STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675085	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at Woodwind Lakes	7215 Windfern Rd Houston, TX 77040

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 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 an allegation of misappropriation of property was reported immediately but not later than 24 hours after the allegation was made to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 of 2 residents (CR #142 and Resident# 134) reviewed for reporting.The Prior administrator failed to report to the State Survey Agency the incident of missing money for Resident #134 on 7/22/2025 and CR #142 on 6-9-25.Facility staff did not immediately notify law enforcement of a suspicion of a crime when Resident #134 reported missing money on 7/22/2025 and when resident CR #142 reported missing money on 6-9-2025These failures could affect residents by placing them at risk of misappropriation of property if the reportable allegations are not reported timely after they are discovered.Findings included: Record review of Resident #134's face sheet printed on 8/14/2025 indicated that Resident #134 was a [AGE] year-old female who was originally admitted to the facility on [DATE] and a readmission date of 6/10/2025 with the following diagnoses to include but not limited to: Pneumonia, unspecified atrial fibrillation, muscle wasting and atrophy, acute on chronic systolic (congestive) heart failure, Difficulty in walking, not elsewhere classified, other lack of coordination, muscle weakness (generalized), Type 2 Diabetes Mellitus with diabetic Neuropathy, Cognitive Communication deficit, Chronic Pain, Generalized Anxiety Disorder (mental health disorder), Mixed Hyperlipidemia, History of Falling, Major Depressive Disorder, Gastro-Esophageal Reflux disease without esophagitis (heart burn), and dysphagia, oral phase (difficulty with speech). A record review of Resident #134's Quarterly MDS dated [DATE] revealed; BIMS score of 15 out of 15 indicating resident was cognitively intact. A record review of the facility's concern report dated 7/22/25 revealed: The concern was Reported to the former Administrator by Resident 134. Resident states she's missing $80 from a week or so ago she last had the money in her room under her pillow and when she realized it money was missing. Investigation details: Administrator immediately called residents [family member] and discussed missing $80 and the time frame when money was discovered missing. Investigation/Resolution: Investigation initiated to resolve $80 whereabouts. Admin called [family member] and [family member] stated no need to refund money at this time. Resident encouraged to use trust fund. Resident encouraged to use lock box. In an interview with Resident #134 on 08/14/2025 5:15 PM Resident #134 stated last month she was missing $80 out of her purse. The purse was located under her behind while she was sleeping. The facility didn't do anything about it. She had to borrow money from others to afford the things she wanted. She really wants her money back. She did discuss this with her family member and that's what they agreed on. Resident felt someone came in her room and stole the money from her purse while she was sleeping. Resident appeared upset about the missing money. Record review of CR #142's face sheet printed on 8/14/2025 indicated that CR#142 was a [AGE] year-old male who was originally admitted to the facility on [DATE] and discharged on 7/3/2025 with the following diagnoses to include but not limited to: Local infection of the skin and subcutaneous tissue, other acute osteomyelitis, left ankle and foot, Type 2 Diabetes mellitus with hyperglycemia, need for assistance with personal care, unspecified lack of coordination, muscle weakness (generalized), unspecified abnormalities of gait and mobility, schizoaffective disorder (mental health disorder), osteomyelitis. Record review of CR# 142's admission MDS dated [DATE], revealed resident had a BIMS score of 10 indicating resident was moderately impaired. Record review of facility's Concern report for CR #142 dated 6/9/2025 revealed: Description of concern: Resident walked in his room door was closed seen Laundry aid A going through his things. He tried talking to her but she wouldn't say nothing. The day went by he didn't leave room after that. When getting ready for bed he realized money missing from wallet he did go to report to nurse not sure of name. Investigation/resolution: Laundry aid was in his room. States employee took $18 total from his room on 6/8. Resident states 2 other residents knew he had cash. Record review of facility's Education In-Service Attendance record dated 6/16/25 revealed: Topic: Missing money and abuse coordination when to report, who to report to immediately Present by the former Administrator. Surveyor attempted to contacted CR #142 on 8/12/2025 at 7:55 AM and 8/14/2025 at 8:16 AM via phone call and texts. CR #142 did not respond or call back. In an interview on 08/14/2025 at 12:50PM with the Laundry Aide she stated she does what she likes to call room rages every day in residents' room. She gathers dirty laundry in resident's room. She will also look through residents' drawers and things to see if they were hiding

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure Residents receive adequate supervision and assistance devices to prevent accidents for Resident # 1. The facility failed to ensure CNA A properly transferred Resident # 1 on 07/16/2025. This failure could place Residents at risk of being injured. Findings include: Record review of Resident #1's face sheet retrieved on 08/12/2015 revealed, a [AGE] year-old female who was admitted to the facility on [DATE]. The resident's diagnoses included: Osteomyelitis, primary osteoarthritis-right hip, generalized muscle weakness, lack of coordination, communication deficit, Gastro-Esophageal Reflux, other seizures, bipolar, Dysphagia, anxiety, insomnia, profound intellectual disabilities, muscle wasting, pain, epilepsy, elevated white blood cell count, unspecified multiple injuries, hypermagnesemia, adrenocortical insufficiency, non-pressure chronic ulcer of the skin, hyperosmolality and hypernatremia, hypokalemia, soft tissue disorders, glaucoma. Currently has an out of hospital Do Not Resuscitate order. Record review of Resident # 1’s MDS dated , 06/08/2025, section C0500-BIMS codes as 00 which indicates severe cognitive impairment. Section C0700 was coded 1 which indicates memory problem. GG0115 was coded 2 which indicates functional limitation on both upper and lower extremities.GG0120 was coded C, which indicates she uses a wheelchair. Record review of Resident #1’s care plan, dated 06/23/2025, revealed the Resident requires extensive assistance of 2 staff for transfer. Record review of facility’s resident care specialist job description presented to surveyors on 08/13/2024 revealed: Perform resident care duties as assigned by charge nurse, including but not limited to transporting and transferring, restocking resident room, changing linen, properly positioning resident, bathing, assisting with bowel and bladder needs, assisting with dressing, assisting with eating and hydration, taking vital signs, and caring for resident as needed or directed Record review dated 07/16/2025 presented to survey team on 08/13/2025 at 1:28 pm revealed: a written disciplinary final warning for CNA A. Record review of facility’s nurses’ notes dated 07/22/2025 revealed: Late Entry on 07/22/2025 at 15:54 pm done by Unit Manager: Notified by CNA that resident #1had hit her head on the wall during a transfer, resident's vitals were taken, and area was assessed. Vitals were BP 118/66, pulse 78, respirations 19, temperature 96.9, and O2 sat 96% on room air. ROM was WNL, small, raised area on the back right side of resident's head. No bleeding, and no discoloration noted. Resident's mentation at baseline. Administrator and DON notified. Hospice company contacted, stated neuros were not necessary if resident was at baseline and no bleeding occurred. During an interview Resident #2 on 08/13/2025 at 08:40 am, she stated: on 7/16/2025, she was asleep when the sound of her roommate’s head against the wall woke her up. She stated the hospice aide narrated what happened to the nurse. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA A on 08/13/2025 at 10:17 am, he stated: On 07/16/2025 HA B, asked CNA A to help her put Resident #1 in the bed. CNA A got Resident #1 rolled back into her room because she was in the hallway in her wheelchair. So, we brought her into her room. The lady did not help him, he ended up doing it by himself. So, the height of the wheelchair was higher than the bed. So, he picked Resident # 1 up and put her in the bed, her body leaned due to the centrical force of him putting her in the bed, so her head bumped on the wall. The resident did not show any sign of pain. CNA A went and got his Unit Manager, and he told her what happened. They called the Administrator. HA B gave her statement, CNA A was written up because the resident hit her head. CNA A stated, in the past he has been doing it alone. She was not that big of a person. I usually pick her up and put her down by myself. The transfer could be done by one staff, it could be a two-person transfer. It was usually in the POC if the resident was a 2 or 1 person assist. She has an air mattress which could have contributed to her bumping her head. During an interview with nurse A on 08/13/2025 at 10:29 am, he stated: I was notified by CNA A that, when he was transferring resident #1, she fell back in bed and hit her head against the wall. I went and assed her, I assessed the back of head there was no swelling, no bleeding and no bruising. Her alertness was the same. She was baseline-her normal. The HA B said resident #1was put back in bed roughly which caused her to hit the back of her head. CNA A told HA B to tell the same story to my UM. She wrote a statement. As a prudent nurse when a resident hit their head, we should assess and call the DR. and initiate neuro checks. I called the DR. The UM took over the care. The Dr. said assess for neuro and notify with any changes. During an interview with the UM on 08/13/2025 at 11:03 am, she stated: On 7/16/2025. CNA A transferred resent #1 back to bed because the hospice aide wanted to give a bath. The UM stated per the hospice policy, the hospice aides were not allowed to transfer residents. Nurse B said, CNA A stated when he transferred resident #1, she hit the side of her head on the wall. Resident #1 was on an air, mattress. The UM said CNA A came and reported to her. The UM said CNA A made sure resident #1 was ok. The UM said, she went in and touched resident # 1’s head and felt a small node, but no discoloration. The UM stated, she asked resident #1 if she was ok, and Resident #1 she said she wanted to eat. The UM stated, there was no visible distress, when she rubbed her hand across resident #1’s head. Resident #1 showed no twisted facial emotions that would have expressed pain or discomfort. CNA A checked resident #1’s blood pressure, temperature, heart, breathing and oxygen levels. Nurse B said, she notified the facility administrator, and the Dr. The UM said, the hospice company stated neuros were not necessary because the nurse was coming that same day. The UM stated resident’s care plan, revealed she was a maximum assist. During a telephone interview on 08/13/2025 at1:05 pm with the former administrator, she stated the hospice aide told her that CNA A transferred resident #1 and she hit her head and there was a bump, on a part of her body. The former administrator stated she, investigated. She said the hospice aide told her when the incident occurred, CNA A went and notified the UM and the primary nurse. The former administrator stated she got a verbal statement from the alert roommate, and the hospice aide. She called the guardian on the same day, but there was no response. She did call the next day, the guardian responded. The former administrator stated she also notified hospice clinical director on the same day the incident occurred. She told the guardian and hospice clinical director that the incident did not meet the criteria for reporting based on the guidelines for CMS, because it was accidental. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 08/13/2025 at 1:28 pm, she stated, she was off duty when the incident occurred. She was notified when she returned that, resident #1 bumped her head during transfer. She said she has further investigated, as she spoke with the hospice company’s DON . The hospice office agreed they called the incident to the state office. The DON said, the former administrator did an investigation and deemed it was not reportable. The DON stated, she just found out resident # 1 had an inappropriate transfer. Thus, she suspended CNA A today pending investigation. The DON said, the CNAs should be looking at the Kardex to know the required number of staff needed for transfer. The DON said inappropriate transfer can lead to potential injury to both the resident and the staff. During an interview with nurse B on 08/14/2025 at10:47 am. Nurse B said, she knows the required number of staff needed to transfer a resident based on the resident’s functionality. She said, you can look at the ADL transfer section in the chart. It will indicate the maximum number of staff required. It will also indicate if there was need for a Hoyer lift or 2 persons assist. Nurse B stated, if a transfer is done inappropriately, the resident might have skin tear, or an injury to a flexible tissue that connects the bones at a joint. During an interview with the Administrator on 08/14/2025 the Administrator who stated resident #1’s incident occurred before she was hired. She said, training was coordinated by the various department heads. She said inappropriate transfer may result to serious injury. A record review of the facility’s policies and procedures for transfers/lifts, revised on 01/2024. The purpose of this policy is to ensure the safety, dignity, and well-being of residents during transfers and lifts within the nursing home facility. This policy aims to minimize the risk of injury to both residents and staff while promoting efficient and respectful care practices. Factors affecting transfers/lifts. Resident: -Medical status -Physical status -Emotional Status -Mental faculties -Communication -Interference Assessment Each resident's mobility and transfer needs shall be routinely assessed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Individualized care plans shall be developed based on the resident's assessment, outlining appropriate transfer techniques, equipment requirements, and staff assistance levels.