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No. 0938-0391

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	01/28/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46678 Based on interview and record review, the facility failed to provide adequate supervision to prevent accidents for 1 (CR#1) of 1 resident reviewed for accidents hazards/supervision. The facility failed to prevent CR#1 from falling from his bed and sustaining a minor head injury on 08/05/24 while CNA A performed a bed bath alone even though the resident required 2-person assist. This failure could place residents at risk of harm, potential accidents, and a diminished quality of life. Findings included: Record review of CR#1's face sheet dated 1/26/25 revealed a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included acute and chronic respiratory failure with hypoxia, cerebral infarction (blood supply to part of the brain that is blocked or reduced), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), history of falling and functional quadriplegia (the lack of ability to use one's limbs or to ambulate due to extreme debility or frailty). Record review of CR #1's quarterly MDS dated [DATE] revealed a BIMS of 0 indicating severe cognitive impairment. Further review of the MDS indicated CR#1 had impairment on both sides of his upper and lower extremities, was dependent on staff for rolling left and right, moving from a sitting position to a lying position, toilet transfers and tub/shower transfers. Record review of CR#1's care plan dated 2/14/24 indicated he was at risk for falls and injuries related to impaired cognition and late effects of Cerebrovascular Accident (blood flow to the brain interrupted, leading to brain tissue damage), and a history of falls. Interventions included staff anticipating the resident's needs, asking for assistance from staff, universal fall precautions, and staff education on 2-person assist, which was added on 8/6/24. Further review of CR#1's care plan also indicated he was prescribed an anticoagulant for embolic stroke and was at risk for increased bleeding and bruising. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of the Provider Investigation Report (PIR) was submitted on 8/5/25 with allegations of Resident/Patient/Client Abuse that were inconclusive and signed by the Administrator on 8/12/24. The Provider Response section read in part .MD and family notified of the incident. Staff educated on abuse and neglect. Resident assessed for injuries . The Investigation Summary section read in part . on 8/7/24 administrator was notified by DON that CR #1 had a witness fall .family member was notified of the incident and told the facility that he was upset .family stated felt like the facility neglected CR#1 . CR #1 had a scratch above left eyebrow, neuros initiated, wound care provided, resident was sent to ER .CT results were negative . Several attempts were made to obtain the CT scan results from the hospital before exiting the facility but were unsuccessful. Record review of the CR #1's MAR for the month of August indicated Eliquis oral table 5 mg was administered via PEG-Tube every 12 hours from 8/1/24 to 8/5/24 for atrial fibrillation. Record review of CR #1's electronic health record did not reveal neuro checks documented for the resident on 8/5/24. Several attempts were made to obtain CR #1's neuro checks for 8/5/24 but were unsuccessful. Record review of progress notes on 8/5/25 entered at 9:44 am, by RN A read in part . at approximately 09:30 CNA A notified me that CR#1 had a fall and was on the floor. I began assessing the patient B/P 149/99, p 100, temp 97.3, 02 98% via trach. Patient had a 2 in laceration above left eyebrow. Neuro checks initiated, NP was notified of patient's condition and ordered a STAT CT scan post fall. Patient was transported to hospital. Patient left the facility at approximately 11:48am . Record review of the facility's investigation documents revealed a handwritten and signed statement from CNA A, dated 08/05/24. CNA A wrote, To whom it may concern .I was in the room with CR#1 this morning giving him a bed bath. He was on his left side. I was trying to pull him on his back, and he went over and fell out of the bed. I try to catch him but in the process I fell down. Record review of CNA A's timesheets for 08/01/2024-09/01/2024 revealed CNA A worked 9.25 hours on 08/05/2024, 8 hours on 08/06/2024 , 0 hours 08/07/2024-08/10/2024 and 8.5 hours on 08/11/2024. Telephone interview on 1/24/25 at 3:14 pm with CNA A, she said she worked with CR#1 often. CNA A said CR#1 was a two-person assist, total care, and non-verbal. She said at the time of the alleged incident the other aide was busy, and she thought she could handle giving the resident a bed bath by herself. She said she took the draw sheet on the left side of the resident's bed and when she tried to push him over on his side, the resident rolled off his bed onto the floor. She said CR#1 rolled out of his bed and fell because he was on the edge of his bed. She said she tried to get on the other side of the bed to catch him but in the process, she fell on the floor as she was trying to catch him. She said she immediately began calling for help from the door of the resident's room. She said the wound care nurse and the restorative aide came in the room to assist with the situation. She said did not know everything that was done for the resident after he fell , but knew he ended up being sent to the hospital. She said she knew she was supposed to have assistance from a second person with CR#1 but believed she could handle the bed bath on her own. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview on 1/24/25 at 6:34 pm with the Administrator, she said the alleged incident was reported to HHSC by the former Administrator. She said she was not aware of the circumstances of the alleged incident. She said she was familiar with the resident and based on his size alone, for the safety of both the aide and the resident, the aide should have known better. She said all CNAs were trained on providing 2-person assists. She said if the incident had occurred while she was the administrator, she would have suspended CNA A and potentially terminated her . She said the risk could have caused a decline in the CR #1's health, or worse, death. Interview on 1/25/25 at 3:47 pm with RN A, she said she was working the day CR#1 had his fall. She said CNA A knew CR#1 was a 2-person assist. RN A said the risk to the resident with not performing a 2-person assist with CR #1 was he could have suffered from internal injuries. RN A said she assessed CR#1 when he was on the floor. She said CR #1 had one facial expression as his baseline, he was not able to communicate, and his pupils were always dilated because he had a head injury. She said CR#1 was lying on his right side and it looked like he hit his head at the base of the feeding pump pole because his eyebrow was touching the leg of the pole. RN A said CR#1 had a cut on his eyebrow which was bleeding. She said the resident's injury was small enough to have a butterfly bandage placed over the cut. RN A said she took vitals, and all vitals were within CR#1's baseline. RN A said she notified the resident's NP, DON, and unit manager. She said she texted the NP regarding the resident's fall, and the NP texted back almost immediately. She said the NP ordered a CT scan for the resident. RN A said she conducted neuro checks on CR#1 every 15 minutes the first hour after his fall and did 1 30-minute check the second hour because the resident was transported to the ER. RN A said there was a book that contained nursing documentation and should have the neuro checks. She said once the book was filled it got moved. Interview on 1/24/25 at 6:34 pm with the ADON, she said she was working the day of the alleged incident with CR#1. She was a unit manager at the time. She said she was working a different hall, so she did not know anything about what took place before or after the resident fell . She said she became aware of the incident that day because CR#1's assigned nurse, RN A, came and told her the resident fell . She said she could not remember the details RN A gave her. She said she could not remember what time of day the incident occurred or the time of day when she spoke with RN A. She said she did not know how the resident fell or what care was provided to the resident afterwards. She said all CNA's had been trained on doing 2-person assists. She said if CNA A knew CR#1 required 2-person assist for a bed bath, she should have waited until a second person was available to give the bath. She said not providing residents with adequate assistance put them at high risk but could not say exactly what the potential outcomes would be. Interview with the Nurse Practitioner on 1/27/25 at 3:57 pm she said according to her notes on 8/5/24, she was notified that CR #1 had a witnessed fall. The Nurse Practitioner said she arrived at the facility shortly after the fall. She said on her documentation, CR #1 had a scratch on the left eyebrow. The Nurse Practitioner said because CR #1 did not have hematoma or bruising, the facility did not have to call 911. She said she would have to look through her records to verify whether the resident was on an anticoagulant on 8/5/24, said she recalled getting notified and ordering a CT scan for the resident. The Nurse Practitioner could not recall if she specified the order for the CT scan as a STAT order . Said even if it was a STAT order, depending on the resident, the need for emergency medical treatment or calling 911 was subjective. The incident took place five months ago, she saw a lot of patients and could not recall the details for this specific resident. She said she could not make a determination on whether the facility should have called 911 for CR#1 on 8/5/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Several attempts were made to obtain the CT scan results from the hospital before exiting the facility but were unsuccessful. Telephone interview with CNA A on 01/27/25 at 1:48 PM, she said she was suspended from work for 3 days due to the incident with CR#1. She said she was also in-serviced on the electronic system to access resident care plans, abuse and neglect, 2-person assists and total care residents. Record review of the facility's policy on Transfers/Lifts dated 1/2024 read in part . to ensure the safety, dignity, and well-being of residents during transfers and lifts . Hoyer lift- x2 staff members .