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	10/15/2024

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15976 Based on observation, interviews, and record reviews, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 5 residents (CR #1) whose assessments were reviewed, in that: CR#1's admission weight was not accurate on the initial MDS dated [DATE]. CR#1's significant weight loss was not reflected on her quarterly MDS dated [DATE]. This failure could place residents at-risk for weight loss for not receiving the care and services to increase weight loss due to inaccurate assessments. Findings Included: Record review of CR#1's face sheet, dated 10/15/2024, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnosis included hypotension (low blood pressure), unspecified intestinal obstruction(blockage of part of the small or large intestine), hypertension (high blood pressure), multiple myeloma not having achieved remission (type of white blood cell that becomes cancerous and multiplies), vascular dementia (memory loss), mild protein calorie malnutrition (diet lacking in protein and starch), dysphagia oral phase (difficulty speaking), cognitive communication (difficulty communication because of brain injury) and anxiety (worry and fear). Record review of CR#1's weight record at the facility revealed the following weights were taken: Admission weight was 4/12/2024: 99.0 lbs Weekly weights were 4/19/2024: 96.4, 4/26/2024: 100.00 lbs., 5/01/2024: 99.3 lbs., 5/03/2024: 101.3 lbs., 5/10/2024: 101.0 lbs. , 6/02/2024: 98.0 lbs., 7/03/2024: 97.7 lbs., 8/01/2024: 89.6 lbs., 8/30/2024: 100.0 lbs., 9/05/2024: 90.4 lbs., 9/27/2024: 80.1 lbs, 10/01/2024: 80.4 lbs, 10/02/2024: 81.1 and 10/09/2024; 78.04 lbs. Further record review revealed a weight loss of 7.9 % between 7/03/2024 97.7 lbs. and 8/01/2024 89.6 lbs. Record review of the hospital discharge report dated 4/12/2024 for CR#1 revealed that on 4/07/2024 the resident weighed 54.3 kg which was equal to 119.46 lbs. Record review of CR #1's admission MDS, dated [DATE], revealed her BIMS score was 07 of 15 reflecting she had moderate cognitive impairment. Further record review of CR #1's Admission MDS Section K0200 revealed a weight of 119 pounds, K0300 coded as no or unknown weight loss. (continued on next page)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CR #1's quarterly MDS dated [DATE] revealed a BIMS score was 07 of 15 reflecting the resident had moderate cognitive impairment. Further review revealed K0200 a weight of 119 lbs, and K0300 revealed no or unknown weight loss. Review of CR #1's quarterly MDS dated [DATE] revealed a BIMS score was 07 of 15 reflecting the resident had moderate cognitive impairment. Further review reveald K0200 a weight of 119 lbs, and K0300 no or unknown weight loss. Interview on 10/15/2024 at 3.00pm with LVN-A regarding the MDS for CR #1, she said they did not have a MDS nurse. She said the MDS nurse who did CR#1's MDS was no longer working at the facility. She said she was the Unit Manage and stated CR #1 had some weight loss. She said the dietitian had evaluated the resident. She was eating and was receiving supplements while she was at the facility. She then looked at the facility's weight records and compare it with the hospital recorded weight and said the MDS nurse must have gotten the 119 pounds recorded on the initial MDS from the hospital report because the initial weight at the facility was 99.0 lbs. She further stated that the resident weight loss at the facility's was gradual weight loss. At that point she agreed that the weight on the initial and quarterly MDSs were not accurate. She said the MDS persons should have checked the facility's weight records on admission and document on the initial MDS. She said if she was not sure of the resident's weigh she should reweigh the resident. Interview on 10/15/2024 at 4.03 p.m. with the DON, she said they did not currently have a MDS nurse. She said she was new to the facility and was working on MDS and care plan issues. She acknowledged that CR#1's MDS's weights were not accurate. She said they recognized that they had issues with MDSs and would be addressing the issues as soon as the new MDS nurse got on board. She said they would have to make corrections to the MDS to reflect the resident's admission weight. Further interview with the DON revealed that the expectation of the MDS nurse was to physically assessed residents, observe residents, weigh residents, interview staff and residents and conduct a complete assessment before documenting on the MDS. Record review of the facility's Nursing Policies and Procedures dated 06/2019 revealed in part, . Subject Minimum Data Set Policy: It is the policy of this facility that a registered nurse will conduct or coordinate each assessment with the interdisciplinary team. An MDS which is a comprehensive, accurate, standardized reproducible assessment will be completed on each resident using the RAI process. Facility staff complete a comprehensive assessment of each resident's needs, strengths, goals. Life history, and preferences and other guidance for further assessment once problems have been identified. Procedures: 1. Review resident records. 2. If a CAA is triggered, the facility will further assess the resident to determine if the resident is at risk. 3. Interview, observe and physically assess the resident to obtain validation of items identified on the medical record and to collect information for items where no documentation exists. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. Each assessment must represent an accurate picture of the resident status during the observation period of the MDS.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15976 Based on interview and record review the facility failed to ensure the interdisciplinary team reviewed and revised each resident's Care Plan after each assessment, including both the comprehensive and quarterly review assessments for 1 of 5 Residents (CR #1) whose records were reviewed. The facility failed to revise CR #1's Care Plan to reflect her significant weight loss. These deficient practices could result in the residents not receiving the care and services needed to increase weight gain. Findings included: Record review of CR #1's face sheet, dated 10/15/2024, revealed the resident was a [AGE] year-old female who was admitted to the facility on [DATE] 24. Her diagnosis included hypotension (low blood pressure), unspecified intestinal obstruction(partial of full bockage of the small and large intestine), hypertension (high blood pressure), multiple myeloma not having achieved remission (type of white blood cell that becomes cancerous and multiplies), vascular dementia(memory loss), mild protein calorie malnutrition(diet lacking in protein and starch), dysphagia oral phase (difficulty speaking), cognitive communication (difficulty communication because of brain injury) and anxiety (worry and fear). Record review of CR#1's weight record at the facility revealed the following weights were taken: Admission weight was 4/12/2024: 99.0 lbs Weekly weights were 4/19/2024: 96.4, 4/26/2024: 100.00 lbs., 5/01/2024: 99.3 lbs., 5/03/2024: 101.3 lbs., 5/10/2024: 101.0 lbs. , 6/02/2024: 98.0 lbs., 7/03/2024: 97.7 lbs., 8/01/2024: 89.6 lbs., 8/30/2024: 100.0 lbs., 9/05/2024: 90.4 lbs., 9/27/2024: 80.1 lbs, 10/01/2024: 80.4 lbs, 10/02/2024: 81.1 and 10/09/2024; 78.04 lbs. Further record review revealed a weight loss of 7.9 % between 7/03/2024 97.7 lbs. and 8/01/2024 89.6 lbs. Record review of the hospital discharge report dated 4/12/2024 for CR#1 revealed that on 4/07/2024 the resident weighed 54.3 kg which was equal to 119.46 lbs. Record review of CR #1's admission MDS, dated [DATE], revealed her BIMS score was 07 of 15 reflecting she had moderate cognitive impairment. Further record review of CR #1's Admission MDS Section K0200 revealed a weight of 119 pounds, K0300 coded as no or unknown weight loss. Review of CR #1's quarterly MDS dated [DATE] revealed a BIMS score was 07 of 15 reflecting the resident had moderate cognitive impairment. Further review revealed K0200 a weight of 119 lbs, and K0300 no or unknown weight loss. Review of CR #1's quarterly MDS dated [DATE] revealed a BIMS score was 07 of 15 reflecting the resident had moderate cognitive impairment. Further review reveald K0200 a weight of 119 lbs, and K0300 no or unknown weight loss. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #1's nurse's progress notes dated 6/27/2024 revealed in part, . Nutrition Note RD made aware of RD consult for resident. RD resident is doing better on pureed diet, fortified food. Resident ate >70% on Wednesday lunch. Labs: Na: 129 (L), Res is on 90 ml House 2.0 BID, 30 ml liquid protein BID, also on lactulose, shows non-significant weight loss x 30d, -3% x 30 days, wt stable x admit. BMI underweight, res with multiple myeloma (type of white blood cell that becomes cancerous and multiplies) , and dx of mild protein calorie malnutrition (diet lacking in protein and starch). RD aware of order for3 day calorie count, RD available to track meal intakes prn, but in building regularly on Mondays. Record review of CR #1's Nutrition notes dated 8/14/2024 RD Note revealed, - Consult/Weight Variance follow up: CBW: 89.6lbs Ht: 64in. BMI: 15.4 (severely underweight for age) Weight trends: -8.29% x 30, -9.76% x 90, no data x 180days Diet: regular, puree, regular/thin (fortified foods) Intake: 51-100% most meals per chart Eating ability: independent supervision most meals per chart Supplements: 2.0 supp; 90mL BID (360cals, 15g pro), prostat 30mL BID (200cals, 30g pro) Intake: accepted well per MAR. Increased energy demands r/t multiple myeloma (note diagnoses mild (PCM) may not be meeting estimate needs with current intake significant weight loss. RD visited resident in dining room, severe temporal wasting & overall thin appearance observed. RD spoke with resident, reports ok appetite. Per conversation with staff, good intake most meals & accepts 2.0 supplement well. Megestrol acetate recently added - beneficial as it may increase appetite. To provide additional calories to further support weight stability, increase 2.0 supplement to 90mL PO TID (540cals, 22.5g protein). Rec to also add to weekly weights x 30 days to closely monitor wt trends. Goals: avoid significant weight loss, maintain skin integrity. Record review of CR #1's care plan dated 4/15/24 and revised 7/16/2024 revealed no documentation of the resident being at risk for weight loss or had actual weight loss. Further record review revealed the care plan was not revised after at 7.9% weight loss between 07/03/2024 and 08/01/2024 . Interview on 10/15/2024 at 3:00 PM with LVN A revealed CR #1's initial care plan, dated 4/15/2024, should have addressed the resident risk for weight loss. She said when there was actual weight loss the care plan should be revised to reflect the resident's significant weight loss. She said they currently did not have a MDS person and the nurse who did the MDS and care plan was no longer working at the facility, She said, the resident had actual weight loss and dietitian had evaluated the resident and that her care plan should address the weight loss. At that time she said she would get someone to answer the care plan questions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/15/2024 at 4.03p.m. with the DON, she said they did not have a MDS nurse currently. She said she was new to the facility and was working on MDS and care plan issues. She said they recognized that they had issues with care plans, and they would be addressing the issues as soon as the new MDS nurse got on board next week. She acknowledged that CR #1 's had weight loss and it was not addressed in the care plan. She further stated that the dietitian had evaluated the resident several times and intervention was in place and she did not know why the weight was not addressed She said the weight loss should be addressed in the care plan. Further interview with the DON revealed that the expectation of the MDS/ care plan nurse was to update care plans to address resident's current status . Record of the facility's Nursing Policies and Procedures titled Care Planning dated 6/2019 read revealed in part . Policy It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident. Procedure: 1. A comprehensive care plan is developed within seven days of the comprehensive assessment.