body's extreme reaction to an infection), and diabetes (high blood sugar). Record review of Resident #9's quarterly MDS assessment, dated 05/20/2024, revealed a BIMS score of 11, which indicated he was moderately cognitively impaired. Section GG- Functional Abilities and Goals, question GG0130 indicated Resident #9 needed supervision for ADLs of toileting, showers, and dressing. Record review of Resident #9's care plan dated 02/14/2024 for ADL's revealed for: Focus: Resident #9 has self-care deficit related to quadriplegia, and Central Cord Syndrome of cervical spinal cord. He is at risk for further decline in ADL functioning and injury. Goal: Resident #9 will be well dressed, groomed, clean, dignity will be maintained and will have no further decline in ADLs. Intervention: Anticipate needs - provide prompt assistance. Encourage independent function as able. Encourage resident to ask for assistance for ADL cares as needed. Observation on 6/04/2024 at 12:53pm revealed Resident #9 in his bed. He was clean and groomed, alert and oriented and could make his needs known. In an interview on 06/04/2024 at 12:56pm with Resident #9 he said did not get showers, he usually gets a bed bath. He said he did not a get bed bath on the weekend. He said his bath days were Tuesdays and Thursday. Record review of Resident #9's electronic health record, showering/bathing for May 2024 and June 2024 revealed the last documented bed bath was on 05/30/2024. There was no documentation that bed baths were given for 6/01/2024 and 6/4/2024. In an interview on 6/5/2024 at 9:05am with Shower Tech A she said she gives showers on Mondays, Wednesdays, and Fridays to residents in the odd numbered rooms and Tuesdays and Thursdays and Saturdays to the residents in the even numbered room. She said she did not work on Saturdays, so the CNAs are supposed to give showers on the weekend. She said she was not working on 6/4/2024. Her first day working on hall 400 was 6/5/2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/5/2024 at 9:10am with CNA G she said that residents in odd numbered rooms were given showers on Mondays, Wednesdays and Fridays and even numbered rooms were given showers on Tuesdays, Thursdays, and Saturdays. She said they did not have shower techs on Saturdays, so CNAs should be giving showers on Saturdays. Further interview revealed that she had worked on the weekend and she was responsible to give Resident #5 and Resident #6 a shower. She said she did not give them a shower. No reasons were given for not giving them a shower. In an interview with CNA L on 6/5/2024 at 9:20am she said residents in odd numbered rooms were given showers on Mondays, Wednesdays and Fridays and Tuesdays, Thursdays, and Saturdays. She said they did not have shower techs on Saturdays, so CNAs are supposed to give showers on Saturdays. CNA L said she worked last weekend. She said she did not work with Resident #5. She said when she works on the weekend, she will give a shower to anyone who needs a shower. In an interview on 06/05/24 at 11:30am with the Regional RN she said residents should be given a shower Monday, Wednesday and Friday or Tuesday, Thursday and Saturday. Regional RN stated residents' showers were provided to residents in odd numbered rooms on Mondays, Wednesdays, and Fridays, and residents in even numbered rooms were Tuesdays, Thursdays, and Saturdays. Regional RN said stated aides were responsible for providing residents showers and the nurse was responsible for signing the shower sheet to confirm the shower was provided. She said that Saturdays should be included on the schedule, and she was going to fix the schedule. She said she will be in-servicing the staff. In an interview on 06/05/2024 at 4:03 p.m., the DON stated ADL care, including showers should be provided to residents according to the schedule and upon request. The DON stated it was all nursing staff responsibility to ensure showers were provided and documented accordingly. The DON stated she would conduct an Inservice on ADL care, the shower schedule and documentation and conduct shower sheet audits to ensure showers were offered, provided and documented regularly. Record review of the facility's policy entitled, Nursing Policies and Procedures revised in 03/2019, read in part . Subject: ACTIVITIES OF DAILY LIVING- HIGHEST LEVEL OF FUNCTIONING Policy: It is the policy of this facility to provide care and services to ensure that a resident is able to maintain their ability to self-perform their activities of daily living, at their level of functioning prior to facility admission, unless circumstances of the individual's clinical condition demonstrate that diminishment in ability was unavoidable. The facility is responsible to provide necessary care to all residents who are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene. Definitions Activities of daily living (ADLs), refer to tasks related to personal care including, grooming, dressing, oral hygiene, transfer, bed mobility, eating, bathing and communication. Procedure: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review the most current comprehensive or quarterly MDS assessment to identify an inability to perform ADLs, or a risk for decline in any ability to perform ADLs. 2. Monitor conditions which may cause an unavoidable decline in the resident's ability to self-perform ADLs (including but not limited to): C. Resident's or his/her representative's decision to refuse care and treatment offered to restore/maintain functional abilities after the facility has informed and educated about the benefit/risks of the proposed care and treatment. 3. Develop and implement interventions for the resident's preferences, assessed needs, goals for care and treatment, and recognized standards of practice to maintain optimal function of ADL performance. Revised 3/2019 4. Provide assistive devices to maximize independence, including but not limited to the following: M. Wheelchair, walker, rolling walker, cane. 6. Monitors and evaluate the resident's response to care plan interventions, therapy and restorative plans, and treatments. 7. Revise care plan approaches and interventions as appropriate.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15976 Based on observation, interview, and record review, the facility failed to ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 2 of 4 residents (Residents #4 and #5) reviewed for respiratory care. 1. The facility failed to ensure the filter in Resident #4's oxygen concentrator was not dirty and the water reservoir attached to oxygen concentrator was not empty and replaced in accordance with the facility's changing schedule. 2. The facility failed to ensure Resident #5 oxygen humidifier bottle on the oxygen concentrator had enough water in the bottle to function properly. These failures could place residents who required respiratory treatments at risk of receiving inadequate respiratory treatments and could result in a decline in health. Findings Included: Resident #5 Record review of Resident #5's face sheet undated revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included primary pulmonary hypertension (high blood pressure that affects the arteries in the lungs), shortness of breath (difficulty breathing), dependence on supplemental oxygen (the need for oxygen when the O2 saturation is low), paroxysmal atrial fibrillation (irregular or rapid heartbeat), bradycardia (slow heart beat), chronic systolic congestive heart failure (when the heart does not pump blood effectively), chronic cough (cough lasting more than eight weeks), chronic obstructive pulmonary disease (difficulty breathing) and pleural effusion (fluid around the lungs). Observation on 6/04/2024 at 12:50pm revealed Resident #5 in her wheelchair and her O2 was infusing at 3ml per minutes. The humidifier bottle on the O2 tank had about a teaspoon of water in it which was not enough water to function properly. Record review of Resident #5's care plan dated 5/28/2024 revealed: Focus: Resident #5 will be free from at risk for respiratory distress/failure and any respiratory distress/failure increased episodes of SOB r/t COPD, h/o and will have min/no further SOB, chronic cough, and smoking. Goal: Resident #5 will be free from respiratory distress. No episodes of shortness of breath over the next 90 days. She is dependent on supplemental oxygen via nasal canula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Intervention: Allow breaks when performing task. Check pulse oximetry as ordered. Minimize stress/anxiety - allow to verbalize feelings when appropriate. Observe for s/sx of respiratory infection - report any noted to MD. Provide respiratory treatments as ordered - observe for signs of relief from SOB. In an interview on 6/4/2024 at 12:51pm Resident #5 said they normally do not check the water container on the oxygen tank when it is empty. She said the nurses told her she should call them when the water container was empty. Observation on 6/4/2024 at 2:20pm LVN D was observed coming from the room with the humidifier bottle with a few drops of water in it. In an interview on 6/4/2024 at 2:20pm LVN D said she had just changed the bottle. She said she usually checked the O2 tank at the start of her shift to ensure everything was working properly and that the bottle had water in it. She said she did not check it that morning as she was busy. She said she did not know when the bottle was changed, because she was off for the last two days. Resident #4 Record Review of the undated face sheet for Resident #4 revealed she was a [AGE] year-old, female who was admitted to the facility on [DATE] and readmitted [DATE]. Her diagnoses included Gastro esophageal reflux disease (heart burn), shortness of breath (difficulty breathing), hypertension (high blood pressure), cough, tracheostomy (a procedure to help air and oxygen in the lungs), atrial fibrillation (rapid heart rate that causes poor blood flow), and cerebral infarction (disrupted blood flow to the brain). Record review Resident #4's Quarterly MDS assessment dated [DATE] revealed a BIMS score 0 indicating the resident was severely impaired for cognition. Review of Section O: Special treatment revealed the resident was coded as receiving respiratory treatment and oxygen therapy. Record Review of the care plan dated 6/23/23 revealed Resident #4 was care planned for oxygen therapy at 2-5LPM continuously for sats below 92% and has a Tracheostomy diagnosis. Record review of the physician's orders dated 2/20/23 revealed Resident #4 was to receive 02 at 2L/m via NC Continuously every shift. Additional order dated 6/4/24 revealed Oxygen at 2-4 LPM via nasal cannula continuously. Monitor 02 sat. every shift. Observation on 6/4/24 at 11:37am revealed Resident #4 lying in bed with the canula in her nostrils and O2 infusing at 2.5 liters per minute. Observed the oxygen tank water bottle was dated 5/28/2024 with initials and had approximately 1/2 teaspoon of water in the bottom. Observation revealed the filter in the back of the oxygen machine to be filled with whitish looking substance. In an interview with the resident's family member on 6/4/24 at 11:40am he said he visited the facility to see his family member at least three times a week. He said he noticed that water was always in the bottle bubbling but today it was empty. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/4/24 at 11:45 with CNA C, he said he was assigned to Resident #4 that day. Regarding the oxygen tank with barely any water, the CNA indicated that he does not service the oxygen tank in anyway, however, the nurses change the water bottle and check the levels. He states at that time he would get the nurse and tell her to come to the resident's room regarding the water bottle on the oxygen tank. In an interview on 6/4/24 at 11:50am with RN B revealed she was the RN assigned to the resident. The nurse was informed that Resident #4's oxygen tank was very low to almost empty of water. The nurse went to the resident's room and checked the water bottle, saturation level, and filter. The nurse indicated that she checked the tank between 8:00am and 9:00am this morning. The nurse stated that she observed there was water in the bottle but could not elaborate how much water. RN stated issues of shortness of breath, may have sinus problems and could cause resident to have mental confusion could occur if resident did not have water in the bottle. Furthermore, it can cause the pulse to become rapid. The nurse checked the resident's oxygen, via finger, and it was 99%. RN B indicated that the filter should be changed more frequently but could not give a time that it should be changed; however, she acknowledged that the filter was very dirty and indicated it could create a situation with the oxygen concentration, which may not be 100% accurate when checked. At that point the Unit Manager retrieved a water bottle at RN B's request, and she changed the bottle. In an interview on 6/4/24 at 1:50pm with the DON, she said the responsibility of the RN was to make rounds and give report. The RN should check the water or the entire oxygen tank during their rounds. When the water bottle was empty, they are required to replace it. The DON stated the oxygen flow without water could lead to resident bleeding, oxygen issues and cause dryness. The DON states RN should check the back filter too. If the filter was dirty, it could cause the machine to malfunction and it would not get appropriate pressure. Record review of the undated Policy Review for Respiratory Training-Oxygen Therapy, revealed under oxygen concentrator section, #10 Routine Maintenance, A. Filter, 1. Clean when visibly soiled.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16989 Based on observation, interview, and record review, the facility failed to establish and maintain a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for two residents (CR #40 and CR #41) of five residents reviewed for drug diversion. -CR #40 was discharged , but the resident's controlled medications were not removed from the medication cart. -Controlled medications for CR #40 were diverted from the medication cart. -CR #41 was discharged , but the resident's controlled medications were not removed from the medication cart. The deficient practice increased the risk of drug diversion and increased the risk of having impaired staff. Findings included: CR #40 Record review of the Admission Record for CR #40, dated 06/06/24, revealed she was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, end stage renal disease, myopathy (disease of muscle tissue, and muscle weakness). Record review of the Transfer/Discharge Report for CR #40, dated 06/06/24 revealed she was discharged to an acute care hospital on 12/22/23. Record review of the Controlled Drug Administration Record for CR #40's hydrocodone/APAP (acetaminophen) 5-325 mg revealed one tablet was signed out on 01/15/24, and one tablet was signed out on 01/16/24 by RN S. Record review of CR #40's January MAR reflected hydrocodone was not signed as administered on 01/15/24 or 01/16/24. Record review of the Provider Investigation Report (PIR) dated 01/24/24 revealed the Administrator received a call from a nurse regarding missing medications. The Report reflected medication had been signed as being administered for residents who were no longer at the facility. The Report reflected all medications for residents no longer at the facility were removed from the carts. The Report read, in part, .Staff educated on removing narcotics from nursing carts after a patient's discharge. CR #41 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Paradigm at Westbury		STREET ADDRESS, CITY, STATE, ZIP CODE 5201 S Willow Dr Houston, TX 77035	

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Admission Record for CR #41, dated 06/06/24, revealed he was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, nontraumatic intracerebral hemorrhage (brain bleed), encephalopathy (disease of the brain), and acute respiratory failure. Record review of the Transfer/Discharge Report, dated 06/06/24, revealed he was discharged to an acute care hospital on 05/15/24. Observation and interview on 06/06/24 at 2:50 p.m. revealed RN T was by the Hall 300 medication cart. She said discontinued controlled medications were to be given to the DON. Observation at that time revealed a blister pack card of Modafinil (medication to treat narcolepsy) 200 mg, fifteen tablets for CR #41. RN T said CR #41 had been in the hospital for 2 weeks. In an interview on 06/06/24 at 3:17 p.m., the DON said when residents were discharged , the controlled medications were to be brought to her. She was not the DON at the facility in January 2024 when the facility had the drug diversion of CR # 40's medications. The Surveyor informed the DON that CR #41's controlled medication was still in the medication cart, and the resident was discharged . She said she would retrieve the medication. Interview and record review on 06/06/24 at 3:40 p.m. revealed the DON presented the facility policy Storage of Controlled Substances (09/2018), and asked the Surveyor to read Part 10. The Policy read, in part, .10. Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are retained in the facility in a securely locked area with restrictive access until destroyed . The DON said the medication was secure in the medication cart. The Surveyor referred to the occurrence in January 2024 when CR #40's controlled medications remained in the cart after she was discharged . The medications were subject of diversion. The DON said it was the facility's responsibility to keep the medications secure.

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	06/06/2024

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47277 Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles in locked compartments for 2 of 2 medication carts reviewed for storage of drugs. The facility failed to ensure medication carts were locked and supervised on two hallways, 100 and 300, reviewed for storage of drugs. This deficient practice could place residents at risk of harm to unauthorized persons for medication misuse and drug diversion. Findings include: Observation on 6/4/2024 at 11:43am revealed the Hall 100 medication cart was unlocked and unattended by the nursing station. There were 3 unidentified residents who were observed near the cart. RN B who had retrieved gloves and other items from the cart and left it unlocked and entered inside a residents' room. The cart was unattended for approximately 12 minutes. In an interview on 6/4/2024 at 11:55am revealed RN B stated she did not realize she had left the cart unlocked and unattended. RN B further stated that the cart should always be locked and if it is left unlocked it can create a dangerous situation because residents could get into the medication cart and take medication that is harmful to them. Observation on 06/06/24 at 3:00 p.m. revealed the Hall 300 medication cart was unlocked and unattended by the nursing station. Two unidentified residents were observed near the cart. At 3:10 p.m. a resident in a wheelchair was propelled past the cart by a family member. Continued observation revealed the cart was unlocked and unattended for 15 minutes. In an interview on 06/06/24 at 3:15 p.m. revealed RN T said she was in a room assisting a resident. Interview on 6/6/24 at 1:50pm with DON revealed the medication carts should be locked at all times. If not locked someone can remove medications from the cart. DON stated medication carts have narcotics and regular medications. Record review of Nursing Policies and Procedures (Medication Administration and Management) Policy revised 6/2019 revealed, Security ad Safety Guidelines #2: Medication cart is kept in sight or locked at all times.

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

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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 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. 15976 Based on observation, interview, 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 in that. 1. The facility failed to ensure food was properly labeled and dated. 2. The facility failed to ensure that milk temperature was checked at delivery and was at the correct holding temperature. 3. The facility failed to ensure that menu items on the steam table was maintained at the correct holding temperature. 4. The facility failed to ensure that ready to eat foods were not touched with bare hands. These failures could place residents who received meals prepared by the kitchen at risk for food borne illness. Findings included: During observations on 6/04/2024 between 10:45am and 11:15am of the kitchen revealed the following: Cook A was observed putting baked rolls in the pan without wearing gloves. Interview with the Dietary Manager at that time she said the [NAME] should be wearing gloves. At the time she instructed the cook to wear gloves. In the free-standing refrigerator revealed milk was at 45 degrees Fahrenheit when it should be at 41 degrees or below Fahrenheit. In the walker-in freezer were 2 bags with frozen peas with no date. In the dry storage room were 2 plain plastic bags with chips that were not labeled and dated. There was a plain plastic bag with chocolate cake mix that was not labeled or dated. In an interview on 6/04/2024 at 11:15am with the Dietary Manager she said she had gotten the milk less than 2 hours before. She said she did not check the milk temperature on delivery. She also discarded the unlabeled and undated menu items. She said she was not sure the exact dates they were opened. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the steam table at lunch on 06/04/2024 at 12:05pm revealed the following menu items not at the correct holding temperature: Pureed chili mac at 131 degrees and chili mac with no tomatoes at 130 degrees. At the time the Dietary Manager took the menu items back to the kitchen to be reheated to 165 degrees Fahrenheit. In an interview on 06/04/2024 at 12:20pm with the Dietary Manager she said that food on the steam table that was not at the correct holding temperature could cause residents to get sick. At that point she said she was going to in-service the staff. Record review of the facility's policy, titled Nutrition Services Policies and Procedures, dated 2012, stated. Subject: Safe Food Temperatures Policy: It is the policy of this facility that food temperatures will be maintained at acceptable levels during food storage, preparation, holding, serving, delivery, cooling and reheating. The steamtable may not be used to reheat food. 5. When hot pureed, ground, or diced food drops into the danger zone (below 135 F), it must be reheated to 165 F for 15 seconds. 6. Hold hot foods at 140 F or higher during meal service (on the tray line). Hold cold foods at 40 F or If the food temperatures are not within acceptable parameters, reheat the food to at least 165 F for 15 seconds (for hot foods) or discard it. Record review of the facility's policy, titled Nutrition Services Policies and Procedures, dated 08/12/2019, read in part . Subject: 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 6. Inspect food when it is delivered to the facility and prior to storage for signs of contamination. Food packages shall be in good condition to protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminants. 10. When adding newly delivered food into current inventory, use the FIFO (First In, First Out) method so old stock is rotated to the front and utilized first. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dry Storage Guidelines 3. Containers holding food or food ingredients that are removed from their original packages such as cooking oils, flour, sugar, herbs, and spices are identified with the common name of the food. Maintain the ambient temperature of refrigerators at 34 to 38 F or per state regulations. Maintain the ambient temperature of freezers so that foods are solidly frozen or per state regulations.