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	03/28/2025

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 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** 47479 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. -MA J would have administered the incorrect dosage if not for Surveyor intervention. -Five medications for Resident #66 were not available. -The facility failed to ensure Midodrine (a blood pressure (BP) medication given to elevate hypotension (low blood pressure) was administered 17 times in March to Resident #96 as ordered on 12/01/2024 by the physician. -The facility failed to ensure Resident #72 was not administered insulin outside of the parameters. These failures could place residents at risk of not receiving desired therapeutic outcomes, increased side effects, or a decline in health. Findings included: Resident #66 Record review of the Admission Record for Resident #66 revealed he was [AGE] years old and was admitted to the facility on [DATE]. His diagnoses included, but were not limited to, major depressive disorder, muscle weakness, and hypertension (high blood pressure). Record review of the March 2025 Physician's Orders for Resident #66 revealed: Isosorbide Mononitrate ER [extended release] 24-hour 30 mg. Give one by mouth one time a day for hypertension. Duloxetine HCL [hydrochloride] Oral Capsule Delayed Release Particles 60 mg. Give one capsule by mouth in the morning for anxiety. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Amlodipine Besylate 10 mg give one tablet by mouth one time a day related to essential hypertension. Calcium + Vitamin D3 oral tablet 600 - 10 mg-mcg (Calcium Carbonate - Cholecalciferol) Give 1 tablet by mouth one time a day for calcium deficiency. Fenofibrate Oral tab 160 mg Give 1 tablet by mouth in the morning for cholesterol. Vitamin D (Ergocalciferol) oral capsule 50 mcg. Give 1 capsule by mouth in the morning for Vitamin D deficiency. Observation on 03/26/25 at 9:10 a.m. revealed MA J prepared to administer medications to Resident #66. LVN I was standing at her medication cart outside of Resident #66' room. Continued observation revealed MA J entered the room and retrieved Resident #66' blood pressure. It was 166 mmHg, and the pulse was 94. She informed LVN I, who said to give the medications. Continued observation revealed MA J returned to her cart and began dispensing medications for Resident #66. The following medications were not available: Eliquis 5 mg (1), Amlodipine 10 mg (1), Isosorbide mononitrate 30 mg (1), Duloxetine HCl 60 mg (1), Calcium 600 + Vitamin D (1), Fenofibrate 160 mg (1), and Vitamin D 50 mg (1). Observation on 03/27/25 at 9:44 a.m. revealed UM K brought 2 tablets of Eliquis 2.5 mg and 2 tablets of Amlodipine 5 mg. MA J placed 2 tablets of Eliquis 2.5 mg and 1 tablet of Amlodipine 5 mg in a med cup. The Surveyor asked MA J what dosage strength the Amlodipine tablet she dispensed was. MA J said It's a 10 mg. MA J closed the drawer of the med cart. The Surveyor asked MA J to look at the emptied Amlodipine blister package. MA J looked at the emptied blister package and said it was 5 mg. MA J then retrieved the other Amlodipine 5 mg tablet and added it to the med cup to complete the 10 mg dosage. MA J entered Resident #66' room and administered the medications. In an interview on 03/27/25 at 1:10 p.m., UM C said Resident #66' Isosorbide Mononitrate 30 mg tablets and Duloxetine HCl 60 mg tablets would not be delivered to the facility until the next day. Record review of Resident #66' March 2025 MAR revealed the resident did not receive the Isosorbide mononitrate 30 mg (1), Duloxetine HCl 60 mg (1), Calcium 600 + Vitamin D (1), Fenofibrate 160 mg (1), or the Vitamin D 50 mg (1) on 03/27/25. In an interview on 03/27/25 at 1:15 p.m. Resident #66 said no one has rechecked his BP since he received his morning medications. At that time LVN I checked Resident #66' BP: 150/94 mmHg and pulse: 103 bpm. In an interview on 03/27/25 at 2:50 p.m. the DON said the medication cards had a blue area on them to indicate when the medication was to be reordered. She said the MA could reorder the medications on the computer program. She said she was not made aware of Resident #66' situation. In an interview on 03/27/25 at 2:55 p.m. UM C said she just called the Nurse Practitioner but has not heard back. She said she rechecked Resident #66' BP, and it was 137/91 mmHg. In an interview on 03/27/25 at 3:00 p.m. the DON said the staff should have rechecked Resident #66' BP 30 minutes after the morning medication administration. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #96 Record review of Resident #96's admission face sheet, undated, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included: traumatic subdural hemorrhage (a type of bleeding near the brain), hypertension (high blood pressure), cognitive communication deficit (disruption in communication due to underlying cognitive difficulties causes may include brain injury or stroke). Record review of Resident #96's Annual Minimum Data Set (MDS) dated [DATE] reflected the resident's Brief Interview for Mental Status (BIMS- a score used to assess cognitive function) was not scored which indicated the resident was unable to complete the interview. The resident's skills for daily decision making was score at three which indicated the resident's decision making was severely impaired. The MDS identified Resident #96's active diagnosis was medically complex conditions. Record review of Resident #96's care plan initiated 03/22/2024, revision updated 01/15/2025, reflected: Focus: The resident had a history of hypertension. The resident was at risk for fluctuation in blood pressure values, hypertension, hypotension (low blood pressure) and other complications. Goal: The resident's blood pressure would stay within normal limits. The resident would not have signs or symptoms of hypertension or hypotension. Interventions: Give medications as ordered Record review of Resident #96's order summary report, active orders dated as of 03/26/2025, revealed, Midodrine 10 mg give one tablet by G-tube (A tube through the skin into the stomach to deliver nutrition and medications) three times a day for hypotension. Hold if SBP (systolic blood pressure; the top blood pressure reading from the pressure in the arteries when the heart beats) > (greater than) 110. Order dated 12/01/2024. Record review of Resident #96's March 2025 Medication Administration Record (MAR) dated 03/01/2025 -03/31/2025 reflected, the resident was administered Midodrine 10 mg outside of the physician set parameter of SBP over 110 on: 03/03/2025 at 1:00 PM with BP 118/77 by RN A 03/03/2025 at 9:00 PM with BP 112/66 by LVN B 03/07/2025 at 9:00 AM with BP 119/71 and at 1:00 PM with BP 122/68 by RN A 03/09/2025 at 9:00 PM with BP 112/59 by LVN B 03/12/2025 at 1:00 PM with BP 111/65 by RN A 03/13/2025 at 1:00 PM with BP 122/67 by RN A 03/17/2025 at 1:00 PM with BP 115/62 by RN A (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	03/18/25 at 1:00 PM with BP 112/67 by RN A 03/21/2025 at 9:00 AM with BP 113/62 and at 1:00 PM with BP 119/61 by RN A 03/21/2025 at 9:00 PM with BP 118/77 by LVN B 03/22/2025 at 9:00 AM with BP 122/67 and at 1:00 PM with BP 111/61 by RN A 03/23/2025 at 9:00 AM with BP 113/67 by RN A 03/25/2025 at 1:00 PM with BP 115/78 by RN A In an interview on 03/26/2025 at 08:40 AM with Resident #96's NP she stated the reason for putting the parameter on the resident's SBP was to keep the Midodrine from being administered over a certain BP reading. The purpose of the medication was to elevate the BP when it was too low. The parameter was to prevent the resident's BP from going to go too high. The NP stated the resident was stable at 110. The resident had chronic low BP and was not at risk for adverse effects. The NP stated the resident was not at risk for hypertension. To prevent the medication from being administered outside parameters again she would change the SBP parameter to 130. In an observation on 03/26/2025 at 9:30 AM revealed Resident #96 was in bed with the head of her bed elevated. In a phone interview on 03/26/2025 at 9:50 AM RN A stated when she gave BP medications, she checked the BP to make sure it was alright to give. RN A stated Resident #96 was consistently low, so she gave the Midodrine to help make the BP go higher. RN A stated she would not have given the medications if the BP was over the ordered parameter. RN A stated she was not sure why she would have given it if the BP was high. In an interview with the DON and record review of the MAR on 03/26/2025 at 10:18 AM the DON stated the initials on the MAR did belong to RN A and the medication was administered. The DON stated according to the physician's order the SBP was over 110 and the medication should have been held not given. The DON stated it was given according to the MAR documentation. The DON stated she did not know why that happened. The DON stated the risk of giving the medication was it could cause hypertension. The DON stated she would begin in-servicing immediately on administering BP meds to prevent this again. In a phone interview on 03/26/2025 at 10:27 AM LVN B stated the Midodrine was not to be given if the resident's BP was over 110 systolic and he would not have given it. LVN B stated she did not know why it was given because the risk was high blood pressure. In a phone interview on 03/26/2025 at 11:27 AM the facility Pharmacist stated Midodrine was to be given for low BP to cause the BP to elevate. The Pharmacist stated the physician ordered the parameter so the resident's BP would remain in a specific set range. He stated the risk of administering the medication when the BP was above the parameter was a result of the BP being too high. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Administrator and record review of the MAR at 03/26/2025 at 2:25 PM the Administrator stated clearly the parameter was not followed. He stated the risk was hypertension. To prevent medication from being given outside parameters again they were training the staff on medication administration. He stated they were looking at ways to highlight the parameter on the MAR for it to show better. In an interview on 03/27/2025 at 11:59 AM Unit Manager LVN C stated new nurses were trained on the unit they were hired to work on along with a trainer. The training reviewed looking at the entire order, knowing the greater than and lesser than sign. LVN C stated when a BP was outside the ordered parameter the medication was to be held. The nurse was to document it was held and why it was held such as outside ordered parameters. The risk of giving this medication was resulting in the BP going too high. LVN C stated the expectations were medications were given as ordered and document accordingly. During a follow up interview on 03/28/2025 at 9:11 AM the DON stated the unit managers were responsible for monitoring the medications were administered according to the physician's order and all medications were available daily. The DON stated the administrative team had met with the Medical Director on how to better monitor and following the MAR. Resident #72 Record review of Resident #72's undated, face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included: Type 2 Diabetes Mellitus (long term condition in which the body has trouble controlling blood), metabolic encephalopathy (Condition where the brain does not receive enough nutrients or oxygen to function properly), and chronic kidney disease, stage 3 (moderate kidney damage and loss of kidney function). Record review of Resident #72's Admission MDS assessment dated [DATE] revealed a BIMS summary score of 13, indicating the resident was cognitively intact. Record review of Resident #72's Care Plan dated 01/26/25 indicated he had a diagnosis of Diabetes Mellitus. Interventions were to give diabetes medications per order, and monitor/document for side effects and effectiveness. Record review of Resident #72's MD order on 03/26/25 revealed orders for: Insulin Glargine Solution100 UNIT/ML Inject 22 unit subcutaneously one time a day for Diabetes, hold if BS less than 120, order date 01/13/2025. Record review of Resident #72's MAR for February 2025 revealed LVN H administered 22 units of Insulin Glargine 100 UNIT/ML on 02/12/25 with a blood sugar reading of 98. Record review of Resident #72's MAR for March 2025 revealed LVN L administered 22 units of Insulin Glargine 100 UNIT/ML on 03/11/25 with a blood sugar reading of 65. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/26/25 at 1:39 PM Resident #72 said last month his BS went too low and he had to eat candy to bring it back up. He said that had happened once since at the facility and denied it being a regular occurrence. He said he knew when his BS was too low or too high. He denied S/S from BS being too high or the need for emergency medication or hospitalization since being admitted to the facility. In a telephone interview on 03/27/25 at 11:48 AM LVN L said she gave the resident food before administering his insulin on 03/11/25. She said she checked Resident #72's blood sugar after he ate but did not record it in the EMR. She said the risk of administering insulin out of parameters set by the MD could place Resident #72 at risk for hypoglycemia (blood sugar levels below the standard range), which could lead to coma or death. In an interview on 03/27/25 at 12: 38 PM LVN C, (unit manager) for 100 and 200 halls revealed medication administration training was conducted with a preceptor to include a check-off. He said the nurses were trained to hold insulin if the BS was not within the parameters per the MD orders. LVN C said the risk of not administering Insulin as ordered or administering too much insulin could cause hypoglycemia or hyperglycemia (blood sugar levels above the standard range), which could result in an adverse reaction or death. In an interview on 03/27/25 at 1:06 PM the ADON said if a resident's blood sugar was outside parameters, the staff should notify the MD, RP and document all interventions. She said the nurse should not give insulin outside of the MD orders because it could place the resident at risk of hypoglycemia or hyperglycemia, which could lead to possible hospitalization . In an Interview on 03/27/25 at 1:19 PM the DON said her expectations were for the nursing staff to read the resident's BS parameters and follow the MD orders. The risk of giving insulin outside the parameters could lead to hospitalization coma and/or death. The DON said if a resident had an elevated or low BS, the staff should immediately notify the MD and follow the MD orders. The DON said hypoglycemia or hyperglycemia could lead to hospitalization or death. An attempt to interview LVN H on 03/27/25 at 1:46 PM was unsuccessful. A voicemail message was provided. In an Interview on 03/27/25 at 6:00 PM the Administrator said the staff needed follow the physician's orders. He said the staff should document and notify the physician if the BS was outside the parameters. He said the risk of administering insulin outside of the physician's orders could lead to a potentially negative outcome. In a telephone interview on 03/27/25 at 6:15PM LVN H said she had on-boarding training on medication administration. She said Resident #72's blood sugar ran high and denied giving him medication when his blood sugar was recorded at 98. She denied that Resident #72 received intervention for S/S of hypoglycemia after the administration of insulin on 02/12/25. LVN H said the risk of administering medication outside of the parameters could lead to hospitalization or death. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Medication Administration and Management policy revised 6/2019 reflected in part, .3. The authorized licensed or certified/permitted medication aide or by state regulatory guidelines staff member follows the MAR prepared for the patient/resident by identifying the: A. The Right Patient/resident, B The Right Drug, C. The Right Dose, D. The Right Time, E. The Right Route, F. The Right Charting, G. The Right Results, H. The Right Reason. 11. The authorized staff member administers SQ, IM, Intradermal medications as follows: A. Review physicians orders. B. Follow 8 Rights of Medication administration . The facility policy Medication Administration and Management (revised June 2019) revealed in part, .9. Medications are administered no more than one (1) hour before or one (1) hour after the designated medication pass time.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47479 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was not 5 percent or greater. The facility had a medication error rate of 16% based on 6 errors for 37 opportunities. Surveyor intervention was required to prevent one MA from administering the incorrect dose of a blood pressure medication. The errors effected 1 resident (Resident #66) of 6 residents reviewed for medication administration. -MA J would have administered the incorrect dosage if not for Surveyor intervention. -Five medications for Resident #66 were not available: Isosorbide Mononitrate (for blood pressure), Duloxetine HCl for (for depression), Calcium 600 + Vitamin D, Fenofibrate (for cholesterol), and Vitamin D. The medications were not administered on 03/27/25. The failures placed resident at risk for inadequate therapeutic outcomes and a decline in health. Findings included: Record review of the Admission Record for Resident #66 revealed he was [AGE] years old and was admitted to the facility on [DATE]. His diagnoses included, but were not limited to, major depressive disorder, muscle weakness, and hypertension (high blood pressure). Record review of the March 2025 Physician's Orders for Resident #66 revealed: Isosorbide Mononitrate ER [extended release] 24-hour 30 mg. Give one by mouth one time a day for hypertension. Duloxetine HCL [hydrochloride] Oral Capsule Delayed Release Particles 60 mg. Give one capsule by mouth in the morning for anxiety. Amlodipine Besylate 10 mg give one tablet by mouth one time a day related to essential hypertension. Calcium + Vitamin D3 oral tablet 600 - 10 mg-mcg (Calcium Carbonate - Cholecalciferol) Give 1 tablet by mouth one time a day for calcium deficiency. Fenofibrate Oral tab 160 mg Give 1 tablet by mouth in the morning for cholesterol. Vitamin D (Ergocalciferol) oral capsule 50 mcg. Give 1 capsule by mouth in the morning for Vitamin D deficiency. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/26/25 at 9:10 a.m. revealed MA J prepared to administer medications to Resident #66. LVN I was standing at her medication cart outside of Resident #66' room. Continued observation revealed MA J entered the room and retrieved Resident #66' blood pressure. It was 166 mmHg, and the pulse was 94. She informed LVN I, who said to give the medications. Continued observation revealed MA J returned to her cart and began dispensing medications for Resident #66. The following medications were not available: Eliquis 5 mg (1), Amlodipine 10 mg (1), Isosorbide mononitrate 30 mg (1), Duloxetine HCl 60 mg (1), Calcium 600 + Vitamin D (1), Fenofibrate 160 mg (1), and Vitamin D 50 mg (1). Observation on 03/27/25 at 9:44 a.m. revealed UM K brought 2 tablets of Eliquis 2.5 mg and 2 tablets of Amlodipine 5 mg. MA J placed 2 tablets of Eliquis 2.5 mg and 1 tablet of Amlodipine 5 mg in a med cup. The Surveyor asked MA J what dosage strength the Amlodipine tablet she dispensed was. MA J said It's a 10 mg. MA J closed the drawer of the med cart. The Surveyor asked MA J to look at the emptied Amlodipine blister package. MA J looked at the emptied blister package and said it was 5 mg. MA J then retrieved the other Amlodipine 5 mg tablet and added it to the med cup to complete the 10 mg dosage. MA J entered Resident #66' room and administered the medications. In an interview on 03/27/25 at 1:10 p.m., UM C said Resident #66' Isosorbide Mononitrate 30 mg tablets and Duloxetine HCl 60 mg tablets would not be delivered to the facility until the next day. Record review of Resident #66' March 2025 MAR revealed the resident did not receive the Isosorbide mononitrate 30 mg (1), Duloxetine HCl 60 mg (1), Calcium 600 + Vitamin D (1), Fenofibrate 160 mg (1), or the Vitamin D 50 mg (1) on 03/27/25. In an interview on 03/27/25 at 1:15 p.m. Resident #66 said no one has rechecked his BP since he received his morning medications. At that time LVN I checked Resident #66' BP: 150/94 mmHg and pulse: 103 bpm. In an interview on 03/27/25 at 2:50 p.m. the DON said the medication cards had a blue area on them to indicate when the medication was to be reordered. She said the MA could reorder the medications on the computer program. She said she was not made aware of Resident #66' situation. In an interview on 03/27/25 at 2:55 p.m. UM C said she just called the Nurse Practitioner but has not heard back. She said she rechecked Resident #66' BP, and it was 137/91 mmHg. In an interview on 03/27/25 at 3:00 p.m. the DON said the staff should have rechecked Resident #66' BP 30 minutes after the morning medication administration. The facility policy Medication Administration and Management (revised June 2019) revealed in part, .9. Medications are administered no more than one (1) hour before or one (1) hour after the designated medication pass time.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47479 Based on observations, interviews and record review, the facility failed to ensure residents were free from significant medication errors for 2 of 41 residents (Residents #'s 96 and Resident #72) reviewed for significant medication errors. 1. The facility failed to ensure Midodrine (a blood pressure (BP) medication given to elevate hypotension (low blood pressure) was administered 17 times in March to Resident #96 as ordered on 12/01/2024 by the physician. 2. The facility failed to ensure Resident #72 was not administered insulin outside of the parameters. These failures could place residents at risk of not receiving desired therapeutic outcomes, increased side effects, or a decline in health. Findings included: 1.Record review of Resident #96's admission face sheet, undated, reflected a [AGE] year-old female admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included: traumatic subdural hemorrhage (a type of bleeding near the brain), hypertension (high blood pressure), cognitive communication deficit (disruption in communication due to underlying cognitive difficulties causes may include brain injury or stroke). Record review of Resident #96's Annual Minimum Data Set (MDS) dated [DATE] reflected the resident's Brief Interview for Mental Status (BIMS- a score used to assess cognitive function) was not scored which indicated the resident was unable to complete the interview. The resident's skills for daily decision making was score at three which indicated the resident's decision making was severely impaired. The MDS identified Resident #96's active diagnosis was medically complex conditions. Record review of Resident #96's care plan initiated 03/22/2024, revision updated 01/15/2025, reflected: Focus: The resident had a history of hypertension. The resident was at risk for fluctuation in blood pressure values, hypertension, hypotension (low blood pressure) and other complications. Goal: The resident's blood pressure would stay within normal limits. The resident would not have signs or symptoms of hypertension or hypotension. Interventions: Give medications as ordered Record review of Resident #96's order summary report, active orders dated as of 03/26/2025, revealed, Midodrine 10 mg give one tablet by G-tube (A tube through the skin into the stomach to deliver nutrition and medications) three times a day for hypotension. Hold if SBP (systolic blood pressure; the top blood pressure reading from the pressure in the arteries when the heart beats) > (greater than) 110. Order dated 12/01/2024. (continued on next page)

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	675612	A. Building B. Wing	03/28/2025

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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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #96's March 2025 Medication Administration Record (MAR) dated 03/01/2025 -03/31/2025 reflected, the resident was administered Midodrine 10 mg outside of the physician set parameter of SBP over 110 on: 03/03/2025 at 1:00 PM with BP 118/77 by RN A 03/03/2025 at 9:00 PM with BP 112/66 by LVN B 03/07/2025 at 9:00 AM with BP 119/71 and at 1:00 PM with BP 122/68 by RN A 03/09/2025 at 9:00 PM with BP 112/59 by LVN B 03/12/2025 at 1:00 PM with BP 111/65 by RN A 03/13/2025 at 1:00 PM with BP 122/67 by RN A 03/17/2025 at 1:00 PM with BP 115/62 by RN A 03/18/25 at 1:00 PM with BP 112/67 by RN A 03/21/2025 at 9:00 AM with BP 113/62 and at 1:00 PM with BP 119/61 by RN A 03/21/2025 at 9:00 PM with BP 118/77 by LVN B 03/22/2025 at 9:00 AM with BP 122/67 and at 1:00 PM with BP 111/61 by RN A 03/23/2025 at 9:00 AM with BP 113/67 by RN A 03/25/2025 at 1:00 PM with BP 115/78 by RN A In an interview on 03/26/2025 at 08:40 AM with Resident #96's NP she stated the reason for putting the parameter on the resident's SBP was to keep the Midodrine from being administered over a certain BP reading. The purpose of the medication was to elevate the BP when it was too low. The parameter was to prevent the resident's BP from going to go too high. The NP stated the resident was stable at 110. The resident had chronic low BP and was not at risk for adverse effects. The NP stated the resident was not at risk for hypertension. To prevent the medication from being administered outside parameters again she would change the SBP parameter to 130. In an observation on 03/26/2025 at 9:30 AM revealed Resident #96 was in bed with the head of her bed elevated. In a phone interview on 03/26/2025 at 9:50 AM RN A stated when she gave BP medications, she checked the BP to make sure it was alright to give. RN A stated Resident #96 was consistently low, so she gave the Midodrine to help make the BP go higher. RN A stated she would not have given the medications if the BP was over the ordered parameter. RN A stated she was not sure why she would have given it if the BP was high. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the DON and record review of the MAR on 03/26/2025 at 10:18 AM the DON stated the initials on the MAR did belong to RN A and the medication was administered. The DON stated according to the physician's order the SBP was over 110 and the medication should have been held not given. The DON stated it was given according to the MAR documentation. The DON stated she did not know why that happened. The DON stated the risk of giving the medication was it could cause hypertension. The DON stated she would begin in-servicing immediately on administering BP meds to prevent this again. In a phone interview on 03/26/2025 at 10:27 AM LVN B stated the Midodrine was not to be given if the resident's BP was over 110 systolic and he would not have given it. LVN B stated she did not know why it was given because the risk was high blood pressure. In a phone interview on 03/26/2025 at 11:27 AM the facility Pharmacist stated Midodrine was to be given for low BP to cause the BP to elevate. The Pharmacist stated the physician ordered the parameter so the resident's BP would remain in a specific set range. He stated the risk of administering the medication when the BP was above the parameter was a result of the BP being too high. In an interview with the Administrator and record review of the MAR at 03/26/2025 at 2:25 PM the Administrator stated clearly the parameter was not followed. He stated the risk was hypertension. To prevent medication from being given outside parameters again they were training the staff on medication administration. He stated they were looking at ways to highlight the parameter on the MAR for it to show better. In an interview on 03/27/2025 at 11:59 AM Unit Manager LVN C stated new nurses were trained on the unit they were hired to work on along with a trainer. The training reviewed looking at the entire order, knowing the greater than and lesser than sign. LVN C stated when a BP was outside the ordered parameter the medication was to be held. The nurse was to document it was held and why it was held such as outside ordered parameters. The risk of giving this medication was resulting in the BP going too high. LVN C stated the expectations were medications were given as ordered and document accordingly. During a follow up interview on 03/28/2025 at 9:11 AM the DON stated the unit managers were responsible for monitoring the medications were administered according to the physician's order and all medications were available daily. The DON stated the administrative team had met with the Medical Director on how to better monitor and following the MAR. 2. Record review of Resident #72's undated, face sheet reflected a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included: Type 2 Diabetes Mellitus (long term condition in which the body has trouble controlling blood), metabolic encephalopathy (Condition where the brain does not receive enough nutrients or oxygen to function properly), and chronic kidney disease, stage 3 (moderate kidney damage and loss of kidney function). Record review of Resident #72's Admission MDS assessment dated [DATE] revealed a BIMS summary score of 13, indicating the resident was cognitively intact. Record review of Resident #72's Care Plan dated 01/26/25 indicated he had a diagnosis of Diabetes Mellitus. Interventions were to give diabetes medications per order, and monitor/document for side effects and effectiveness. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #72's MD order on 03/26/25 revealed orders for: Insulin Glargine Solution100 UNIT/ML Inject 22 unit subcutaneously one time a day for Diabetes, hold if BS less than 120, order date 01/13/2025. Record review of Resident #72's MAR for February 2025 revealed LVN H administered 22 units of Insulin Glargine 100 UNIT/ML on 02/12/25 with a blood sugar reading of 98. Record review of Resident #72's MAR for March 2025 revealed LVN L administered 22 units of Insulin Glargine 100 UNIT/ML on 03/11/25 with a blood sugar reading of 65. In an interview on 03/26/25 at 1:39 PM Resident #72 said last month his BS went too low and he had to eat candy to bring it back up. He said that had happened once since at the facility and denied it being a regular occurrence. He said he knew when his BS was too low or too high. He denied S/S from BS being too high or the need for emergency medication or hospitalization since being admitted to the facility. In a telephone interview on 03/27/25 at 11:48 AM LVN L said she gave the resident food before administering his insulin on 03/11/25. She said she checked Resident #72's blood sugar after he ate but did not record it in the EMR. She said the risk of administering insulin out of parameters set by the MD could place Resident #72 at risk for hypoglycemia (blood sugar levels below the standard range), which could lead to coma or death. In an interview on 03/27/25 at 12: 38 PM LVN C, (unit manager) for 100 and 200 halls revealed medication administration training was conducted with a preceptor to include a check-off. He said the nurses were trained to hold insulin if the BS was not within the parameters per the MD orders. LVN C said the risk of not administering Insulin as ordered or administering too much insulin could cause hypoglycemia or hyperglycemia (blood sugar levels above the standard range), which could result in an adverse reaction or death. In an interview on 03/27/25 at 1:06 PM the ADON said if a resident's blood sugar was outside parameters, the staff should notify the MD, RP and document all interventions. She said the nurse should not give insulin outside of the MD orders because it could place the resident at risk of hypoglycemia or hyperglycemia, which could lead to possible hospitalization . In an Interview on 03/27/25 at 1:19 PM the DON said her expectations were for the nursing staff to read the resident's BS parameters and follow the MD orders. The risk of giving insulin outside the parameters could lead to hospitalization coma and/or death. The DON said if a resident had an elevated or low BS, the staff should immediately notify the MD and follow the MD orders. The DON said hypoglycemia or hyperglycemia could lead to hospitalization or death. An attempt to interview LVN H on 03/27/25 at 1:46 PM was unsuccessful. A voicemail message was provided. In an Interview on 03/27/25 at 6:00 PM the Administrator said the staff needed follow the physician's orders. He said the staff should document and notify the physician if the BS was outside the parameters. He said the risk of administering insulin outside of the physician's orders could lead to a potentially negative outcome. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a telephone interview on 03/27/25 at 6:15PM LVN H said she had on-boarding training on medication administration. She said Resident #72's blood sugar ran high and denied giving him medication when his blood sugar was recorded at 98. She denied that Resident #72 received intervention for S/S of hypoglycemia after the administration of insulin on 02/12/25. LVN H said the risk of administering medication outside of the parameters could lead to hospitalization or death. Record review of the facility's Medication Administration and Management policy revised 6/2019 reflected in part, .3. The authorized licensed or certified/permitted medication aide or by state regulatory guidelines staff member follows the MAR prepared for the patient/resident by identifying the: A. The Right Patient/resident, B The Right Drug, C. The Right Dose, D. The Right Time, E. The Right Route, F. The Right Charting, G. The Right Results, H. The Right Reason. 11. The authorized staff member administers SQ, IM, Intradermal medications as follows: A. Review physicians orders. B. Follow 8 Rights of Medication administration .

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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. 47479 Based on observation and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for food procurement. 1. The facility failed to ensure foods were labeled and dated. 2. The facility failed to ensure that all kitchen staff were wearing a beard guard. 3. The facility failed to ensure food was safely stored in designated areas at all times. These failures could place residents who ate food from the kitchen at risk of food borne illness and disease. Findings Included: Observation on 03/25/25 at 8:15 AM during the kitchen tour with the Dietary Manager revealed the following: 1. There was 1 bag of shredded cheddar cheese in the refrigerator that was open but not dated . 2. There was a 50-pound bag of flour in the kitchen's dry storage room that was not properly sealed . In an interview on 03/25/25 at 10:52 AM the Dietary Manager said food should be dated and sealed. She said the flour that she had been using was sealed in a container and the flour observed was just the extra flour that was leftover and not properly sealed. She said the risk of not properly sealing the flour could lead to insects in the flour which could lead to foodborne illnesses. Observation on 03/26/25 at 11:53 AM revealed [NAME] A not wearing a beard guard while in the kitchen. He was prepping to make mashed potatoes. In an interview on 03/26/25 at 11:59 AM the Dietary Manager said everyone with facial hair should wear a beard guard. She said the risk was hair could fall in the food, which could cause food borne illness. In an interview on 03/27/25 at 3:31 PM [NAME] A said he was supposed to wear a beard guard prior to entering the kitchen. He said the risk of not wearing a beard guard could lead to food contamination. In an interview on 03/27/25 at 3:35 PM [NAME] B said all staff with facial hair should have a beard guard. He said the last in-service on beard guards was approximately 2 weeks ago. He said the risk of not wearing a beard guard was hair could drop in the food and cause a food illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/28/25 at 10:27 AM the Administrator said his expectations was for all kitchen personnel to wear beard guards when in the kitchen. He said he had address beard guards previously, and the staff had been in-services on both beard guards and appropriated storage and labeling. The surveyor requested policy on 03/28/25 on beard guards, but the policy was not received prior to exit. Record review of the Food and Drug Administration Food Code Policy, dated 2022, read in part, .Section 2-402 Hair Restraints 2-402.11 Effectiveness.(B) FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 47479 Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly for 1 of 1 garbage dumpsters reviewed for disposal of garbage. The facility failed to ensure 1 of 1 dumpster lid was secured. This failure could place residents at risk for exposure to germs and diseases carried by vermin and rodents. Finding included: Observation on 03/25/25 at 8:19 AM of the facility's dumpster location revealed the dumpster lid was open with debris on the outside of the dumpster. Interview on 03/27/25 at 10:52 AM with the Dietary Manager , she said she had worked at the facility for 8 months. She said the entire facility used the dumpster, but she knew the kitchen staff were responsible for making sure the dumpster lids were closed. She said some of the staff had a hard time closing the lid on the dumpster. The Dietary Manager said they had to use a stick to open and close the dumpster lid. The Dietary Manager said if the lids were left open it could attract more rodents. Interview on 03/27/25 at 3:31PM with [NAME] A, who worked at the facility for 6 months, he said the dumpster should be always closed. He said the expectation was for the area around the dumpster to be cleaned and the dumpster lid to be closed at all times. He said rodents can get into the dumpster. Interview on 03/28/25 at 10:27 AM with the Administrator who said the dumpster should be closed. He said he was trying to get a new dumpster because it was hard to close. He said making sure the dumpster was closed had been discussed with staff on 03/17/25. He said the risk of having the dumpster open was rodents and vermin. Record review of the facility's Nutrition Services Policies and Procedures policy, revised 06/2019 revealed in part . Policy: Waste will be disposed of in a manner to prevent transmission of disease, nuisance or breeding place for insects and feeding places for rodents and other mammals. Procedure: 5 Cover waste containers and close dumpsters at all times .