STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676064	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at Katy	1480 Katy Flewellen Katy, TX 77494

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment which included injuries of unknown sources and misappropriation of resident property in accordance with state law through established procedures and the facility failed to report the results of all the investigations to the administrator or his or her designated representative and to other officials in accordance with the state law which included to the survey agency within 5 working days of the incident and if the alleged violation was verified appropriate corrective action must be taken for 1 of 4 residents (CR #1) reviewed for abuse and neglect. -The facility failed to report results of a self-reported incident when CR #1 had a fall with injury and was sent to the hospital on [DATE].This failure could place residents involved in abuse incidents at risk of continued abuse, further injury, pain, and physical and emotional distress. Record review of CR#1's face sheet dated 11/20/2025 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Record review CR#1's face sheet had diagnoses of unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, muscle weakness, hypertension (high blood pressure), insomnia (difficulty with sleeping), hyperlipidemia (high fat content in the blood), abnormal findings of blood chemistry, anxiety disorder (chronic excessive worry), Alzheimer's disease (a progressive brain disease causing memory loss), acute kidney failure and unspecified anemia (low iron in the blood).Record review of CR#1's Comprehensive Care Plan dated 11/20/2025 reflected that on 7/28/25 CR#1 had an unwitnessed fall with left hip intertrochanteric fracture of left femur.Record review of CR#1's clinical record during her stay in the facility reflected there was not a provider investigation report sent to the state survey agency.Record review of CR #1's progress notes for July 2025:-07/28/2025 at 2:48am, CR#1 was noted wandering along the corridor and night staff attempted to redirect her. CR #1 was given Hydroxyzine 25 mg for anxiety and pain medication for pain. CR #1 laid in bed afterward.-07/28/2025 at 8:36am, CR #1 was noted as having a fall on at 4:30am, witnessed and without head injury. CR #1's medication was reviewed and RP was notified.-0728/2025 at 10:50am, CR #1 had 2 x-rays completed which came back with acute left hip fracture. CR #1's MD notified and the MD gave orders for CR#1 to be sent out to the hospital.Record review of CR #1's x-rays dated 07/28/2025, she had acute left hip fracture at the intertrochanteric region (upper leg).Record review of CR #1's hospital visit dated 07/28/2025, she was admitted with leg pain and unable to walk after the fall. Imaging showed CR#1 had a fracture with a negative brain scan. CR #1 was admitted for further evaluation and medication.Interview on 11/29/2025 at 10:58am, the DON said the facility had taken steps before the fall on 07/28/2025 to transfer CR #1 to another facility with a locked unit due to wandering. The DON said that was when the new Administrator was taking over and was getting orientation, so she did not know if the previous Administrator had sent the 5-day investigation in or not. But the new Administrator will include the DON in submissions so that the Administrator and DON will be on the same page. Interview with the Administrator on 11/20/ 2025 at 1:44pm, he said he was not the Administrator at the time and was not notified or aware about the fall on 07/28/2025. He found the initial report and facility investigation but could not find the 5-day investigation. The Administrator said if the investigation report was not sent in, there was a possibility that the investigation would not be completed. If the investigation was not done, then an issue related to CR #1's fall could have remained unaddressed. The Administrator said the goal was to focus on taking care of residents.Record review of facility's Abuse/ Neglect & Exploitation Policy dated 04/2024 reflected the facility will report all alleged violations, involving abuse, neglect, exploitation or mistreatment including injuries of unknown source to the administrator or a designee and reports any alleged abuse, neglect, exploitation or mistreatment including injuries of unknown source should also be reported to other officials including to the state agency in accordance with applicable state law.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based observation, interview, and record review, the facility failed to 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 one (Hallway A) of four hallways observed for infection control. -CNA K left her hooded jacket and eyeglass case of the clean linen cart in Hallway A.This failure could place the residents at risk of cross-contamination and development of infection. During an observation and interview with RN C of a clean linen cart on Hallway A on 11/19/2025 at 12;19pm, there was an eyeglass case laying directly on top of a black zip-up jacket which was laying on top of the green mesh covering of the clean linen cart. The wheeled cart contained folded linen sheets and briefs inside the mesh cover. RN C said those items should not have been there and that it was an infection control issue. Interview with CNA B on 11/19/2025 at 1:55pm, she said she was one of the CNAs working on Hallway A but was not the person who put the jacket on the cart. CNA B said the jacket and eyeglass case should not have been there and that could be an infection control issue. Personal items could be placed in a locker or purse. Interview with CNA K on 11/19/2025 at 2:00pm, she said she was giving a resident a bed bath and then her sleeves of her jacket got wet, so she took it off and placed it along with her eyeglass case on the clean linen cart because she had to get back to the resident. CNA K apologized and said she shouldn't have done that and that it was an infection control issue. CNA K said she should have put it up somewhere else. Interview with the ADON on 11/20/2025 at 1:39pm, he said he was also the Infection Preventionist at the facility. The ADON said everything in the cart was for residents and that staff items like the jacket and eyeglass case should not have been on the cart. The facility had halls with major infections and if those items came into contact with staff, infections could spread to residents and vice versa. Interview with the Administrator on 11/20/2025 at 1:44pm, he said that the staff personal items should not have been on the cart. He said it would have been hard to say if the jacket would have caused an infection control issue. If the jacket was wet, then it might be an infection control issue, but he did not know the state of the jacket on the linen cart. Interview with the DON on 11/20/2025 at 3:01pm, she said the clothing items should not have been on the cart. She was going to do another audit on CNA K and do some re-training. The DON said a negative outcome of the clothing item on the clean linen cart could be infection control and that the facility needed to maintain their isolation protocol.Record review of the facility's policy on Infection Control last revised on 6/2024 read in part, The Facility is dedicated to maintaining a safe and healthy environment by implementing an effective infection control program that adheres to state and federal regulations . Environmental Safety . The cleanliness and hygiene standards within The Facility are paramount for effective infection control practices .Includes: regular disinfection of high-touch surfaces, proper handling and disposal of contaminated materials, and maintenance of optimal ventilation and air quality.