Inspections Report

Paradigm at Faith Memorial

Nursing Facility Abuse, Neglect, Exploitation, and Misappropriation

March 18, 2025
OIG Report No. INS-25-007

Inspector General

Texas Health and Human Services

Paradigm at Faith Memorial

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Results in Brief

Why OIG Conducted This Inspection

In 2020 and 2021, the U.S. Department of Health and Human Services Office of Inspector General conducted audits of nursing facilities that reported allegations of potential abuse or neglect of Medicaid beneficiaries. The audits determined California, Florida, and New Jersey did not comply with federal requirements to report potential abuse or neglect of Medicaid beneficiaries. The Texas Health and Human Services (HHS) Office of Inspector General Audit and Inspections Division (OIG Inspections) initiated this inspection to determine whether the issues found in the 2020 and 2021 reports were present in Texas Medicaid nursing facilities.

Summary of Review

The inspection objective was to determine whether Paradigm at Faith Memorial (Faith Memorial) has processes and procedures to document and report abuse, neglect, exploitation, and misappropriation incidents as required by state law. The inspection scope covered the period from September 1, 2022, through August 31, 2023.

For more information, contact:
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Key Results

Faith Memorial has policies and procedures that describe how to identify and report abuse, neglect, exploitation, and misappropriation. However, Faith Memorial did not comply with state requirements regarding provider investigation reports, employment checks, and training during orientation related to abuse, neglect, exploitation, and misappropriation. Specifically:

- Of 49 provider investigation reports tested, 43 (87.8 percent) had errors with timeliness or retention. Nursing facilities must report incidents of suspected abuse, neglect, exploitation, and misappropriation within certain timeframes and retain the records of the incidents.
- Of 61 employee records tested:
  - 38 (62.3 percent) had late or inaccurate employment checks. Nursing facilities must check employment eligibility before an employee is hired and annually thereafter.
  - 18 (29.5 percent) did not contain documentation that employees received training during orientation related to identifying and reporting abuse, neglect, exploitation, and misappropriation. Nursing facilities must develop, implement, and maintain effective orientation training programs.

Recommendations

Faith Memorial should:

- Create and implement controls over its processes to report incidents and submit provider investigation reports timely and retain provider investigation reports as required.
- Create and implement controls over its processes to perform accurate and timely employment checks and maintain evidence of employment checks.
- Retain documentation to verify orientation training related to abuse, neglect, exploitation, and misappropriation is provided to all employees.

Management Response

Faith Memorial declined the opportunity to respond to the findings and recommendations in this report.

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Inspection Overview

Overall Results

The Texas Health and Human Services (HHS) Office of Inspector General Audit and Inspections Division (OIG Inspections) conducted an inspection to determine whether Paradigm at Faith Memorial (Faith Memorial) protects residents by screening employees and training them to identify, report, and document abuse, neglect, exploitation, and misappropriation, as required.

Faith Memorial did not always:

- Timely report incidents and submit provider investigation reports to HHSC Complaint and Incident Intake or retain incident reports.
- Accurately conduct Employee Misconduct Registry, Nurse Aide Registry, and criminal history checks.
- Timely conduct Employee Misconduct Registry and Nurse Aid Registry checks.
- Ensure all employees receive training during orientation on identifying, reporting, and documenting abuse, neglect, exploitation, and misappropriation.

OIG Inspections offered recommendations to Faith Memorial, which, if implemented, will help Faith Memorial consistently report incidents and submit provider investigation reports, conduct accurate and timely employment checks, and ensure personnel receive training during orientation regarding identifying and reporting abuse, neglect, exploitation, and misappropriation. OIG Inspections shared other less significant issues with Faith Memorial in a separate communication.

This report is considered written education in accordance with Texas Administrative Code.[1] Inspection findings identified in this report (a) may be referred to the Texas Health and Human Services Commission (HHSC) for potential pursuit of enforcement remedies or (b) may be subject to OIG administrative enforcement

[1] 1 Tex. Admin. Code § 371.1701 (May 1, 2016).

measures,[2] including administrative penalties.[3] This report does not address compliance beyond the scope and objective of this inspection.

OIG Inspections presented preliminary inspection results, observations, and recommendations to Faith Memorial in a draft report dated February 26, 2025. Faith Memorial declined the opportunity to respond to the findings and recommendations in this report. OIG Inspections thanks the management and staff at Faith Memorial for their cooperation and assistance during this inspection. Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

Objective

The inspection objective was to determine whether Faith Memorial has processes and procedures to document and report abuse, neglect, exploitation, and misappropriation incidents as required by state law.

Scope

The inspection scope covered the period from September 1, 2022, through August 31, 2023.

Background

Faith Memorial is a skilled nursing facility licensed for 112 beds located in Pasadena, Texas, in Harris County, as shown in Figure 1. The facility provides skilled nursing, rehabilitation services, and long-term care.

Figure 1: Faith Memorial Location

Source: Google Maps

[2] 1 Tex. Admin. Code § 371.1603 (May 20, 2020).

[3] Tex. Hum. Res. Code § 32.039 (Apr. 2, 2015).

What Prompted This Inspection

In 2020 and 2021, the U.S. Department of Health and Human Services Office of Inspector General conducted audits of nursing facilities that reported allegations of potential abuse or neglect of Medicaid beneficiaries. The audits determined California, Florida, and New Jersey did not comply with federal requirements to report potential abuse or neglect of Medicaid beneficiaries.[4,5,6]

OIG Inspections initiated this inspection to determine whether the issues found in the 2020 and 2021 reports were present in Texas Medicaid nursing facilities.

[4] U.S. Department of Health and Human Services Office of Inspector General, "California Did Not Ensure That Nursing Facilities Always Reported Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries and Did Not Always Prioritize Allegations Properly," A-09-19-02005 (June 9, 2021).

[5] U.S. Department of Health and Human Services Office of Inspector General, "Florida Did Not Ensure That Nursing Facilities Always Reported Allegations of Potential Abuse or Neglect of Medicaid Beneficiaries and Did Not Always Assess, Prioritize, or Investigate Reported Incidents," A-04-17-08058 (Mar. 4, 2021).

[6] U.S. Department of Health and Human Services Office of Inspector General, "New Jersey Did Not Ensure That Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries Residing in Nursing Facilities Were Always Properly Investigated and Reported," A-02-18-01006 (Aug. 19, 2020).

Detailed Results

Nursing facilities must develop and implement written policies and procedures that prohibit and prevent the mistreatment, abuse, neglect, exploitation of a resident, and misappropriation of a resident's property.[7] OIG Inspections tested records of incident reports, employment checks, and orientation training to determine whether Faith Memorial follows its policies and complies with state requirements.

Faith Memorial has policies and procedures that describe how to identify and report abuse, neglect, exploitation, and misappropriation. However, Faith Memorial did not always comply with state requirements regarding provider investigation reports, employment checks, and training during orientation related to abuse, neglect, exploitation, and misappropriation. Specifically:

- Of 49 provider investigation reports tested, 43 (87.8 percent) had errors of timeliness or retention of incident reports.
- Of 61 employee records tested:[8]
  - 38 (62.3 percent) employment checks were performed late or contained inaccuracies, or both.
  - 18 (29.5 percent) did not have evidence of abuse, neglect, exploitation, and misappropriation training during orientation.

The following sections of this report provide additional detail about the findings of noncompliance observed by OIG Inspections.

[7] 26 Tex. Admin. Code § 554.601(c) (Jan. 15, 2021).

[8] An employee record may have one or more issues associated with employment checks and orientation training.

Chapter 1: Faith Memorial Did Not Always Report Incidents Timely or Retain Documentation

Nursing facilities must report incidents of suspected abuse, neglect, exploitation, and misappropriation within certain timeframes and retain the records of the incidents.

Allegations must be reported to HHSC Complaint and Incident Intake:[9]

- No later than two hours if they involve abuse or result in serious bodily injury.
- No later than 24 hours for all other allegations that do not involve abuse and do not result in serious bodily injury.

The facility must conduct an investigation of the reported acts and: [10]

- Have evidence that all alleged violations were thoroughly investigated.
- Submit the results of the investigation to HHSC Complaint and Incident Intake within five working days of the incident.
- If the alleged violation is verified, take appropriate corrective action.

Nursing facilities must also maintain incident reports for two years after occurrence. These reports must include the resident's name, witnesses, date and time of the incident, description of the incident and the resident's health status after the incident.[11]

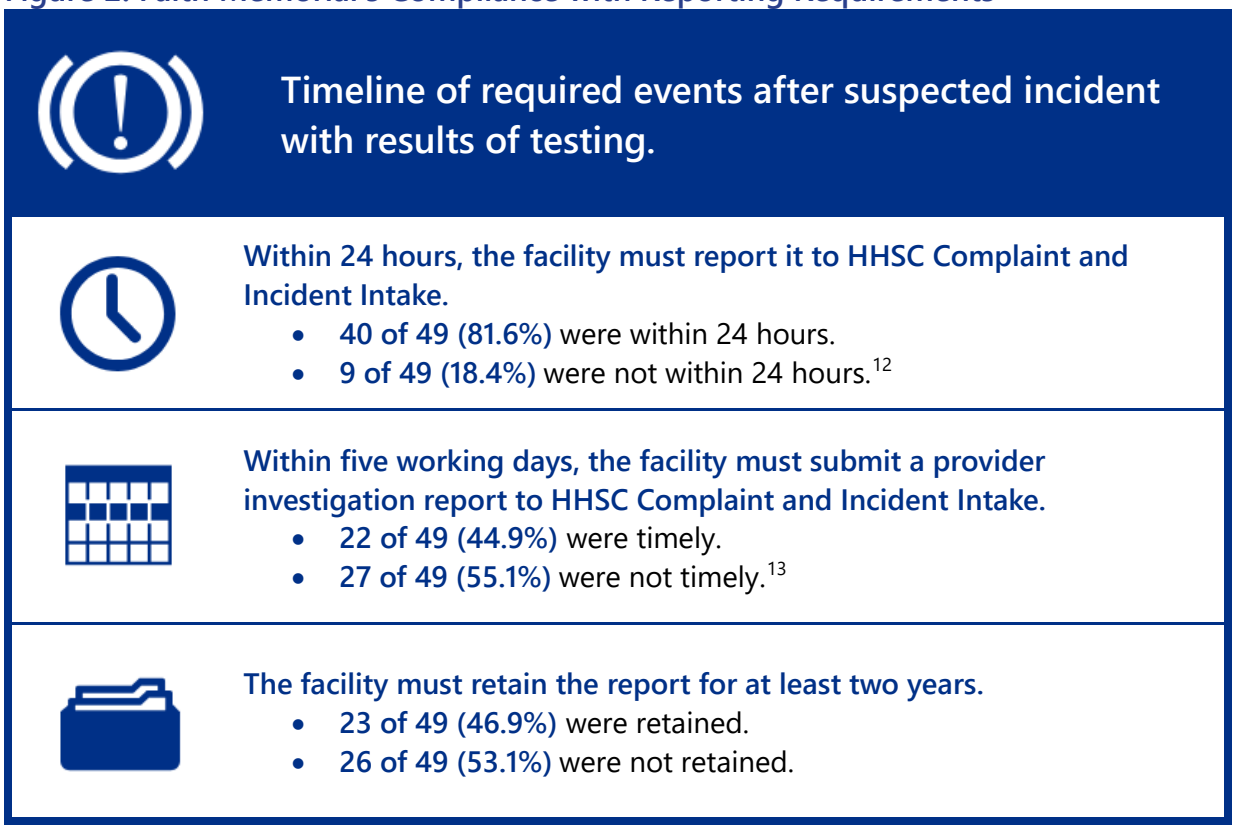
[9] 26 Tex. Admin. Code § 554.602(a)(1) (Jan. 15, 2021).

[10] 26 Tex. Admin. Code §§ 554.602(a)(2) and 554.602(a)(4) (Jan. 15, 2021).

[11] 26 Tex. Admin. Code § 554.1923 (c)(1) (Jan. 15, 2021).

Figure 2 summarizes the requirements and Faith Memorial's compliance.

Figure 2: Faith Memorial's Compliance with Reporting Requirements



Source: OIG Inspections

Faith Memorial did not always report incidents and submit reports timely or retain incident reports, as required. Not reporting and submitting incidents timely may endanger residents because opportunities to strengthen protections against abuse, neglect, exploitation, and misappropriation are delayed.

[12] Of the nine incidents Faith Memorial reported later than the first 24 hours, eight were two to seven days late. The ninth was 38 days late.

[13] Of the 27 provider investigation reports that were not submitted timely, 14 were not submitted at all, 12 were five to 10 days late, and one was 44 days late.

Recommendation 1

Faith Memorial should create and implement controls over its processes to report incidents and submit provider investigation reports timely and retain provider investigation reports as required.

Chapter 2: Faith Memorial Did Not Always Conduct Accurate or Timely Employment Checks

Nursing facilities must search the Employee Misconduct Registry and Nurse Aide Registry through the Employability Status Check Search website,[14] provided by HHSC, before an employee is hired to determine if the person applying for employment is listed as unemployable on either registry. The Employee Misconduct Registry and Nurse Aide Registry must be rechecked annually, and the record of all searches must be retained.[15] In addition, nursing facilities must perform criminal history checks to determine if an individual has a conviction that bars them from employment before the individual has direct contact with a resident.[16]

Initial Checks

Of employee records tested for the 61 employees during the inspection scope, 38 (62.3 percent) had at least one[17] error on the criminal history, Employee Misconduct Registry, or Nurse Aide Registry initial employment checks. Specifically:

- One used a misspelled name for both the criminal history and the registry checks.
- One record of criminal history checks did not exist.
- Three records of registry checks did not exist.
- 34 registry checks were performed after the date of hire.

On July 3, 2024, OIG Inspections conducted the Employment Misconduct Registry and Nurse Aide Registry checks using the correctly spelled name and for all active employees. The employees did not appear on either registry as unemployable.

Faith Memorial asserted some employment records may have been lost during a change in ownership on October 1, 2022.

[14] HHSC requires nursing facilities and agencies to conduct Employee Misconduct Registry and Nurse Aide Registry checks through the Employability Status Check website.

[15] 26 Tex. Admin. Code § 561.3 (Apr. 21, 2022).

[16] Tex. Health & Safety Code § 250.003 (Jan. 1, 2014).

[17] An employee record may have one or more issues associated with employment checks.

Annual Checks

Of the 19 employees due for annual registry checks during the scope period, six separated from Faith Memorial during the scope before their annual check was required.[18] Of the remaining 13:

- Seven employee records (53.8 percent) did not contain documentation of an annual registry check during the scope.
- Six employee records (46.2 percent) contained documentation that annual registry checks were conducted but were late.

Faith Memorial had processes for conducting annual checks but did not always perform timely Employee Misconduct Registry and Nurse aide Registry checks. By not performing initial employment and annual checks as required, Faith Memorial put residents' health and safety at risk.

Recommendation 2

Faith Memorial should:

- Create and implement controls over its processes to perform accurate and timely employment checks.
- Maintain evidence of employment checks.

[18] Of the 61 employee records reviewed, 42 were hired during the scope period and so an annual check was not due.

Chapter 3: Faith Memorial Did Not Maintain Documentation That Abuse, Neglect, Exploitation, and Misappropriation Training During Orientation Was Provided

Nursing facilities must develop, implement, and maintain effective orientation and training programs to develop the skills of their staff. As part of orientation, each employee must receive instruction regarding (a) activities that constitute abuse, neglect, exploitation, or misappropriation of resident property and (b) procedures for reporting incidents of abuse, neglect, exploitation, or misappropriation of resident property.[19]

Faith Memorial's orientation program policy requires all newly hired employees to attend the orientation program, which includes instruction on abuse, neglect, exploitation, misappropriation identification and reporting processes.[20]

However, Faith Memorial did not provide documentation that it consistently provided orientation training related to abuse, neglect, exploitation, and misappropriation for employees. Specifically, 18 of 61 (29.5 percent) employee records did not contain documentation that employees received the required orientation training related to abuse, neglect, exploitation, and misappropriation.

Nursing facility residents are at an increased risk of abuse and neglect if personnel are not properly trained to identify and report incidents of potential abuse, neglect, exploitation, or misappropriation.

Recommendation 3

Faith Memorial should retain documentation to verify orientation training related to abuse, neglect, exploitation, and misappropriation is provided to all employees.

[19] 26 Tex. Admin. Code § 554.1929 (Jan. 15, 2021).

[20] Faith Memorial "Abuse, Neglect, and Exploitation Prevention Policy and Procedures" (2022).

Appendix A: Methodology, Standards, and Criteria

Detailed Methodology

Of the 1,195 nursing facilities in Texas, Faith Memorial was among the facilities with the highest number of incidents of six nursing facilities identified by HHSC Long-term Care Regulation related to abuse, neglect, exploitation, or misappropriation in 2023.

To achieve its objective, OIG Inspections collected information through (a) interviews with Faith Memorial's administrator and HHSC Long-term Care Regulation staff and (b) a review of reported incidents and complaints of abuse, neglect, exploitation, and misappropriation for 2023. OIG Inspections also reviewed information provided by Faith Memorial including:

- Policies and processes
- Provider investigation reports
- Orientation program documents
- Employee records

OIG Inspections reviewed personnel records for 61 Faith Memorial employees between September 1, 2022, through August 31, 2023, as well as 49 provider investigation reports for the same period. OIG Inspections compared employee personnel records and provider investigation reports to state requirements to determine whether Faith Memorial (a) timely reported incidents and submitted Provider Investigation Reports, as required, (b) conducted accurate criminal history, Employment Misconduct Registry, and Nurse Aide Registry checks, (c) conducted Employment Misconduct Registry and Nurse Aide Registry checks prior to the date of hire and annually, and (d) provided orientation instruction on identifying, reporting, and documenting abuse, neglect, exploitation, and misappropriation.

Standards

OIG Inspections conducts inspections of Texas HHS programs, systems, and functions. Inspections are designed to be expeditious, targeted examinations into specific programmatic areas to identify systemic trends of fraud, waste, or abuse.

Inspection reports present factual data accurately, fairly, and objectively, and present findings, conclusions, and recommendations in a persuasive manner to strengthen program effectiveness and efficiency. OIG Inspections conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

Criteria

OIG Inspections used the following criteria to evaluate the information provided:

- Tex. Health & Safety Code § 250.003 (2014)
- 26 Tex. Admin. Code §§ 554.601 (2021), 554.602 (2021), 554.1923 (2021), 554.1929 (2021), and 561.3 (2022)
- Faith Memorial, "Abuse, Neglect, and Exploitation Prevention Policy and Procedures" (2022)

Appendix B: Resources for Additional Information

The following resources provide additional information about the topics covered in this report.

For more information on Long-term Care

"Long-term Care Providers," HHSC https://www.hhs.texas.gov/providers/long-term-care-providers (accessed September 30, 2024)

"Nursing Facilities (NF)," HHSC https://www.hhs.texas.gov/providers/long-term-care-providers/nursing-facilities-nf (accessed September 30, 2024)

For more information on Faith Memorial

Faith Memorial, https://www.paradigmatfaithmemorial.com/ (accessed September 30, 2024)

Appendix C: Related Reports

- Nursing Facility Abuse, Neglect, Exploitation, and Misappropriation: Midtowne Meadows Health and Rehab, INS-25-002, October 28, 2024

Appendix D: Report Team and Distribution

Report Team

OIG staff members who contributed to this inspection report include:

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- Bruce Andrews, CPA, CISA, Director of Inspections
- James Aldridge, CFE, Manager of Inspections
- Bridney Jones, Lead Inspector
- Kenin Weeks, Senior Inspector
- Tiana Clayton, Senior Inspector
- Gabriel Moreno, Senior Inspector
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Report Distribution

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Paradigm at Faith Memorial

- LaTonya Autrey, Administrator, Paradigm at Faith Memorial
- Norma Lozano, Human Resources Director, Paradigm at Faith Memorial

Appendix E: OIG Mission, Leadership, and Contact Information

The mission of OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Raymond Charles Winter, Inspector General
- Susan Biles, Principal Deputy Inspector General
- Kacy J. VerColen, Chief of Audit and Inspections
- Eugenia Krieg, Chief of Staff, Chief of Policy and Performance
- Erik Cary, Chief Counsel
- Diane Salisbury, Chief of Data Reviews
- Matt Chaplin, Chief of Operations
- Steve Johnson, Chief of Investigations and Utilization Reviews

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- Phone: 1-800-436-6184

To Contact OIG

- Email: oig.generalinquiries@hhs.texas.gov
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