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	05/30/2026

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for 2 of 3 residents (Resident #57 and Resident #91) reviewed for nutrition status. The facility failed to identify and verify significant weight loss for Resident #91 who lost 32.4 pounds in 27 days. The facility failed to provide dietary interventions for Resident #91's initially identified weight loss on 5/13/2026 (118.8lbs from 148.6 lbs.), until 5/27/2026. The facility failed to ensure Resident #57 had daily weights obtained per physician order. These failures could place residents at risk for compromised nutrition, decline in function and unplanned weight changes. Findings included: Resident #91 Record review of Resident #91's admission record, dated 05/29/2026, revealed a [AGE] year-old male, admitted [DATE], with the following diagnoses including chronic diastolic congestive heart failure (a condition where the heart muscle becomes stiff and cannot relax properly between heart beats causing a backup of blood into the body and lungs), chronic viral hepatitis C (long lasting persistent infection caused by the hepatitis C virus that targets the liver), and chronic obstructive pulmonary disease (a group of progressive long-term lung disease that cause obstructed airflow and make it difficult to breath). Record review of Resident #91's admission MDS assessment, dated 12/21/2025, revealed a BIMS score of 9 out of 15 indicating moderate cognitive impairment. Resident #57 Record review of Resident #57's admission record, dated 05/29/2026, revealed a [AGE] year-old female, admitted [DATE], with the following diagnoses including acute kidney failure (a sudden and rapid decline in kidney function that develops within hours or a few days), end stage renal disease 9the final most severe stage of chronic kidney disease and indicate the kidneys have lost 85% to 90% of their normal function and can no longer filter enough waste to keep a person alive), acute on chronic systolic congestive heart failure (describes a person with a longstanding history of heart failure[a condition where the heart muscle becomes stiff and cannot relax properly between heart beats causing a backup of blood into the body and lungs] who experience a sudden, severe worsening of their symptoms), moderate protein calorie malnutrition (a condition where a deficiency in macronutrients[protein and calories] causes measurable physical decline), and required hemodialysis (a life-sustaining medical procedure for people with kidney failure). Record review of Resident #57's admission MDS assessment, dated 05/07/2026, revealed a BIMS score of 10 out of 15 indicating moderate cognitive impairment and required set-up assistance with meals and could feed himself. During an interview and observation with Resident #91, on 5/26/26 at 11:15 a.m., he said he was supposed to have large portions with his meals, and he was not getting them. The resident stated he was hungry after meals and felt like he was not getting enough food. Resident #91 could not recall who he told when he was hungry. In an observation of Resident #91, he appeared thin, gaunt, and emaciated and his limbs appeared to be spindly. Resident #91 said he had no wounds, open sores or skin breakdown, and no wounds or skin issues were observed at that time. Resident #91 said he was given breakfast, lunch and dinner daily and also received snacks and beverages throughout each day. During an observation on 05/26/2026 at 12:54 pm of Resident (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 0692 Level of Harm - Actual harm Residents Affected - Few	#91's lunch meal tray revealed a regular portion of food and his meal ticket delivered with the meal revealed no note for large portions. The resident consumed 100% of the meal. Resident #91 did not complain of hunger at that time and did not request additional food. Record review on 05/26/2026 at 1:54 pm of Resident #91's physician orders revealed no order for large portions. Record review on 05/26/2026 at 2:10 pm of Resident #91's May 2026 weight log revealed Resident #91's weight was documented as 118.8lbs on 05/13/2026. Record review on 05/26/2026 at 3:57 pm of Resident #91's care plan revealed Resident #91 was at risk for malnutrition initiated on 01/05/2026 with a goal of Resident #91 will not experience an adverse effect of malnutrition through the review date and included the intervention to consult RD as indicated and intervene with any weight loss. Record review on 05/26/2026 at 2:15pm of Resident #57's May 2026 MAR-TAR revealed an order with a start date of 05/01/2026 to Monitor weight daily every, day shift, for fluid overload and there were no weights documented on 05/01/2026, 05/02/2026, 05/03/2026, 05/07/2026, 05/12/2026, 05/16/2026, 05/27/2026, 05/21/2026, 05/25/2026, 05/26/2026 or 05/28/2026. Continued record review revealed Resident #57's first weight recorded on 05/06/2026 as 126.2lbs and on 05/27/2026 as 115.7lbs. Record review on 05/26/2026 at 4:02 pm of Resident #57's care plan revealed Resident #57 was at risk for malnutrition/malnourished initiated on 05/21/2026 with a goal Resident #57 would not experience any adverse effects of malnutrition and interventions that included, weigh as indicated and document/intervene with any weight loss. Record review on 05/26/2026 at 4:22 pm of Resident #91's EMR revealed no RD notes since 01/28/2026 and revealed his BMI of 21.8 was low for his height and revealed a weight at that time of 143.6lbs. His meal intake revealed 75%-100% eaten at each meal. During an interview with RNA A on 5/27/26 at 2:20 pm, she said she weighed Resident #91 on 5/13/26 and reported the weight (118.9lbs.) to Unit Manager A. During an interview with Unit Manager A on 5/27/26 at 2:25pm, she stated that she had requested RNA A to reweigh Resident #91 via text message on 5/18/26 after reviewing the 5/13/26 weights RNA A had submitted. Unit Manager A said she requested a reweight for any resident who had significant weight changes to verify they were correct. She said she did not reweigh the residents herself because the RNAs were responsible for weighing residents. Unit Manager A said she did not follow up on Resident #91's weight after the text message on 5/18/26 and could not explain why. During an observation and interview of Resident #91 on 5/27/26 at 2:38pm he was reweighed by RNA A and RNA B via Hoyer scale. He was wearing a facility gown and incontinent brief, and his bony prominences were visible on his bilateral legs. Surveyor observed the digital weight screen which read 116.2 lbs. and RNA A stated oh, you've lost some more weight. Record review on 05/27/2026 at 2:55 pm of Resident #91's MD order summary revealed an order dated 5/27/26 for Dietician consult re-weight loss. Record review of Resident #91's physician orders revealed an order, dated 5/27/26 at 4:31 p.m. after the surveyor requested the resident be weighed. Mirtazapine Oral tablet 7.5 mg give 1 tablet by mouth at bedtime for appetite stimulation for 60 days. Record review on 05/27/26 at 4:37 pm of a facility provided undated list of residents being followed for weight loss revealed Resident #91 and Resident #57 were not on the list to see the Registered Dietician. Record review on 5/27/26 at 5:45 pm of Resident #91's nursing progress note, dated 5/27/26 at 5:33 pm, revealed gave new orders for the resident to be seen and additionally followed by Registered Dietician, weekly weights for eight weeks, Mirtazapine 7.5mg daily at bedtime, labs, and House 2.0 with all meals. During an interview with DON on 5/27/26 at 6:20 pm and again on 5/28/29 at 10:10 am, she said Unit Manager A was over the weight, and nutrition resident systems. The DON said she did not know why Resident #91's weight loss had not been reported on 05/13/2026 or 05/18/2026, and she was not sure if Resident #91 had been seen, evaluated, or followed by the facility RD. She explained that Monitor daily weights, order actually meant the resident required daily weights. The DON said she was unsure if Resident #57 or if any resident had a daily weight order. The DON said the order usually was required for residents who had weight loss, dialysis and or congestive heart failure, to ensure there was no fluid overload. The DON said the RNAs were responsible for obtaining any daily weights and Unit Manager A was responsible (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	for all weights and entering orders and then communicating the orders to the RNAs. The DON said the facility held daily clinical meetings in the morning and could not recall if Resident #91 or Resident #57 had been discussed. The DON said that monthly orders were reviewed by each Unit Manager for their respective units, and she did not know if Resident #57 or Resident #91's orders had been reviewed for the month of May 2026. The DON said she was just made aware of the weight concerns for Resident #57 and Resident #91 on 05/26/2026 and 05/27/2026 after the survey team entered the facility. Record review on 5/28/26 at 10:02 a.m. of undated facility list titled: Residents being followed by Dietician Company A revealed neither Resident #91 nor Resident #57 were on the list. During an interview with Unit Manager A on 5/28/26 at 11:55 am she said she was responsible for monitoring resident weights and maintaining weight lists for residents under 100 lbs., with significant weight loss, residents with congestive heart failure, and residents that required dialysis pre and post weights. Unit Manager A said residents should be weighed upon admission or readmission within 24-48 hours, and dialysis residents should have a post dialysis weight that should be recorded on the dialysis communication sheets before and after each dialysis visit. Unit Manager A said Resident #57 should have dialysis weights at least 3 times per week post dialysis and did not know why there were no dialysis weights on at least 2 dates for Resident #57 and why she had no daily weights as ordered. Attempts made to contact NP and MD for residents #57 and #91 on 5/28/26 at 11:14 am and at 1:55pm and did not receive return calls prior to facility exit. Interview with RNA B on 5/28/26 at 1:10 pm she said there were no weekly weights obtained or logged for any resident including Resident #57 because she had been working the floor as a CNA the entire month of May and had not had time to complete any daily weights. RNA B said Unit Manager A and the DON were aware the RNAs could not complete daily weights. Repeatedly requested facility policy and procedure on weight management on 05/27/2026 at 6:30 pm from Administrator and DON, 05/28/2026 at 09:27 am from the DON and again on 5/30/2026 at 4:00pm and was informed via email, by the DON that the facility had no Policy specifically titled Weight Management. Record review of undated facility policy and procedure titled, Weights-Obtaining revealed in part: It is the policy of this facility that resident weights will be recorded and monitored at least monthly. Procedures:1) Weigh Residenta. Upon admission / Readmissioni. Then weekly x 3 weeksii. Monthly and/ or per physician orders. 3) Record all weights on the Vitals tab in (EMR).4) If there is an actual 5% or more gain or loss in one month, notify the resident/family, physician, and Clinical Dietitian. Document this notification per facility protocol. 6) Review significant, unplanned changes and insidious gradual weight loss or gain trends in weightsduring weekly at risk and QA meetings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for 4 (Resident #81, Resident #12, Resident #92 and Resident #101) of 9 residents reviewed for infection control. The facility failed to ensure Resident #81's and Resident #101's urinary catheter bags were not touching or lying on the ground. The facility failed to ensure RN B used a gown when providing enteral feeding to Resident #12 and LVN D used a gown and followed appropriate wound care protocol when providing wound care to Resident # 92. These failures could place residents at risk of infection, decline in health, or cross contamination.Findings included: 1. Record review of Resident #81's face sheet, dated 5/27/26, revealed a [AGE] year-old female admitted on [DATE] with diagnoses including epilepsy (chronic brain disorder characterized by seizures) and obstructive (condition where urine is prevented from flowing normally) and reflux uropathy (condition where urine flows backward into the kidneys). Record review of Resident #81's quarterly MDS, dated [DATE], section C (Cognitive Patterns) revealed a BIMS score of 3 that indicated severe cognitive impairment. Section H of the MDS for Bowel and Bladder revealed an indwelling catheter. Record review of Resident #81's physician orders, dated 5/29/26, revealed an order for indwelling urinary catheter using a closed drainage system to change monthly and as needed with revision date of 12/31/25. Record review of Resident #81's care plan, dated 5/27/26, revealed Resident #81 had an indwelling urinary catheter and was at risk for increased urinary tract infections with intervention to keep the tubing/bag below the bladder level and to secure the tubing via clip as indicated. 2. Record review of Resident #101's face sheet, dated 5/12/26, revealed a [AGE] year-old female admitted on [DATE] with diagnoses including unspecified focal traumatic brain injury (a brain injury localized to a specific area of the brain) and peritonitis (a serious potentially life-threatening inflammation of the peritoneum [a silky smooth transparent membrane that lines the abdominal and pelvic cavities and encases most of your internal organs]. Record review of Resident #101's admission MDS assessment, dated 5/19/26, section C (Cognitive Patterns) revealed a BIMS could not be conducted as the resident was rarely or never understood. Section H of the MDS for Bowel and Bladder revealed an indwelling catheter. Record review of Resident #101's physician orders, dated 5/29/26, revealed an order for indwelling urinary catheter using a closed drainage system to change monthly and as needed with revision date of 5/12/26. Record review of Resident #101's care plan, dated 5/28/26, revealed Resident #101 had an indwelling urinary catheter and was at risk for increased urinary tract infections. 3. Record review of Resident # 12's face sheet, dated 05/30/2026, revealed a [AGE] year-old male admitted [DATE] with diagnoses including gastrostomy status (a tube is surgically inserted into the stomach) and dysphagia (difficulty swallowing) Record review of Resident #12's quarterly MDS assessment, dated 03/05/2026, revealed the resident did not have a BIMS score to identify level of cognition. Further review revealed the resident was dependent on staff for all ADL care and had a G-tube. Record review of Resident #12's physician order, dated May 2026, revealed an order dated 02/09/2026 for continuous enteral feeding via pump for 22 hours and an order dated 3/13/2026 for Enhanced Barrier Precautions PPE- gloves/gown during high contact resident care activities for C. Auris. Record review of Resident #12's care plan, dated 03/05/2026, revealed Resident #12 had an enteral feeding for nutrition and required Enhanced Barrier Precaution. 4. Record review of Resident #92's face sheet, dated 5/30/2026, revealed a [AGE] year-old male admitted [DATE] and readmitted on [DATE] with diagnosis including pressure ulcers (localized damage to the skin and underlying tissue)for sacral region(large triangular shaped bone situated at the base of the spine, directly below the lumbar region and just above the tailbone) (stage IV) {the most severe form of pressure injury}and right and left buttock (stage IV). Record review of Resident # 92's quarterly MDS assessment, dated 05/08/2026, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed a BIMS score of 15 indicating cognitively intact. Further review revealed the resident had pressure ulcers and wound infection. Record review of Resident #92's physician order, dated r May 2026, revealed an order dated 2/21/2026 for daily wound care to sacral, right ischial (lower and back part of the hip bone) and left ischial and an order dated 04/04/2024 for Enhanced Barrier Precautions PPE, gloves/gown, during high contact resident care activities. Record review of Resident # 92's care plan, dated 03/26/2026, revealed Resident #92 had pressure ulcers to sacral, right and left ischial and was at risk for further skin breakdown and infection. During an observation on 5/26/26 at 9:34 a.m., Resident #81was lying in bed and her urinary catheter bag was hanging on Resident #81's bed rail and the bag was tilted lying on the floor and the bottom on the bedside table that was next to Resident #81's bed. During an observation on 5/27/26 at 1:46 p.m., Resident #81was lying in bed and her urinary catheter bag was hanging on the bed rail below the level of Resident #81 and the bag was halfway lying on the floor mat that was next to the bed and on the ground. During an observation and interview on 5/27/26 at 1:34 p.m., RN Z said urinary catheter bags should hang on the foot of the bed below the level of the resident and should not be on the floor. Observation indicated RN Z raised Resident #81's bed and added a strap that also secured the urinary catheter bag to the bed rail. RN Z said the urinary catheter bag touching the floor was an infection concern. After adjusting Resident #81's bed and adding the strap to the urinary catheter bag, RN Z said this was how it should be. RN Z said sometimes the CNAs changed the resident and left the bed down which caused the urinary catheter bag to touch the floor. During an interview on 5/27/26 at 1:52 p.m., CNA Z said urinary catheter bags should be positioned on the bed below the resident's bladder. CNA Z said urinary catheter bags should not be dragging on the floor and should be hanging on the side rail of the bed. CNA Z said when she changed Resident #81 and did her peri care (the cleansing of the genital and anal areas)he urinary catheter bag was hanging on the end of the bed and not on the floor. CNA Z said usually during her last round she emptied the urinary catheters, and she probably would have caught that the urinary bag was on the floor when she emptied Resident #81's urinary catheter. CNA Z said the effect it could have on the resident if the urinary catheter bag was touching the floor was that the urinary catheter bag could get contaminated, urine could not drain properly, leak out or obstruct the flow of urine. During an observation on 05/26/2026 10:38 A.M., Resident #101 who was seated in her bed and her entire urinary catheter bag and drainage port, was lying on the floor.During an observation and interview on 5/26/26 at 10:40 a.m., RN Y said Resident #101's urinary catheter bag was not supposed to be on the floor, and Resident #101 could get an infection because her catheter bag was lying on the floor. RN Y said and then demonstrated there was no hook for the bag to attach to the bed, so the bag ended up on the floor. The charge nurse picked the bag up off of the floor with her gloved hand and was holding it low so that it remained below the resident's bladder. RN Y said she was sure the night shift put it there and then called RNA A to the room because she was the aide working with the resident for the day. RN Y said she would change Resident #101's entire indwelling foley catheter bag system and notify the MD.During an observation and interview on 5/26/26 at 10:42 a.m. with RNA A who said she did 6 am shift rounds on Resident #101 and at least one additional round and Resident #101's the indwelling catheter bag was not on the floor. RNA A said they did not know how it got on the floor again and grabbed a large pink emesis basis for RN Y to set the urinary bag into without it touching the floor. RNA A said the catheter bag should never be on the floor because the resident could get an infection or a worsened infection from it being on the floor. During an observation on 5/28/2026 at 11:12 a.m., Resident #101 was clean and dressed lying in bed with her urinary catheter bag hanging on the bed rail below Resident #101 with the urinary catheter bag lying face down on the floor on the right side of the bed. During interview and observation on 5/28/26 at 11:28 a.m., LVN Z accompanied the surveyor to Resident #101's room. LVN Z said it fell when she saw Resident #101's urinary catheter bag on the floor. LVN Z said the urinary catheter bag was supposed to be hanging and she did not know what happened. LVN Z repositioned Resident #101's urinary catheter bag on the lower bed rail hanging below the level of Resident #101. LVN Z said that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview on 5/29/2026 at 1:02 p.m., CNA Z said regarding Resident #81 they always had the bed in the lowest position, so the urinary catheter bag dragged the floor. CNA Z said after she did Resident #81's peri care this morning she had positioned her urinary catheter correctly, so she did not know what happened regarding Resident #81's urinary catheter bag positioning. CNA Z said that when she did her rounds, she put Resident #81's urinary catheter bag in a basin so it was not on the floor. CNA Z said they tried to keep Resident #81s bed in the lowest position since Resident #81 was a fall risk. During an interview on 5/29/2026 at 2:31 p.m., the DON said, regarding urinary catheter bags not being on the floor, it was nursing knowledge and nothing should be on the floor as the floor was dirty. During an observation on 5/26/2026 at 11:25 a.m., LVN B provided wound care to Resident #92 without wearing a gown as per EBP protocol. LVN B removed all three dirty dressings at the same time and discarded the dirty gloves. LVN B donned (put on) clean gloves and cleaned wound #1 with wound cleanser and applied a clean dressing to wound #1 using the same gloved hands. LVN B discarded the dirty gloves, donned clean gloves to clean wound #2 and using the same gloved hands applied a clean dressing for wound #2. LVN B repeated the same for wound #3. During an interview on 5/26/2026 at 11:47 a.m., LVN B stated he should have changed gloves after cleaning the wound. He said he should have sanitized his hands and donned clean gloves when applying a clean dressing to each wound. LVN B stated the negative outcome was cross contamination and infection if the infection prevention protocols were not followed. LVN B did not respond as to why he did not use a gown while providing wound care for Resident #92. During an observation on 05/27/2026 at 8:56 a.m., RN B provided medication administration through the g-tube to Resident #12 without wearing a gown as per EBP protocol. During an interview on 5/27/2026 at 12:41 pm, RN B said she was not familiar with the EBP protocol. After reading the poster posted by a resident's bed, RN B stated EBP was used as a precaution to prevent transmission of infections to others and herself. RN B stated she did not wear a gown while administering medication via g-tube to Resident # 12 this morning. Record review of the facility's policy titled, Catheter Care, dated 2/2024, revealed catheter management positioning that included to ensure the catheter bag was positioned below the level of the bladder to allow for proper drainage and avoid reflux of urine. Record review did not reveal any information regarding urinary catheter bags and their relation to the ground. Record review of the facility's policy titled, Enhanced Barrier Precaution, revised 03/2024, read in part, . Policy: Enhanced Barrier Precaution is an infection control intervention designed to reduce the transmission of multidrug-resistance organism and employs targeted gown and glove use during high-contact resident care activities.Guidance/Procedure: EBP are indicated for residents with the following: wounds and /or indwelling medical devices. examples of indwelling medical devices: central lines, urinary catheters, feeding tubes.

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	05/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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** Based on interview, observation and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised by an interdisciplinary team for 1 (Resident #41) of 6 residents reviewed for care plan.The facility failed to ensure that Resident #41 was care planned regarding refusal to have a privacy cover on his urinary catheter bag. This failure could place residents at risk of not being able to attain or maintain their highest practicable level of physical, mental, and psychosocial well-being. Findings included: Record review of Resident #41's face sheet, dated 5/7/26, revealed a [AGE] year-old male, admitted [DATE], with diagnoses including paraplegia (loss of the ability to move in part or most of the legs and lower body) and obstructive (condition where urine is prevented from flowing normally) and reflux uropathy (condition where urine flows backward into the kidneys).Record review of Resident #41's admission MDS assessment, dated 5/9/26, section C (Cognitive Patterns) revealed a BIMS score of 15 that indicated was intact. Section H (Bladder and Bowel) revealed an indwelling catheter. Record review of Resident #41's progress noted, dated 5/26/26 at 12:56 p.m. by Unit Manager B, revealed, Nursing staff offered to change the resident's urinary bag to the bag that has the privacy cover on it. The resident refused to have the correct foley (urinary) bag with privacy cover placed. Record review of Resident #41's progress note, dated 5/28/26 at 8:17 p.m. by LVN Z, revealed, Resident refused facility privacy bag. Record review of Resident #41's Order Listing Report, dated 5/29/26, revealed a physician order for an indwelling urinary catheter using a closed drainage system to be changed monthly and as needed with revision date of 5/7/26. Record review of Resident #41's care plan, dated 5/29/26, revealed Resident #41 had a urinary catheter with intervention to provide a privacy bag. Resident #41's care plan also revealed a care plan focus of refusal to let staff change the urinary catheter bag, but no information was found regarding refusing privacy bag for urinary catheter. During an observation on 5/26/26 at 10:25 a.m., Resident #41 was lying in bed with his blanket over his head with his urinary catheter hanging on the bed with no privacy cover. During an interview on 5/27/2026 at 3:04 p.m., LVN Z said the urinary catheter bags should have a privacy bag all of the time. LVN Z said when residents entered from the hospital, they arrived with clear urinary bags and the facility put their own privacy bag on the urinary catheter bag. LVN Z said if there was not a privacy cover on the urinary catheter bag it could be a body image issue.During an interview on 5/28/2026 at 10:20 a.m., LVN Z said Resident #41 always refused and had said I will do what I want to do, and you can't control me. LVN Z said that the MDS nurse updated the care plans. LVN Z said if a resident refused the urinary privacy bag it should have been put on the care plan. LVN Z said she documented refusals and then let the MDS nurse know about the refusal. During an interview on 5/28/2026 at 10:36 a.m., Resident #41 said he did not care much about the privacy bag for the urinary catheter bag. Resident #41 said he refused to let the facility change the urinary catheter bag because he did not like the bags that the facility had that already had the cover on it. Resident #41 said that someone from the facility had tried to talk to him a couple times and he just rode off. Resident #41 said that not having a privacy cover on the urinary catheter bag did not really bother him and he was barely inside and was not around people. Resident #41 said it is on me; they tried to add it referring to the privacy cover for the urinary catheter bag. During an interview on 5/28/26 at 4:35 p.m., the MDS Nurse said if a resident refused a privacy cover on the urinary catheter bag should be care planned. The MDS Nurse said she was responsible for care planning refusals if the floor nurse let her know and then she would care plan the issue. The MDS nurse said she care planned Resident #41 regarding refusal to have his urinary catheter changed but denied being informed regarding Resident #41's refusal to have a privacy cover on his urinary catheter bag. The MDS Nurse said the floor nurses or the unit Manager told her information regarding updating the care plan. The MDS Nurse said the effect it could have on the resident if refusals were not care (continued on next page)

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	675612	A. Building B. Wing	05/30/2026

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Paradigm at Westbury	5201 S Willow Dr Houston, TX 77035

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	planned was that the staff would not know how to take care of the resident. During an interview on 5/29/26 at 9:36 a.m., the ADON said if a resident refused care, it should have been on the care plan. The ADON said Resident #41's refusal to have a privacy cover on his urinary catheter bag should have been on the care plan. The ADON said she was involved in the daily standup/clinical meetings, but she did not add information to the care plans. The ADON said they did not have separate privacy covers for the urinary catheter bags and the privacy cover comes attached to the facility's urinary catheter bag. The ADON said Resident #41 did not have the facility's urinary catheter bag. During interview on 5/29/2026 at 10:11 a.m., the DON said if a resident refused care, it should have been on the care plan. The DON answered yes that Resident #41's refusal to have a privacy cover on his urinary catheter bag should have been on the care plan. The DON said that MDS Nurse updated the care plans. The DON said they have daily standup/clinical meetings where the MDS Nurse received communication to update the care plan. The DON said Resident #41 went to the hospital and had his urinary catheter changed out while he was at the hospital and returned to the facility without a privacy cover. During an interview on 5/29/2026 at 11:10 a.m., RN Y said Resident #41 refused to have a privacy cover on his urinary catheter bag. RN Y said Resident #41 said it was ok referring to the urinary catheter bag without the privacy cover and said leave this one like this referring to the urinary catheter bag without a privacy cover. During an interview on 5/29/2026 at 11:45 a.m., RN Y said regarding Resident #41 refusal of the privacy cover to the urinary catheter bag that she told them in the office this information. When asked who she told in the office, RN Y said Unit Manager B. RN Y said I don't know regarding this information being on the resident's care plan. Record review of the facility's policy titled, Care Plan Revisions, with revision date 5/2022, revealed, Care plans will be modified as needed by the MDS Coordinator or other designated staff member.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was not 5 percent or greater. The facility had a medication error rate of 12.0% based on 3 errors out of 25 opportunities (Resident #108 and Resident #80) reviewed for medication administration. The facility failed to ensure RN A administered insulin injection at the appropriate site as per physician's order for Resident #108.The facility failed to ensure MA A accurately dispensed and administered oral medication and eye drops as per physician's orders for Resident #80. These failures could place residents at risk for incomplete therapeutic outcomes and decline in health. Findings included: 1. Record review of Resident # 108's face sheet, dated 05/30/2026, revealed a [AGE] year old female admitted [DATE], with diagnoses including Type 2 Diabetes Mellitus with Hyperglycemia (inability of the body's cell to respond properly to the hormone insulin), Cerebral Infarction (death of brain tissue cause by prolonged lack of blood flow and oxygen) and Heart Failure (heart is not pumping blood efficiently to meet body's need for oxygen and nutrients). Record review of Resident #108's quarterly MDS assessment, dated 04/06/2026, revealed a BIMS score of 7, indicating severe cognitive impairment with thinking and memory. Record review of Resident #108's Medication Administration Record dated May 2026, revealed an order for Novolog Flex Pen 100 unit/ml solution pen-injector. Inject as per sliding scale: if 70-149 = 0 units; 150-199 = 2 units; 200-249 4 units; 250-299 = 6 units; 300+ = 8 units; Notify NP/MD, subcutaneously (under the skin) before meals for DM II with start date of 4/11/2026. During medication observation on 5/27/2026 at 8:42 a.m., RN A entered Resident #108's room and Resident #108 was finishing her breakfast. RN A performed finger stick using aseptic technic (free from harmful germs that can cause infections). Observation indicated Resident #108's blood glucose level was 255. RN A, went to her medication cart and prepared 6 units of insulin Novolog and 25 units of insulin Toujeo SoloStar . RN A checked her computer and stated based on site rotation, the two insulins would be administered on Right Lower Quadrant of abdomen. Upon entering Resident #108's room, RN A instructed the resident to expose her abdominal area. Instead, Resident #108 exposed her right arm. RN A cleaned Resident # 108's deltoid area (large triangular muscle that covers shoulder joints) with an alcohol wipe and administered 6 units of insulin Novolog. Then RN A cleaned the back area under the right arm with an alcohol wipe and administered 25 units of insulin Toujeo under the skin. During an interview with RN A on 5/27/2026 at 8:52 a.m., RN A stated she should not have administered the Novolog insulin on Resident #108's deltoid (intramuscular) area because that was not an appropriate site for insulin injections. RN A stated insulin injections were supposed to be injected into areas of fatty tissue such as the subcutaneous area (under the skin) for better insulin absorption. RN A stated she automatically administered the Novolog insulin on the deltoid (intramuscular) area because Resident # 108 had exposed the right arm and stated she wanted it on her arm. RN A had no response to why she administered the Toujeo insulin correctly but not the Novolog insulin. 2. Record review of Resident # 80's face sheet, dated 5/30/2026, revealed a [AGE] year old female, admitted [DATE], with diagnoses including Constipation (when having a bowel movement becomes difficult, painful or happens less often than normal), Essential Hypertension (when the force of blood pumping through the blood vessels are consistently high) and Cerebral Infarction (death of brain tissue cause by prolonged lack of blood flow and oxygen). Record review of resident # 80 quarterly MDS record dated 05/12/2026 revealed a BIMS score of 2, which indicates the resident has severe cognitive impairment with thinking and memory. Record review of Resident # 80's Medication Administration Record for MAY 2026 revealed an order for Sennosides Tablet 8.6 mg - Give 2 tablet by mouth two times a day for constipation with a start date of 02/18/2026 and an order for Artificial Tears Solution 0.5-06% (Polyvinyl Alcohol-Povidone) - Instill 2 drops in both eyes two times a day for dry eyes with a start date of 08/13/2024. During an observation of medication administration for Resident # 80 on 5/27/2026 at 10:20 am, MA A took resident's blood pressure and dispensed the (continued on next page)

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	675612	A. Building B. Wing	05/30/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following medications: Aspirin 81mg - 1 tablet, Lisinopril 5 mg - 1 tablet, Omega 3 fish oil 1000mg - 1 tablet, Senna Plus 8.6mg - 1 tablet, Vitamin D3 1000 iu (25mcg) - 1 tablet. After administering all the medication, MA A returned to medication cart and started checking off the EMAR in her computer. MA A stated Resident # 80 was supposed to receive artificial tears eye drops but she did not have one in her cart. She said she would get the mediation from the central supplies room. Med Aide A walked to an unidentified door nearby and knocked several times. When no one answered, MA A returned to her medication cart and stated, I suppose no one is in there. They must all be in a meeting. MA A then signed off her computer. After medication reconciliation for Resident # 80 on 5/27/2026 at 11.00 a.m., it was identified that Resident # 80 was supposed to receive 2 pills of Sennosides Tablet. During an interview on 5/27/2026 at 4:45 pm, DON stated her expectations were for the nurses and Med Aides to audit their carts and replenish the cart accordingly. DON stated the Med Aide should notify the nurse or let the unit manager know if they need OTC medications so that they can get it for the Med Aides. Record review of facility's policy on Medication Administration and Management read in part .Administering the Medication Pass, # 5: The authorized licensed or certified/permitted medication aide or by state regulatory guidelines staff member reads the label on the medication 3 times; a) before removing the medication from the drawer; b)before pouring the medication; c) after pouring the medication.

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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. Based on observation, interview, and record review, the facility failed to ensure that drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles for 1 (D Hall) of 4 medication aide carts, 2 (B Hall and D Hall) of 4 nurse medication carts and 2 (A Hall and D Hall) of 4 medication storage rooms reviewed for medications storage. -Facility failed to ensure medication aide cart and nurse cart did not have medications that were discontinued. -Facility failed to ensure medication storage room did not have any items stored under the sink. These failures could place residents at risk for drug diversion and contamination of supplies placed under the sink. Findings included: During an observation on 5/27/2026 at 2:15pm, D hall medication aide cart revealed the following medications: Quetiapine 25mg - pharmacy issue date 3/28/2026 with remaining 9 pills for Resident # 74, Potassium Chloride Liquid 10% - pharmacy issue date 12/8/2025, give 15ml in the evening for 5 days for Resident # 64 and Amlodipine 2.5mg give 1 tab daily - pharmacy issue date 7/15/2025 for Resident # 44. During a record review and interview on 5/27/2026 at 2:25pm, Med Aide J stated Resident # 74 was no longer taking Quetiapine 25 mg and Resident # 44 was no longer taking Amlodipine because those medications were discontinued. Med Aide J stated discontinued medication should be removed from the cart and returned to pharmacy. Med Aide J stated she audited her cart weekly to make sure expired and discontinued medications were removed. During an observation of D hall medication storage room on 5/27/2026 at 2:35 pm with LVN C, a box of mixed supplies was discovered under the sink. The box contained IV start kits, feeding tubes, piston syringes and suction catheters. During an interview on 5/27/2026 at 2:40 pm, LVN C stated there should not be anything stored under the sink because the items could get destroyed if the ink leaked. LVN C stated these items should be kept on the rack provided for storing supplies. During an observation on 5/27/2026 at 2:45 pm, D hall nurse cart revealed 2 unopened bottles of Ketoconazole 2% shampoo - pharmacy issue date 9/01/2025 and 9/10/2025 with instructions to use on shower days for Resident # 75 and one bottle of Ketoconazole 2% cream - pharmacy issue date 1/14/2026 with instructions to be applied on shower days for Resident # 103. During a record review and interview on 5/27/2026 at 3:04 pm, LVN C stated she was unsure if Resident # 75 was given this shampoo on his shower days. LVN C stated newer dispensed bottles may have been used first instead of using bottles dispensed on 09/01/2025 and 09/10/2025. LVN C stated she would ensure Resident # 75 got this shampoo on his upcoming shower days. LVN C stated Resident # 103's Ketoconazole 2% cream was discontinued. LVN C stated expired medications should not be in the cart due to possibility of medication administration error. During an observation on 5/27/2026 at 3:10 pm, B hall nurse cart revealed a bottle of Potassium Chloride - pharmacy issue date 3/4/2026 with instructions give 20ml daily for 5 days for Resident # 3. During interview on 5/27/2026 at 3:20pm, RN A stated expired and discontinued medications should be removed from cart to eliminate medication error. RN A stated she audited her cart weekly, but she was unsure how this was missed. During an observation of A hall medication storage room on 5/27/2026 at 3:50 pm with Unit Manager A, 11 urine measuring hats for over toilet use, 1 pair of Booties in a plastic wrap and 3 suction machines under the sink. One of the lower cabinets had an opened colostomy bag with a hair strand stuck on the colostomy bag, a bottle of medication Sevelamer Carbonate (a medication used to remove excess phosphorus from the body) with no name on the bottle, an opened container of piston syringe containing the piston syringe and an opened container of urethral catheterization tray containing a catheter, sterile gloves, and a packet of lubrication. During an interview on 5/27/2026 at 4:05 pm, Unit Manager A stated no items should be stored under sink due to risk of damage if there was a sink leak or burst pipes. Unit Manager A stated she audited the medication room daily and audited the medication cart weekly. During an interview on 5/27/2026 at 4:45pm, the DON stated expired and (continued on next page)

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	675612	A. Building B. Wing	05/30/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discontinued medications should be removed from medication cart. The DON stated her expectation is for nurses and unit managers to audit carts and medication storage room weekly. The DON stated medications carts are also audited by Pharmacy Consultants weekly. During an interview on 5/27/2026 at 4:50 pm, the facility policy on medication storage was requested from the DON and the Administrator. The policy was not provided upon exit. During an interview on 5/28/2026 at 1:30 p.m., the facility policy on medication storage was requested from the DON and it was not provided upon exit.

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	675612	A. Building B. Wing	05/30/2026

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident's medical records included documentation that indicated the resident, or their responsible party, received education of the benefits, and potential side effects, of the influenza or pneumococcal immunization, receipt of the influenza or pneumococcal immunization, or residents did not receive the influenza or pneumococcal immunization due to medical contraindication, or refusal, for 2 of 9 residents reviewed for immunizations. (Resident #2 and Resident #115)The facility failed to document, in Resident #2's and Resident #115's medical records, having had received education, whether by self or with responsible party, of the benefits and potential side effects of the influenza immunization and receipt of the of the pneumococcal immunization or having had not received the pneumococcal immunization due to medical contraindication or refusal.This failure could place residents at risk of contracting a viral illness, influenza and pneumococcal, or being informed of the benefits/risk which could cause respiratory complications and potential adverse health outcomes. Findings included : Resident #2Record review of Resident #2's face sheet dated 5/29/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including acute kidney failure with tubular necrosis (disorder where the kidney's ability is impaired to filter blood and regulate fluids and electrolytes). Record review of Resident #2's admission MDS dated [DATE], section C (Cognitive Patterns) revealed a BIMS could not be conducted as the resident was rarely or never understood. Section O revealed Resident #2 did not receive the influenza vaccine in this facility and was not in the facility during this year's influenza vaccination season. Section O revealed Resident #2's pneumococcal vaccination was not up to date and was offered and declined. Record Review of Resident #2's care plan did not reveal any information related to immunizations. Record Review of Resident #2's electronic medical record revealed No data available under the immunization's tab. Resident #115Record review of Resident #115's face sheet dated 5/29/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including end stage renal disease (final stage of chronic kidney disease characterized by a permanent loss of kidney function). Record review of Resident #115's entry MDS dated [DATE] did not reveal any information related to Resident #115's cognition or immunization status. Record review revealed Resident #115's Medicare 5 Day and Death in facility MDS both dated 5/26/26 were In Progress. Record Review of Resident #115's care plan did not reveal any information related to immunizations. Record Review of Resident #115's electronic medical record revealed No data available under the immunization's tab. During interview on 5/29/2026 at 9:36 a.m., the ADON said she was the facility's Infection Preventionist. The ADON said residents were asked during the admission process if they have had flu, pneumonia and/or COVID vaccines and if they have not had then the facility offered the vaccines and administered the vaccines. The ADON said if the resident refused vaccines, then their refusal was documented. The ADON said immunization information should have been documented in the immunization tab in electronic medical record or in the admission packet. The ADON said it was the infection nurse's responsibility to enter vaccine information in the electronic medical record which would be her, the ADON. The ADON said with new admissions she looked at the residents' paperwork to see if they have had the vaccines. The ADON said vaccines were offered during care plan meetings and updated in the electronic medical record, especially if the resident was new. The ADON said for new residents said she tried to get immunization information entered within a 72 hour time frame from admission and that was her goal. The ADON was unable to find Resident #115's admission packet with information regarding vaccines.During interview on 5/29/2026 at 1:08 p.m., the ADON said Resident #115 he had came late to the facility the past Friday 5/22/26 and had passed away on 5/26/26. The ADON said she was not sure if the social worker had a chance to get Resident #115's admission paperwork done as she did not see it in the system. The ADON said the admission paperwork should have been (continued on next page)

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	675612	A. Building B. Wing	05/30/2026

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed in the 72 hour time span from admission. The ADON said she was still looking for Resident #2's admission paperwork. During interview on 5/29/2026 at 2:31 p.m., the DON said obtaining immunization information from residents fell on the infection control nurse but nursing management which includes the DON and unit managers could also assist with entering immunization information and the admitting nurse could also input information. The DON said the effect it could have on the resident if immunization information was not obtained was not major as immunization history could be looked up to see if they have had immunizations and if not then immunizations were offered to see if they want the immunization. The DON said not all people believe in immunizations so she could not say it was a high risk. During interview on 5/29/2026 at 2:31 p.m., the ADON said regarding Resident #2 she was not able to find the admission paperwork. The ADON said she had called Resident #2's family member to get her immunization information and was entering that information now. The ADON said that not having immunization information could put residents at risk of infectious diseases and spreading of things. The ADON said she was not sure who was responsible for completing the admission paperwork that included the immunization paperwork, but she would find out. The ADON said the Administrator would check in the morning meetings that things had been completed when asked if anyone checked that the admission paperwork was completed. During interview on 5/29/2026 at 2:59 p.m., the DCE (Director of Customer Engagement) said in the admission packet residents were given information regarding flu, pneumonia and COVID vaccinations. The DCE said there were also consents for flu, pneumonia and COVID vaccinations that the resident could either accept or decline the vaccination. The DCE said she was the person responsible for completing the admission packets. The DCE said had been in contact with Resident #2's family member this morning and would email the admission paperwork to the family member to sign as Resident #2 was unable to sign the admission paperwork herself. The DCE said she had just started 5/26/26 at the facility and a DCE from another location had been helping and training her. The DCE said the facility did not have a DCE prior to her starting at the facility but did not know for how long. The DCE said her training regarding her position was the training she received from the other DCE. Regarding Resident #115, the DCE said she did not see him on her unresolved list of things that should be completed. The DCE said she received the list of items that needs to be completed on the application reside. During interview on 5/29/2026 at 3:15 p.m., the Administrator said the DCE (Director of Customer Engagement) or Admissions was responsible for completing the admission paperwork. The Administrator said the current DCE started this week. The Administrator said the last day for the previous DCE was 4/30/26. The Administrator said that they had a DCE from a sister facility who came out and assisted but was not at the facility full time during the time the facility was without a DCE. The Administrator said there was a corporate employee that pulled information and did audits weekly to check that admission packets were completed.Record review of the facility's Infection Control Policies and Procedures with the subject of Immunizations: Resident/Employees with revision date of 2/2022 revealed federal and state regulations are followed regarding immunizations for residents and The facility offers pneumococcal immunizations to residents at risk for pneumococcal disease.

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	05/30/2026

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review , the facility failed to implement their policy to ensure the residents, or their responsible party, received education of the benefits and risks, or potential side effects of Covid-19 immunizations, receipt of Covid-19 immunizations, or the residents did not receive the Covid-19 immunizations, due to medical contraindication, or refusal, for 2 of 9 residents who were reviewed for immunizations. (Resident #2 and Resident #115) The facility failed to document, in Resident #2's and Resident #115's medical records, having had received education, whether by self or with their responsible party, of the benefits and risk, and potential side effects, of the Covid-19 immunization, receipt of the of the Covid-19 immunization, or having had not received the Covid-19 immunization due to medical contraindication or refusal.This failure could place residents at risk of not being informed of complications and potential adverse health outcomes.Findings included: 1. Record review of Resident #2's face sheet, dated 5/29/26, revealed a [AGE] year-old female admitted [DATE] with diagnosis including acute kidney failure with tubular necrosis (disorder where the kidney's ability is impaired to filter blood and regulate fluids and electrolytes). Record review of Resident #2's admission MDS assessment, dated 5/11/26, section C (Cognitive Patterns) revealed a BIMS could not be conducted as the resident was rarely or never understood. Section O (Special Treatments, Procedures, and Programs) revealed Resident #2 did not receive the influenza vaccine in this facility and was not in the facility during this year's influenza vaccination season. Section O revealed Resident #2's pneumococcal vaccination was not up to date and was offered and declined. Record review of Resident #2's care plan, dated5/29/26 did not reveal any information related to immunizations. Record review of Resident #2's electronic medical record, accessed 5/28/26 at 3:02 p.m. revealed No data available under the immunization's tab. 2. Record review of Resident #115's face sheet, dated 5/29/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including end stage renal disease (final stage of chronic kidney disease characterized by a permanent loss of kidney function). Resident #115 was discharged [DATE].Record review of Resident #115's entry MDS assessment, dated 5/22/26, revealed no information related to Resident #115's cognition or immunization status. Record review revealed Resident #115's Medicare 5 Day and Death in facility MDS both dated 5/26/26 were In Progress. Record review of Resident #115's care plan, dated 5/29/26, did not reveal any information related to immunizations. Record review of Resident #115's electronic medical record accessed 5/28/26 at 3:02 p.m., revealed No data available under the immunization's tab. During an interview on 5/29/2026 at 9:36 a.m., the ADON said she was the facility's Infection Preventionist. The ADON said residents were asked during the admission process if they had received the influenza , pneumonia and/or COVID vaccines and if they had not, then the facility offered the vaccines and administered the vaccines. The ADON said if the resident refused vaccines, then their refusal was documented. The ADON said immunization information should have been documented in the immunization tab in electronic medical record or in the admission packet. The ADON said it was her responsibility as the infection nurse to enter vaccine information in the electronic medical record. The ADON said with new admissions she looked at the residents' paperwork to see if they had the vaccines. The ADON said vaccines were offered during care plan meetings and updated in the electronic medical record, especially if the resident was new. The ADON said for new residents said she tried to get immunization information entered within a 72 hour time frame from admission and that was her goal. The ADON said she was unable to find Resident #115's admission packet with information regarding vaccines.During an interview on 5/29/2026 at 1:08 p.m., the ADON said Resident #115 arrived late Friday 5/22/26 and passed away on 5/26/26 . The ADON said she was not sure if the social worker had a chance to get Resident #115's (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission paperwork done as she did not see it in the system. The ADON said the admission paperwork should have been completed in the 72 hour time span from admission. The ADON said she was looking for Resident #2's admission paperwork. During an interview on 5/29/2026 at 2:31 p.m., the DON said obtaining immunization information from residents fell on the infection control nurse but nursing management which included the DON and unit managers also assisted with entering immunization information and the admitting nurse could also input information. The DON said the effect it could have on the resident if immunization information was not obtained was not major, as immunization history could be looked up to see if they had immunizations and, if not, then immunizations were offered. The DON said not all people believed in immunizations so she could not say it was a high risk. During an interview on 5/29/2026 at 2:31 p.m., the ADON said she was not able to find Resident #2's admission paperwork. The ADON said she had called Resident #2's family member that morning to get her immunization information and was entering that information now . The ADON said that not having immunization information could put residents at risk of infectious diseases. The ADON said she was not sure who was responsible for completing the admission paperwork that included the immunization paperwork, but she would find out. The ADON said the Administrator checked during the morning meetings that the admission paperwork was completed. During an interview on 5/29/2026 at 2:59 p.m., the DCE (Director of Customer Engagement) said in the admission packet residents were given information regarding flu, pneumonia and COVID vaccinations. The DCE said there were also consents for flu, pneumonia and COVID vaccinations that the resident could either accept or decline the vaccination. The DCE said she was the person responsible for completing the admission packets. The DCE said had been in contact with Resident #2's family member this morning and would email the admission paperwork to the family member to sign as Resident #2 was unable to sign the admission paperwork herself. The DCE said she had just started 5/26/26 at the facility and a DCE from another location had been helping and training her. The DCE said the facility did not have a DCE prior to her starting at the facility but did not know for how long. The DCE said her training regarding her position was the training she received from the other DCE. Regarding Resident #115, the DCE said she did not see him on her unresolved list of things that should be completed. The DCE said she received the list of items that needs to be completed on the app reside. During an interview on 5/29/2026 at 3:15 p.m., the Administrator said the DCE (Director of Customer Engagement) or Admissions was responsible for completing the admission paperwork. The Administrator said the current DCE started this week. The Administrator said the last day for the previous DCE was 4/30/26. The Administrator said that they had a DCE from a sister facility who came out and assisted but was not at the facility full time during the time the facility was without a DCE. The Administrator said there was a corporate employee that pulled information and did audits weekly to check that admission packets were completedRecord review of the facility's policy titled, Infection Control Policies and Procedures: Immunizations: Resident/Employees, revised 2/2022, revealed federal and state regulations were followed regarding immunizations for residents.