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	03/27/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment for 2 of 3 (Resident #1 and Resident #3) residents reviewed for comprehensive assessments.1. The facility failed to ensure that Resident #1's care plan included the physician ordered hand splint interventions for his hand contractures, and the implementation of the device.2. The facility failed to implement the care plan interventions for Resident #3's persistent wandering when she had an unwitnessed fall and sustained a hematoma to the right side of the forehead, which resulted in hospital treatment.This deficient practice could place residents at risk of not receiving proper care and services.Findings included:Resident #1Record review of Resident #1's face sheet dated 03/26/26 revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease (a progressive brain disorder that slowly destroys memory and eventually the ability to carry out simple tasks), parkinsonism (a nervous system disorder), stroke, muscle weakness, and need for assistance with personal care.Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 9 out of 15, indicating he had moderately impaired cognition. Further review revealed the resident was dependent on staff for ADL care. Resident #1 had impairment to the upper extremity on one side.Record review of Resident #1's care plan revision dated 01/08/26 revealed Resident #1 had contractures and was at risk for skin breakdown, increased pain to affected areas, and further worsening of contracted areas as evidenced by contractures to bilateral hands. Interventions included keeping contractured areas clean and dry, providing PROM (donot force contractured areas), monitoring for increased pain/stiffness, and providing medications/treatments as ordered.Record review of Resident #1's March physician orders revealed an order for an RNA program 6x/week x 6 months that might have included: L resting hand splint; passive-to-active-assisted ROM exercises to BUEs to maintain ROM in BUEs or prevent further complications; and stretching to each wrist and hand to prevent further contractures, ordered 03/26/26.During an observation and interview on 03/25/26 at 3:09 p.m., it was revealed Resident #1 had contractures on both hands and there was no splint or carrot in his hands. Resident #1 said the nurse had not applied any carrot or rolled-up towel to his hands that day. Resident #1 stated that the staff applied the carrot or hand roll to his hands when they wanted, and he could not complain because they were the ones providing care for him since he could not do anything for himself.During an interview on 03/25/26 at 3:29 p.m., RN B said he was Resident #1's nurse for that day and he came to work at 7:00 a.m He stated he had not seen any carrot on his left hand, but he was supposed to have a carrot in his hand. RN B said the ADON had told him to apply the carrots for Resident #1's hands as soon as therapy brought the carrots to him. RN B said if Resident #1 did not have any preventative rolls or carrots in his hands, the contractures would worsen. RN B said the aide or restorative aides were supposed to apply carrots for Resident #1's hands.During an interview on 03/25/26 at 4:24 p.m., CNA T said she was Resident #1's CNA for the (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	morning shift, and Resident #1 did not have any carrot in his hand during that morning shift. She said the restorative aide was responsible for applying the carrot to the resident's hands. CNA T said if the carrots were not applied to the resident's hands, the contractures could get worse.During an interview on 03/25/26 at 4:28 p.m., RA S said Resident #1 was supposed to have carrots in each hand. RA S said it was the responsibility of the restorative aides and the CNAs to apply carrots on Resident #1. She said Resident #1's hands could get worse if the staff did not apply the carrots as ordered. RA S said if there were no carrots, then they could use towels. She said carrots should be applied to Resident #1's hands for four hours, then removed for a two-hour break with hand massage before the carrots would be reapplied until the next day. She said the other restorative aide had applied the carrots, and she would have taken them off for a two-hour break. RA S said she went to Resident #1's room to reapply the carrots, but there were no carrots in his room, and she checked the resident's drawers as well. She said a staff member brought two carrots and gave them to her, and she applied the carrots on Resident #1's hands.During an interview on 03/25/26 at 4:55 p.m., the DON said she would look into the care plan regarding the care for Resident #1 because carrots were not on his care plan. She said the restorative aides did not document on the POC and they were still charting on paper. The surveyor requested the paper charting, and the DON said she was still putting it together.During an interview on 03/26/26 at 1:54 p.m., CNA C said she had applied a carrot on Resident #1's left hand close to the window, and she took the carrot off after four hours and placed it in his drawer. She said she would tell Resident #1's aide that she had applied the carrot on his hand the previous day. However, she did not see Resident #1's aide and did not tell the aide. CNA C said she documented care on the POC in the computer. She said Resident #1's hand could become more contracted if the carrot was not applied to the resident's hands. CNA C said it was on Resident #1's POC to apply carrots on Resident #1's hands.During an interview on 03/26/26 at 3:20 p.m., the ADON said the restorative aides were supposed to apply the carrots on Resident #1's hands, and he did not know if there was an order for the carrots or if it was in the resident's care plan. The ADON said the therapy department was in charge of training the restorative aides. He said Resident #1's contractures would get worse if therapy did not apply the carrots on Resident #1's hands.During an interview on 03/27/26 at 8:50 a.m., the MDS Coordinator said the DON and therapy worked together after therapy to place a resident in a restorative program, and there should have been an order for restorative care for contractures. She said the DON would notify her, and she would update the care plan with the order, which would include the interventions. She said if Resident #1 needed carrots for his contracted hands, and they were not applied, the contractures could worsen. The MDS Coordinator said she was called after hours the previous day while she was at home and was notified that the facility would be reviewing all residents with contractures, and she was updating the contracture care area for Resident #1's care plan.During an interview on 03/27/26 at 11:36 a.m., the DON said the carrot was a nursing intervention, and they could not find where it was documented or signed off by the staff that they had provided the care for Resident #1. The DON said it was a broken system, and they were going to reassess all residents with contractures. She said she had a physical therapist in the building at that time, and the therapist was evaluating all the residents with contractures. Resident #3Record Review of Resident #3's face sheet dated 03/21/2026, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #3's diagnoses included Dementia with psychotic disturbance (visual and auditory hallucinations or delusions related to Dementia); difficulty walking not elsewhere classified (general gait impairment or mobility issues); other lack of coordination (non-specific motor control issues or general clumsiness); altered mental status (significant confusion or disorientation with no definitive cause); and, restlessness and agitation (a state of mental tension, inability to relax, or excessive, non-productive activity).Review of Resident #3's Quarterly MDS dated [DATE], indicated the resident had difficulty communicating words or finishing thoughts; sometimes responded adequately to simple, direct communication only; and, had a BIMS score of 00. Inattention, and disorganized thinking was present and fluctuated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Presence and frequency of wandering behavior occurred 1 to 3 days. Resident #3 required setup or clean up assistance to walk 10 feet and 50 feet with two turns. Other neurological conditions and non-Alzheimer's dementia noted. Pain assessment interview not to be conducted as the resident was rarely or never understood. Noted to have 1 fall without injury since admission or reentry to facility. Record review of the comprehensive care plan last reviewed on 12/29/2025, indicated Resident #3 had ADL deficits and required staff to anticipate the resident's needs and provide prompt assistance; provide limited assistance with 1 support person for locomotion on/off unit; provide supervision assistance with 1 support person for walking in room/down corridor; and, to provide PROM during ADL care as needed.Further review of the care plan last reviewed on 12/29/2025 indicated the resident had a history of unintentionally walking into objects. Staff interventions included frequent checks on the resident, especially during high-risk times; maintain the resident's safety during increased episodes of wandering; and offering engaging activities to reduce restlessness. The resident had impaired communication and was at risk for further decline and injury. Staff interventions included reducing or removing interfering environmental stimuli, and using communication tools, terms and gestures the resident could understand. The resident also had a history of taking off her footwear.Review of Resident #3's records reflected a progress note by RN A on 3/16/26 at 6:30 PM, indicated Resident #3 had an unwitnessed fall in the dining room. Prior to the fall, the resident was wandering. Vital signs post fall BP 122/76; Pulse 72; Temperature 97.4; Respirations; 17; O2 saturation 97%. DNP was notified and reviewed medications with RN A. RP also notified.Record Review of the SBAR Change of Condition documentation for Resident #3, dated 3/16/2026 at 6:30 PM, RN A noted the resident had an unwitnessed fall in the dining room. Resident was noted to be wandering before the fall. No notable findings after environment surrounding the fall was assessed. Vital signs noted as BP 122/76; Pulse 72; Temperature 97.4; Respirations; 17; O2 saturation 97%. Assessment of range of motion indicated no changes from baseline of right upper and lower extremities or left upper and lower extremities. Resident did not have onset of pain or visible injuries related to the fall. No other significant conditions contributed to the fall. Notifications made to DNP and RP. New orders to send the resident to ER.Observation of resident #3 on 3/21/26 at 2:12 PM, revealed the surveyor followed Resident #3 to the dining room. Resident #3 ambulated independently; however, every few steps and when stopping, Resident #3 experienced loss of balance lasting about 2 - 3 seconds. The surveyor attempted to engage Resident #3. Resident #3 appeared to hear the surveyor but did not respond and continued to walk in the opposite direction. The surveyor requested nursing assistance to assess Resident #3. Resident #3 had visible discoloration on the right side of the face, including the area above the eyebrow, below the eye, and extending toward the nose. The discoloration was yellow and purple. Resident #3 did not allow LVN C to assist any longer than about 15 seconds, moved staff hands away, and continued walking down the corridor.During an interview on 3/21/26 at 5:15 PM, CNA A said Resident #3 was nonverbal, not oriented, continuously walked, and did not remain seated. She said Resident #3 required staff to watch her while walking due to fall risk. She said she was trained on Resident #3's care plan and understood supervision was required.On 3/21/26 at 5:28 PM, CNA B said Resident #3 walked constantly, did not sit still, and did not communicate verbally. She said she documented in the point-of-care system to track Resident #3's needs but was unsure whether Resident #3's care plan specifically included supervision interventions.On 3/22/26 at 11:22 AM, LVN A said Resident #3 continuously moved and walked around. She said Resident #3 did not remain seated. She said staff accessed Resident #3's care needs through the care plan and the point of care (POC) used by CNAs. She said there were no specific interventions addressing Resident #3's constant movement other than general supervision and her non-skid socks. She said following the incident, she assessed Resident #3, notified the DNP of the unwitnessed fall, and again regarding the hematoma, and Resident #3 was sent to the hospital.On 3/22/26 at 1:00 PM, the ADON said staff were expected to follow care plans to ensure residents received necessary care and that failure to follow care-planned interventions placed (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents at risk for harm and failure to receive required services.On 3/22/26 at 1:37 PM, the DON said Resident #3 was care planned for supervision due to wandering and fall risk. She said the MDS Coordinator worked with the nursing department to create and update resident care plans. She said ultimately, the MDS Coordinator was responsible for ensuring care plans were accurate. She said staff were trained to use care plans. She said aides documented the care they provided in the same system that outlined resident care. She said failure to follow care-planned interventions placed residents at risk for injury and failure to identify changes in condition. She said lack of care plans being individualized could lead to lack of appropriate care of a resident. She said as far as she knew, Resident #3's care planned interventions were appropriate for the resident.On 3/22/26 at 2:31 PM, CNA A said sometimes Resident #3 seemed like she could be on 1:1 supervision because she walked so much.An observation in the memory care unit on 3/22/26 at 2:18 PM, revealed Resident #3 was observed wandering up and down the hallway and spinning in a circle several times. 1 staff stood in the middle of the hall with the wandering residents in their line of sight. Resident #3 was wearing non-skid socks.On 3/22/26 at 2:43 PM, the MDS Coordinator said staff were expected to be familiar with care plans and had daily access to them. She said failure to follow care-planned interventions could result in residents not receiving necessary services. She said Resident #3's care plan was updated after the incident on 3/16/26 to include Resident #3 wearing non-skid socks. She said the care planned interventions for Resident #3 were appropriate.On 3/22/26 at 3:42 PM, the Administrator said Resident #3 was care planned for supervision at the time of the incident on 03/16/26, and required monitoring due to behaviors and fall risk. She said failure to follow the care plan resulted in residents not receiving necessary care and increased the risk of preventable incidents. She said the incident might have been preventable if the care plan had been followed. She said she would have to review the care plan again to determine whether the resident's care planned interventions were appropriate regarding walking and supervision.On 3/27/26 at 12:28 PM, the DNP said she was notified of Resident #3's condition following the fall and later notified of the hematoma with discoloration. She said the discoloration was related to the hematoma and consistent with the injury. She said she instructed staff to send Resident #3 to the hospital immediately. She said she was not willing to provide a statement regarding potential risk and did not provide hypothetical risk statements.Record review of the facility's policy titled Care Plan Revisions revised May 2022 read in part, .The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents within the facility.Guidelines #2e. Care plans would be modified as needed by the MDS Coordinator or other designated staff member.#2f. The Unit Manager or other designated staff member would conduct an audit on all residents experiencing a change in status, at the time the change in status was identified, to ensure care plans had been updated to reflect current resident needs.Review of the facility's policy titled Standards of Care revised 10/2023 indicated All care provided will comply with current guidelines, best practices, and Federal/State regulations.Safety measures will be in place to prevent accidents and injuries, including fall preventions strategies.All staff members are responsible for adhering this policy and for providing care that meets these standards. The Administrator will oversee the implementation and compliance with this policy.Review of the facility's policy titled Dementia Care indicated Resident who display symptoms or are diagnosed with dementia should receive the appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being.The facility provides treatment and services that include, but are not limited to:.necessary person-centered care and services that reflect the resident's goals.while maximizing their dignity, autonomy, privacy, socialization, independence choice, and safety.Staff providing care to residents with dementia.will have competencies and skills to support the resident with dementia through the implementation individualized approaches to care that are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress of loss of abilities.Review of the facility's policy titled Fall Management revised 07/2025 indicated The facility will provide a safe environment for all residents by implementing a fall management program. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The program includes.individualized care plans.Develop an individualized fall prevention plan for each resident identified at risk. Examples of interventions: Environmental modifications.non-slip footwear; supervision during high risk activities e.g.ambulation.

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F 0689 Level of Harm - 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 each resident received adequate supervision to prevent accidents for 1 of 5 residents (Resident #3) reviewed for quality of care.LVN A and CNA B failed to prevent Resident #3 from an unwitnessed fall while being unsupervised in the memory care unit's dining room. Resident #3 sustained a hematoma to the right side of the forehead, which resulted in hospital treatment.This failure could place residents at risk for harm, pain, and injury. Findings Include:Record Review of Resident #3's face sheet dated 03/21/2026, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Resident #3's diagnoses included Dementia with psychotic disturbance (visual and auditory hallucinations or delusions related to Dementia); difficulty walking not elsewhere classified (general gait impairment or mobility issues); other lack of coordination (non-specific motor control issues or general clumsiness); altered mental status (significant confusion or disorientation with no definitive cause); and, restlessness and agitation (a state of mental tension, inability to relax, or excessive, non-productive activity).Review of Resident #3's Quarterly MDS assessment dated [DATE], indicated the resident had difficulty communicating words or finishing thoughts; sometimes responded adequately to simple, direct communication only; and, had a BIMS score of 00, which indicated severe cognitive impairment. Inattention, and disorganized thinking was present and fluctuated. Presence and frequency of wandering behavior occurred 1 to 3 days. Resident #3 required setup or clean up assistance to walk 10 feet and 50 feet with two turns. Other neurological conditions and non-Alzheimer's dementia noted. Pain assessment interview was not conducted as the resident was rarely or never understood. Noted to have 1 fall without injury since admission or reentry to facility. Record review of Resident #3's comprehensive care plan last reviewed on 12/29/2025, indicated Resident #3 had ADL deficits and required staff to anticipate the resident's needs and provide prompt assistance; provide limited assistance with 1 support person for locomotion on/off unit; provide supervision assistance with 1 support person for walking in room/down corridor; and, to provide PROM during ADL care as needed.Further review of Resident #3's care plan last reviewed on 12/29/2025 indicated the resident had a history of unintentionally walking into objects. Staff interventions included frequent checks on the resident, especially during high-risk times; maintain the resident's safety during increased episodes of wandering; and offering engaging activities to reduce restlessness. The resident had impaired communication and was at risk for further decline and injury. Staff interventions included reducing or removing interfering environmental stimuli, and using communication tools, terms and gestures the resident could understand. The resident also had a history of taking off her footwear.Review of Resident #3's records reflected a progress note by RN A on 3/16/26 at 6:30 PM, indicated Resident #3 had an unwitnessed fall in the dining room. Prior to the fall, the resident was wandering. Vital signs post fall BP 122/76; Pulse 72; Temperature 97.4; Respirations; 17; O2 saturation 97%. DNP was notified and reviewed medications with RN A. RP also notified.Record Review of the SBAR Change of Condition documentation for Resident #3, dated 3/16/2026 at 6:30 PM, RN A noted the resident had an unwitnessed fall in the dining room. Resident was noted to be wandering before the fall. No notable findings after environment surrounding the fall was assessed. Vital signs noted as BP 122/76; Pulse 72; Temperature 97.4; Respirations; 17; O2 saturation 97%. Assessment of range of motion indicated no changes from baseline of right upper and lower extremities or left upper and lower extremities. Resident did not have onset of pain or visible injuries related to the fall. No other significant conditions contributed to the fall. Notifications made to DNP and RP. New orders to send the resident to ER.Review of Resident #3's records revealed a neuro check, dated 03/16/26 at 6:30 PM indicated the following: RN A documented BP 122/76; Pulse 72; Respiration 17; Temperature 97.4; Alert; 0 abnormal eye movements; pupil reactions .3 millimeters; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	opens eyes spontaneously; no motor deficits; confused conversation. Further review indicated 3/16/26 7:00 PM-3/17/26 resident was at the hospital.Further review of Resident #3's hospital discharge paperwork, dated 3/16/26, indicated the following: Resident's CT scan (noninvasive imaging to create detailed 3D images of bones, soft tissues, and blood vessels, often to diagnose internal injuries), laboratory results, chest X-ray and pelvis X-ray were all reassuring. Additional instructions were to ice the hematoma, which would go away on its own in the next several weeks. Further instructions also included reporting back to the emergency department if the resident developed significant headaches, altered mental status, weakness, unexplained vomiting, or any other cause for concern.Records review of Resident #3's care plan, updated on 03/16/2026, indicated the resident was at risk of falls and injuries related Dementia. The focus was on the resident's fall on 3/16/2026 with a nodule (a small, rounded lump, swelling, or knot of tissue that can form in skin, or other body tissues due to inflammation, infection, or cell accumulation) noted to the right side of forehead. Staff interventions included head-to-toe assessment, notify MD and RP, neuro checks, and send the resident to the ER for evaluation and treatment. Staff interventions also included assisting the resident with proper footwear (non-skid socks).Further review of Resident #3's care plan dated 3/16/2026, reflected an update to the pain focus area indicated the resident was at risk for further episodes of increased pain/discomfort and injury related the hematoma. Interventions included nursing staff administering medications prescribed related to the hematoma; utilize the FACES pain scale to assess the resident's pain level; and, to monitor for effectiveness of pain medication or other interventions, report ineffectiveness to MD.Record review of CNA A's written statement, dated 3/16/2026, reflected the following: CNA A was in a room providing patient care at the time of Resident #3's incident and was not aware of what occurred.Record review of CNA B's written statement dated 3/16/2026, reflected the following: CNA B was charting, turned around and saw Resident #3 on the ground. She wrote she immediately notified the nurse and assisted the nurse with getting the resident up.Record review of the facility interview forms dated 03/16/2026, reflected the following: CNA D reported, to the DON, providing patient care down the hall when she was made aware Resident #3 had a fall.Review of RN A's interview form dated 3/16/2026, reflected the following: RN A reported to the DON, RN A was at the nurses' station charting on the computer when the aide notified RN A was on the floor in the day room. RN A assessed the resident and no apparent injuries were noted immediately. While giving report to the oncoming nurse near the nurses station, RN A noted the resident had swelling and immediately called 911.Review of RN A's interview dated 3/16/26, reflected the following: RN B reported to the DON, RN B was making rounds down the hall and was made aware of Resident's #1's fall when she RN B returned to the nurses station.Unsuccessful attempts were made on 3/21/26 at 9:51 AM and 3/22/26 at 10:18 AM to interview Resident #3's RP.Observation of Resident #3 on 3/21/26 at 2:12 PM, the surveyor followed Resident #3 to the dining room. Resident #3 ambulated independently; however, every few steps and when stopping, Resident #3 experienced loss of balance lasting about 2 - 3 seconds. The surveyor attempted to engage Resident #3. Resident #3 appeared to hear the surveyor but did not respond and continued to walk in the opposite direction. The surveyor requested nursing assistance to assess Resident #3. Resident #3 had visible discoloration on the right side of her face, including the area above the eyebrow, below the eye, and extending toward the nose. The discoloration was yellow and purple. Resident #3 did not allow LVN C to assist longer than about 15 seconds, moved staff's hands away, and continued walking down the corridor.During an interview on 3/21/26 at 2:12 PM, LVN C said Resident #3 never sat still including during meals, and did not communicate verbally or make needs known. She said if Resident #3 was in pain, she might cry, and staff had to rely on nonverbal indicators such as crying or grimacing to identify changes in condition, requiring continuous direct observation to ensure Resident #3's safety. LVN C said residents in the memory care unit were expected to be supervised at all times and staff were required to communicate with one another when leaving an area, including for breaks or other tasks, to ensure continuous monitoring and that another (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	staff member was aware and observing residents. She said when seated at the nurses' station, full visibility of the dining room was not maintained without turning her head, and this position did not allow for continuous direct observation of all residents.On 3/21/26 at 5:15 PM, CNA A said the incident occurred toward the end of the shift on 3/17/26 at approximately 6:30 PM. She said Resident #3 was in the dining room prior to the incident. She said Resident #3 walked around continuously, did not stay seated, and was not oriented to her surroundings. She said Resident #3 did not communicate verbally and could not make her needs known. She said Resident #3 required staff to watch her while walking. She said she placed Resident #3 on the couch in the dining area and left to provide care to another resident. She said she did not notify other staff she was leaving the area because staff were present near the nurses' station and did not need to provide a handoff of supervision.On 3/21/26 at 5:28 PM, CNA B said the incident occurred toward the end of the shift. She said Resident #3 walked around constantly, did not sit unless eating or sleeping, and did not communicate verbally. She said she was at the nurses' station completing documentation at the time of the incident and was not directly observing Resident #3. She said she did not see or hear the fall and was unaware of the exact whereabouts of other staff at the time. She said Resident #3 was on the floor in the dining room in a sort of seated position on her bottom. She said she was not sure how long Resident #3 had been on the floor. She said she had been charting for about 5 minutes before she saw resident #3 on the floor. She said the last time she saw Resident #3, she was walking around in the dining room. She said she and the LVN A, who was sitting at the nurse's station, immediately went to Resident #3, and the nurse completed an assessment, including vital signs. She said she and LVN A moved Resident #3 to the couch after the nurse said this was okay. She said Resident #3 immediately got back up and continued walking. She said she remained near Resident #3 and monitored her after the initial assessment while the nurse returned to the nurses' station. She said she and the nurse later observed swelling forming on Resident #3's forehead at the same time. She said the nurse immediately called 911 and made additional notifications.On 3/22/26 at 11:22 AM, LVN A said the incident occurred on 3/17/26 at approximately 6:30 PM while Resident #3 was in the dining room. She said Resident #3 was not oriented, did not remain seated, and continuously walked, including during meals. She said she was seated at the nurses' station documenting and could only see a portion of the dining room from that position. She said she was notified by CNA B, Resident #3 was on the floor. She said both she and CNA B immediately responded and assessed Resident #3, including a head-to-toe assessment and vital signs, and observed no visible injuries at that time. She said she contacted the DNP after the initial assessment. She said Resident #3 was moved to the couch and then immediately began walking again. She said CNA B remained with and monitored Resident #3 after the initial assessment. She said maybe 5 - 10 minutes later she observed a bump forming on Resident #3's head. She said she and CNA B noticed the knot at the same time. She said she immediately called 911 due to the head injury and contacted the DNP and DON to report the change. She said she documented her assessments and notes related to the incident.On 3/22/26 at 1:00 PM, the ADON said residents in the memory care unit were at risk for injury due to behaviors and mobility. He said staff were expected to have their eyes on residents at all times and communicate with one another to ensure supervision was maintained to prevent falls and injuries. He said the situation was handled appropriately once LVN C found Resident #3 and the injury was identified.On 3/22/26 at 1:37 PM, the DON said Resident #3 was not oriented, could not communicate her needs, and wandered continuously. She said Resident #3 required monitoring at all times. She said staff were expected to ensure someone always had eyes on all the memory care residents, including Resident #3. She said staff were also trained and expected to ensure supervision coverage was verbally passed on to another staff before leaving an area where residents were present. She said staff positioned at the nurses' station might not be able to see the entire dining room and would not be able to see Resident #3 on the floor. She said lack of supervision placed residents at risk for injury, failure to identify changes in condition, and other adverse outcomes. She said once LVN A notified her of the resident's (continued on next page)

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	675085	A. Building B. Wing	03/27/2026

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	hematoma, emergency services had already been contacted, she notified the administrator and EMS arrived at the facility within minutes.On 3/22/26 at 3:42 PM, the Administrator said Resident #3 required constant supervision due to inability to ensure her own safety and continuous wandering. She said residents in memory care were at increased risk for falls and injury without supervision. She said staff were expected to maintain direct visual observation at all times and communicate with each other on passing on supervision responsibilities to keep the residents safe. She said the incident might have been preventable if appropriate supervision was maintained. She said staff reported that once Resident #3 was found on the floor, the nurse assessed Resident #3 and notifications were made, and once the hematoma was identified, 911 was called and Resident #3 was sent out. She said the staff acted appropriately once the change in condition was identified.On 3/27/26 at 12:28 PM, the DNP said she was notified of Resident #3's unwitnessed fall and was informed Resident #3's vital signs were within normal limits. She said she instructed staff to monitor Resident #3 and notify her of any changes in condition. She said she was later notified that Resident #3 developed a hematoma and was being sent out to the hospital. She said the discoloration observed was related to the hematoma and consistent with the injury. She said the facility staff acted appropriately in notifying her and sending Resident #3 out once the hematoma was identified. She said she was not willing to provide a statement regarding potential risk and did not provide hypothetical risk statements.Review of the facility's policy titled Dementia Care indicated Resident who display symptoms or are diagnosed with dementia should receive the appropriate treatment and services to attain or maintain their highest practicable physical, mental, and psychosocial well-being.The facility provides treatment and services that include, but are not limited to:.necessary person-centered care and services that reflect the resident's goals.while maximizing their dignity, autonomy, privacy, socialization, independence choice, and safety.Staff providing care to residents with dementia.will have competencies and skills to support the resident with dementia through the implementation individualized approaches to care that are directed toward understanding, preventing, relieving, and/or accommodating a resident's distress of loss of abilities.Review of the facility's policy titled Fall Management revised 07/2025 indicated The facility will provide a safe environment for all residents by implementing a fall management program. The program includes.individualized care plans.Develop an individualized fall prevention plan for each resident identified at risk. Examples of interventions: Environmental modifications.non-slip footwear; supervision during high risk activities e.g.ambulation.Review of the facility's policy titled Standards of Care revised 10/2023 indicated All care provided will comply with current guidelines, best practices, and Federal/State regulations.Safety measures will be in place to prevent accidents and injuries, including fall preventions strategies.All staff members are responsible for adhering this policy and for providing care that meets these standards. The Administrator will oversee the implementation and compliance with this policy.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 10 residents (Resident #2) reviewed for quality of care.The facility failed to ensure proper care and monitoring of an indwelling urinary catheter, which resulted in Resident #2's penis slit increasing from 0.3 cm in length by 0.1 cm in width to 1.5 cm in length by 0.5 cm in width, and the color of the slit area was beefy red and slightly bleeding.2. The facility failed to ensure proper care and monitoring of Resident #2's indwelling urinary catheter, which resulted in urine draining onto the resident's incontinent brief.These failures could have placed residents at risk for pain, infection, injury, and hospitalization.Record review of Resident #2's face sheet dated 03/26/26 reflected a [AGE] year-old male originally admitted on [DATE] and re-admitted on [DATE] with medical diagnoses of hypertension (high blood pressure), pressure ulcer of sacral region, stage 3 (is a deep, crater-like wound where the skin had broken down through all layers, revealing the fatty tissue underneath but not muscle, tendon, or bone), obstructive and reflux uropathy (obstructive uropathy is a condition where urine flow is blocked, causing a damming effect that can damage the kidneys, while reflux uropathy is a condition where urine flowed backward (the wrong way) in the urinary tract, also potentially damaging the kidneys), pressure ulcer of other site (stage 3).Record review of Resident #1's annual MDS assessment dated [DATE] revealed his BIMS score was 07, indicating severe cognitive impairment. He required total assistance with toileting. He was incontinent of bladder and bowel and had an indwelling catheter.Record review of Resident #2's care plan dated 04/18/2025 revealed Resident #2 had a suprapubic foley catheter and was at risk for increased UTIs and skin breakdown related to neurogenic bladder and obstructive uropathy. Interventions included: follow physician orders for catheter insertion, changes, and maintenance; monitor site for signs/symptoms of infection or skin breakdown and report to MD; monitor urine for odor, color, sediment, and amount, and report abnormalities to MD.Record review of Resident #2's order summary for March 2026 revealed orders to monitor for potential complications of indwelling urinary catheter use such as redness, irritation, signs/symptoms of infection, obstruction, urethral erosion, bladder spasms, hematuria, or leakage around the catheter every shift, with a start date of 12/08/25.Record review of Resident #2's MAR for March 2026 revealed monitoring for potential complications of indwelling urinary catheter use such as redness, irritation, signs/symptoms of infection, obstruction, urethral erosion, bladder spasms, hematuria, or leakage around the catheter dated 12/08/25 showed the nurse signed off that there were no issues with the foley and skin area.Record review of Resident #2's order summary report for March 2026 revealed a urethral indwelling urinary catheter: (20) Fr with (5) cc normal saline balloon using a closed drainage system, to be changed monthly and as needed related to infection and inflammation, and changed as needed if plugged or out, with an order date of 03/24/26.Record review of Resident #2's MAR for March 2026 revealed the urethral indwelling urinary catheter: (20) Fr with (5) cc normal saline balloon using a closed drainage system, to be changed monthly and as needed related to infection and inflammatory reaction due to indwelling urethral catheter, and changed as needed if plugged or out, was transcribed on 03/26/26.Record review of Resident #2's MAR for March 2026 revealed an order to verify the catheter securement device was present, intact, and properly attached every shift, with an order date of 03/06/2026.Record review of statement of deficiencies dated 1/9/26 revealed Observation and interview of Resident #12's [Resident #2] incontinent and foley care on 01/07/2026 at 10:32 am with CNA AA and CNA BB, there was no leg strap or Statlock (stabilization device for a foley catheter) to secure the catheter. There was small redness to the top side of the penis near a slit. Resident #12 did not verbalize he was in pain or displayed any facial grimacing while staff cleaned indwelling catheter. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	should have monitored and reported changes. He stated improper turning could pull the foley and worsen the slit. He stated sediment could block the foley and cause leakage, leading to skin breakdown if unrecognized.During an interview on 03/26/26 at 4:09 p.m., the DON stated the penile area was normal in color with a slit and she did not observe blood because staff had cleaned the area. She stated she saw a small slit. She stated she did not know the brief was wet. She observed sediment and noted a history of UTIs. She stated sediment can be normal but must be reported. She stated only the bag was changed. She stated the NP did not express concern, but was unsure of timing. She stated the meatus could bleed due to foley use and contractures. She stated the balloon could leak or deflate and prolonged moisture could cause breakdown.During an interview on 03/26/26 at 4:18 p.m., the Corporate Nurse stated a deflated balloon or sediment could cause leakage. She stated LVN M should notify the physician if clogging occurred. She was not aware of the worsening slit. She stated the physician previously indicated the slit was due to chronic foley use. She stated irritation could occur if the foley was pulled, although a stat lock was present.Record review of the facility's policy on catheter care revised 02/2024 stated in part: to ensure proper hygiene, minimize infection risk, and maintain resident comfort during catheter care. Exposure of Catheter Site: Male Resident: If uncircumcised, retract the foreskin and hold the penis just below the glans. Maintain this position throughout the procedure.