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	12/15/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 5 residents reviewed (Resident #1).The facility failed to provide timely assistance to Resident #1, who had a chronic history of Chronic Obstructive Pulmonary Disease (COPD), congestive heart failure, and anxiety, when the resident experienced shortness of breath, required staff assistance and called 911 emergency assistance. This failure could place the residents with respiratory needs at risk for respiratory compromise.Record review of Resident #1's face sheet, dated 12/13/2025, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #1's admission MDS assessment, dated 09/02/2025, reflected diagnoses included of Chronic Obstructive Pulmonary Disease (a progressive lung condition characterized by persistent airflow limitation), Respiratory Failure (a condition where there's not enough oxygen or too much carbon dioxide in your body) and Anxiety Disorder (a disorder characterized by persistent and extreme worry and anxiety about different things, which causes significant distress or impairment). Resident #1's BIMS score of 11 indicated moderate cognitive impairment. The MDS further revealed that Section J - Health Conditions indicated Resident #1 had Shortness of [NAME] or trouble breathing when sitting at rest, when lying flat and with exertion (walking, transferring, bathing). Record review of hospital records dated 12/05/2025 revealed Resident #1 presented to the hospital with a complaint of shortness of breath. Initial assessment reflected no abnormal vital signs at the time of presentation. The resident was subsequently admitted with acute hypoxic and hypercapnic respiratory failure and was later diagnosed with respiratory failure secondary to healthcare-acquired pneumonia with exacerbation of chronic congestive heart failure. Record review of Resident #1's care plan, dated 10/22/2025, reflected: Focus Area: Oxygen Use: Resident #1 requires supplemental oxygen via nasal cannula related to decrease oxygenation. Goal: Resident #1 will maintain adequate oxygen saturation levels and respiratory comfort through the review date. Interventions /Tasks: Assess for signs of hypoxia (cyanosis, confusion, restlessness) and respiratory distress and report to MD as needed; Routinely monitor the resident's oxygen saturation levels; and Follow physician orders for oxygen therapy delivery. Focus Area: Behaviors: Resident #1 has episodes of behaviors and is at risk for further increased episodes and injury AEB Refusals of Care/ Behaviors removing nasal canula from face/nose. Goal: Resident #1 will decrease behavioral episodes through behavioral monitoring and interventions through the review date. Interventions /Tasks: Monitor and chart behaviors as they occur and report progress/declines to MD; and observe for early warning approach in a calm manner, call by name, remove from unwanted stimuli. Focus Area: Resident #1exhibits Ineffective coping related to anxiety or lack of problem-solving skills, as evidenced by inappropriate use of emergency services. Goal: The resident will have no evidence of behavior problems or repeated non-emergency calls to 911 through review date. Interventions /Tasks: Anticipate and meet the resident's needs; and educate the resident/family/caregivers on successful coping and interaction strategies such as notifying staff via call light. The resident needs encouragement and active support by family/caregivers when the resident use these strategies. Interview on 12/13/2025 at 9:48 AM, EMT stated his team responded to an incident on 12/05/2025 at approximately 6:15 PM, during which Resident #1 attempted to call for assistance, but no staff responded. EMT stated that 911 had to call the facility's front desk to alert staff that the residents were having trouble breathing and required assistance returning to bed from a wheelchair. EMT further stated that during the response, they asked the resident and facility staff to demonstrate how the nurse call system functioned. EMT observed that the nurse call system activated only a light above the resident room door, with no audible alert to the nurse station, hallway, or resident room. EMT reported the hallway lights were not visible from the nurse station, limiting staff awareness when residents activated the call system. EMT stated the expectation was for HHS to investigate the facility to ensure residents receive appropriate care with adequate resources and that the nurse call system functions in accordance with required standards. The EMT staff stated that vitals on assessment were O2 saturation of 97% and HR of 104 transported to hospital with SOB. EMT stated it was unknown by him if Resident #1's symptoms were related to delayed call light response times. Interview on 12/13/2025 at 12:13 PM, Resident # 1 recalled an incident that occurred on 12/05/2025, Resident # 1 said she had trouble breathing and wanted assistance returning to bed. Resident # 1 stated she activated the call light; however, staff did not

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure the facility was adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area 1 of 5 residents (Resident #1) residents reviewed for resident call system in that: The facility failed to provide a reliable and effective nurse call system and timely staff response to Resident #1 who required assistance, with respiratory needs.This failure could result in delayed staff response and placed residents at risk of respiratory compromise and injury related to delayed call light response. Record review of Resident #1's face sheet, dated 12/13/2025, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Record review of Resident #1's admission MDS assessment, dated 09/02/2025, reflected diagnoses included of Chronic Obstructive Pulmonary Disease (a progressive lung condition characterized by persistent airflow limitation), Respiratory Failure (a condition where there's not enough oxygen or too much carbon dioxide in your body) and Anxiety Disorder (a disorder characterized by persistent and extreme worry and anxiety about different things, which causes significant distress or impairment). Resident #1's BIMS score of 11 indicated moderate cognitive impairment. The MDS further revealed that Section J - Health Conditions indicated Resident #1 had Shortness of [NAME] or trouble breathing when sitting at rest, when lying flat and with exertion (walking, transferring, bathing). 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