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	11/24/2025

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 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. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 (Resident #1) of 3 residents reviewed for resident rights. This failure could affect the resident who required assistance with her Activities of Daily Living (ADL) from facility staff by placing them at risk for social isolation, loss of dignity, and self-worth. - The facility failed to ensure Resident #1 was provided with personal grooming (changed brief and clean clothing) before her discharge to the hospital on [DATE]. This failure placed residents at risk for embarrassment, at risk of loss of dignity and a decrease in quality of life.The findings include: Record review of Resident #1's Face Sheet dated 10/17/2025 revealed a [AGE] year-old female who was admitted to the facility on [DATE] and discharged on 10/17/2025. Resident #1 had diagnoses included: End stage renal disease (inadequate kidneys function), acute kidney failure (condition where the kidneys suddenly lose their ability to filter waste products from the blood), protein-calorie malnutrition (inadequate food intake), hypertensive heart and chronic kidney disease without heart failure (damages the heart and kidneys, but the heart does not experience heart failure), cognitive communication deficit (difficulty with memory, problem solving, and speech), and aphasia (inability to speak). Record review of Resident #1's 10/09/2025 psychosocial evaluation reflected the residents had a Brief Interview for Mental Status (BIMS) score of 11 indicating the resident had moderate cognitive impairment. Record review of Resident #1's undated Care Plan reflected: FOCUS: ADL self-care performance deficit related to immobility. GOAL: Maintain current level of function through the review date. INTERVENTION/TASKS: Bathing/Showering: the resident had total dependency on 2 staff to provide bath/shower as necessary. Dressing: The resident required Partial/moderate assistance by 1 staff to dress. Record review of Resident #1's Progress Note dated 10/16/2025 at 01:10 a.m. reflected Resident #1 had a Change of Condition (critical labs) and was sent to the hospital, created by Registered Nurse (RN) A. During an interview on 10/17/2025 at 06:45 pm. Hospital RN A stated that Resident #1 had been admitted to the hospital with dirty clothes, dirty brief, unclean skin, and an odor. Hospital RN A stated it appeared that Resident #1's less than well appearance had contributed to the inadequate ADLs the resident received at the facility she had admitted from. She stated that the hospital staff had to changed Resident #1's out of her dirty clothes and soiled brief when the resident arrived at the hospital. During an observation on 10/20/2025 at 08:05 am. Resident #1 was observed in bed. The resident appeared clean and groomed with no odors. The resident had not aroused to voice or sound. During an observation on 10/20/2025 at 08:12 a.m. Hospital RN B stated that Resident #1 had been compliant with ADLs, but staff were performing 100% of care ADL care. Resident #1 had not been communitive or able to answer or respond to questions or commands and had been disoriented times 4 (refers to a state where an individual is not aware of four key aspects: person, place, time, and event). During an interview on 10/20/2025 at 11:41 a.m. Family A stated Resident #1's hair had to be cut off because the facility had not groomed the resident's hair and it had continuously become tangled and unmanageable. Family A stated that no formal complaint had been made with the facility. She stated that the issues were addressed with the on shift staff at the times of the occurrences (no specific days or times were provided). Family A stated that staff had to be asked for clean gowns to change Resident #1 out of dirty gowns at least 3x a week after observing the resident in soiled briefs, unbrushed and tangled hair, unbrushed teeth, and dirty gowns. During an interview on 10/21/2025 at 02:07 p.m. RN A stated that on 10/16/2025 at about 01:00 a.m. Resident #1 had been prepared to discharge to the hospital. She stated that a certified nurse aid (CNA) had been responsible for changing the resident's brief and clothing to ensure that the resident discharged in an appropriate manner to the hospital. RN A stated that she had not recalled who the CNA had been who changed the resident for discharge because she had been preparing the resident's face sheet and ensuring that the resident's heart vest had a charged battery. During an interview on 10/21/2025 at 03:08 p.m. CNA A stated she had worked on 10/15/2025 from 10 p.m. through 10/16/2025 at 6 a.m. She stated she had not assisted in preparing Resident #1 for discharge on the early morning hours of 10/16/2025. During an interview on 10/21/2025 at 03:16 p.m. CNA B stated she had worked on 10/15/2025 from 10 p.m. through 10/16/2025 at 6 a.m. and had not been aware of Resident #1's discharge to the hospital nor prepared the resident for discharge. During an interview on 10/21/2025 at 05:27 p.m. CNA C stated she had worked on 10/15/2025 from 10 p.m. through 10/16/2025 at

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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 - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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 0677 Level of Harm - Minimal harm or potential for actual harm 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 a resident who was unable to carry out activities of daily living (ADLs) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 1 of 3 residents (Resident #1) reviewed for ADLs. The facility failed to ensure Resident #1 was provided with personal grooming before her discharged to the hospital on [DATE]. This failure could place residents at risk for discomfort and dignity issues.Findings included: Record review of Resident #1's Face Sheet dated 10/17/2025 revealed a [AGE] year-old female who was admitted to the facility on [DATE] and discharged on 10/17/2025. Resident #1 had diagnoses included: Acute kidney failure (condition where the kidneys suddenly lose their ability to filter waste products from the blood), contusion (bruising) of right lower leg, End stage renal disease (inadequate kidneys function), hypertensive heart and chronic kidney disease without heart failure (damages the heart and kidneys, but the heart does not experience heart failure), protein-calorie malnutrition (inadequate food intake), dysphagia (difficulty swallowing), cognitive communication deficit (difficulty with memory, problem solving, and speech), and aphasia (inability to speak). Record review of Resident #1's psychosocial evaluation dated 10/09/2025 reflected the residents had a Brief Interview for Mental Status (BIMS) score of 11 indicating the resident had moderate cognitive impairment. Record review of Resident #1's undated Care Plan reflected: FOCUS: The resident had an ADL self-care performance deficit related to immobility. GOAL: Resident will maintain current level of function in through the review date. INTERVENTION/TASKS: Bathing/Showering: the resident is totally dependent on 2 staff to provide bath/shower as necessary. Dressing: The resident requires Partial/moderate assistance by 1 staff to dress. FOCUS: The resident had oral/dental health problems. GOAL: Resident will remain free of infection, pain or bleeding in oral cavity by review date. INTERVENTION/TASKS: Administer medications as ordered. Monitor/document for side effects and effectiveness. Coordinate arrangements for dental care, transportation as needed/as ordered. Monitor/document/report as needed (PRN) any signs and symptoms (s/sx) of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, debris in mouth, lips cracked or bleeding, teeth missing, loose, broken eroded, decayed, tongue (black, coated, inflamed white, smooth), ulcers in mouth, lesions. Record review of Resident #1's Progress Note dated 10/16/2025 at 01:10 a.m. and created by RN A reflected Resident #1 had a Change of Condition (critical labs) and was sent to the hospital. During an observation on 10/20/2025 at 08:05 am. Resident #1 was observed in bed. The resident had not aroused to voice or sound. The resident appeared clean and groomed with no odors. During an interview on 10/17/2025 at 06:45 pm. Hospital Registered Nurse (RN) A stated that Resident #1 had been admitted to the hospital with a less than well appearance: dirty clothes, soiled brief, with unclean skin, and an odor. She stated the hospital staff had to change the resident's soiled brief and clothing immediately upon arriving at the hospital. She stated that it appeared that Resident #1 had not been receiving inadequate ADLs at the facility she had arrived from. During an observation on 10/20/2025 at 08:12 a.m. Hospital RN B stated that Resident #1 had not been communitive or able to answer or respond to questions or commands and had been disoriented times 4 refers to a state where an individual is not aware of four key aspects: person, place, time, and event). Hospital RN B stated Resident #1 had been compliant with ADLs, but staff were performing 100% of care. During an interview on 10/20/2025 at 11:41 a.m. Family A stated since Resident #1 had been admitted , observations had been made at least 3 times a week (no specific days or times were provided) where resident had been uncleaned in soiled briefs, unbrushed and tangle hair, unbrushed teeth, and stained/dirty gowns. Family A stated that staff had to be asked for clean gowns to change Resident #1 and change soiled briefs. Family A stated Resident #1's hair had to be cut off because the facility had not groomed the resident's hair. Family A stated that she had not made a formal complaint, only addressed the issue with the staff on shift at the times. During an interview on 10/21/2025 at 2:07 p.m. RN A stated that on 10/16/2025 at or about 01:00 a.m. she prepared Resident #1 to discharge to the hospital. She stated a certified nurse aid (CNA) changed the resident's brief and put on appropriate clothes for the hospital. RN A stated that she had not recalled who the CNA had been who changed the resident's brief and clothing because she had been preparing printing the resident's face sheet and ensuring that the resident's heart vest had a charged battery. During an interview on 10/21/2025 at 3:08 p.m. CNA A stated she had worked on 10/15/2025 from 10 p.m. through 10/16/2025 at 6 a.m. She stated she had been aware that Resident #1 had a change of condition and had been sent out to the hospital, but CNA stated she had