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	04/28/2026

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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to inform residents, both orally and in writing in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility for 1 of 8 residents (CR #1) reviewed for resident rights. - The facility failed to provide/communicate to CR#1's and/or her RP the contents of admissions packet which provided the resident's rights, the rules governing resident conduct, their responsibilities during their stay at the facility, and acknowledgement of advance directives when the resident admitted on [DATE]. On [DATE] CR #1 received CPR after she was unresponsive, even though her wishes were DNR. This deficient practice could place residents at risk of not being aware of their rights, responsibilities, and the facility's policies. Findings include: Record review of CR #1's Face Sheet dated [DATE] revealed, an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of: UTI, history of colon cancer and large intestine, high blood pressure, irregular heartbeat, the presence of a pacemaker and mild cognitive impairment. CR #1 discharged to an acute care hospital on [DATE]. Family Member #1 was documented as Emergency Contact 1 POA Healthcare and Her Advance Directives were blank. Record review of CR #1's admission Assessment completed on [DATE] and signed by RN A revealed, she arrived at the facility on [DATE] at 07:10 PM and the NP was notified of her admission on [DATE] at 07:56 PM, but medication reconciliation was not completed. Family Member #1 was notified of her admission on [DATE] at 07:34 PM. Record review of CR #1's Progress notes dated [DATE] at 09:53 Pm revealed, the resident came to the facility at [07:10 PM] on a stretcher with the assistance of two EMS assist. The resident was AOx2 (the person knows who they are and where they are but does not know the time or situation0. The NP was notified about the arrival of the resident and medication was reconciled. The DON was also notified and the family member was called. The resident was oriented to the room, call light light, bed control and TV. The resident was alert and stable and did not voiced out any concern. Record review of CR #1's BIMS Assessment Completed [DATE] revealed, moderately impaired condition as indicated by a BIMS score of 12 out of 15. Record review of CR #1's EMR revealed no admission packet or agreement on record. In an interview on [DATE] at 11:23 AM, the Administrator said resident rights were communicated through the admissions process and the admissions packet; and the admission Coordinator was responsible for the completion and communication of the contents of the admission packet. In an interview on [DATE] at 11:57 AM the Admissions Coordinator said her responsibilities during the admissions process was to get the resident's room ready and ensure the resident had a good stay. She said she was not responsible for reviewing any documentation. In an interview on [DATE] at 11:41 PM, the DON said the Admissions Coordinator and Marketing were responsible for the completion of admissions packet. She said the admissions packet was sent/communicated prior to the resident arriving at the facility, and the facility tried to get it signed and completed within 72 hours of admission. In an interview on [DATE] at 12:27 PM, Family Member #1 said she was CR #1's POA said she arrived shortly after the ambulance dropped the resident off at the facility. She said on admission CR #1 was very confused, yelling that they tried to kill her and rape her in this truck (the ambulance). Family Member #1 said the (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	04/28/2026

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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident kept saying people were trying to kill her and beat her so Family Member #1 should not leave her at the facility. Family Member #1 said she never received an admission packet, and no one ever talked to her or gave her any documentation of their rights or anything else. Family Member #1 said the hospital took care of the DNR paperwork. In an interview on [DATE] at 12:50 PM, the Admissions Coordinator said she was responsible for the admission packet, and it was usually completed after the resident admitted . She said the packet was provided to the resident or RP via email or presented in person and it was usually completed within 48 hours of admission. The Admissions Coordinator said the admission packet addressed residents wishes, laundry and consent to take pictures. She said she did not go through the admissions packet with the resident or their RP, and she only emailed the packet after the resident admitted to the facility. The Admissions Coordinator said she did not have an admissions packet for CR #1, and Family Member #1 (CR #1's POA) never received the admissions packet. She said Family Member #1 was with CR #1 when she arrived with the resident, but she never received the admissions packet, there were no communications of the resident's rights or anything contained in the packet. The Admissions Coordinator said she intentionally did not send Family Member #1 the admissions packet because she had to confirm she was the POA, and the executed POA was provided to the facility with admissions documentation that came before and after the resident admitted but she didn't know it was at the time. The Admissions Coordinator said she had no obligation to communicate the contents of the admissions packet to the resident or their designee. She said failure to deliver the admissions packet would leave residents and their families unaware of their rights. In an interview on [DATE] at 11:58 AM, the Administrator said the Admissions Packet functioned as a way to make sure residents were aware of any information they needed while they lived at the facility and their rights. She said the packet contained the residents' rights, advance directive wishes and the resident/designee should be provided the packet before they arrived or at the very least at admission. The Administrator said failure to deliver or communicate the contents of the admissions packet could leave residents unaware of their rights, and the facility would not know the resident's wishes. Record review of a blank facility TX admission Packet revealed, the packet included charges, Resident Rights, and polices that included: state resident rights, federal resident rights, smoking policy notification, and the bed-hold policy notification. The packet contained forms, Resident Preferences, Financial Information, and Acknowledgements: selection of resident preferences, statement of resident rights acknowledgement, notice of privacy practices acknowledgement. The packet also contained, Clinical and Consent Forms: consent to treatment, consent to photograph, video, and Media Use, Pharmacy Services Agreement, Advance Directive Notice and Acknowledgement.

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	04/28/2026

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents had the right to formulate an advance directive for 4 of 8 Residents (CR#1, Resident #1, Resident #2, Resident #3) reviewed for Advance Directives. - The facility failed to ensure there was a system in place to ensure all residents wishes for advanced directives were implemented and discrepancies regarding DNR wishes were addressed immediately upon admission.- The facility failed to clarify discrepancies in CR #1's wishes of DNR when she admitted on [DATE]. On [DATE] CR #1 was found unresponsive and received CPR from 06:26 AM to 07:04 AM in the facility and until 07:28 AM in the hospital until the POA notified the staff of the DNR wishes and rescue efforts were stopped. CR #1 expired at 07:28 AM. - The facility failed to clarify discrepancies in Resident #1's advances directive upon admission on [DATE] when wishes of DNR were communicated prior to admission. She was a full code from [DATE] to [DATE] and [DATE] to [DATE]. - The facility failed to ensure there was a system in place to ensure all residents wishes for advance directives were implemented and discrepancies regarding DNR wishes were addressed immediately upon admission. An Immediate Jeopardy was identified on [DATE]. The IJ template was provided to the Administrator and DON on [DATE] 02:22 PM. While the immediacy was removed on [DATE] at 01:29 PM, the facility remained out of compliance at a severity level of no actual harm, with a potential for more than minimal harm that was not an immediate jeopardy, and at a scope of widespread due to the facility's need to evaluate the effectiveness of the corrective systems. The failures could affect all residents who have implemented Advance Directives and established their choice not to be resuscitated at risk of receiving CPR against their wishes. Findings included: CR#1 Record review of CR #1's Face Sheet dated [DATE] revealed, an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of: UTI, history of colon cancer and large intestine, high blood pressure, irregular heartbeat, the presence of a pacemaker and mild cognitive impairment. CR #1 discharged to an acute care hospital on [DATE]. Her Advance Directives were blank. Record review of CR #1's admission Assessment completed on [DATE] signed by RN A revealed, she arrived at the facility on [DATE] at 07:10 PM and the NP was notified of her admission on [DATE] at 07:56 PM, but medication reconciliation was not completed. Family Member #1 was notified of her admission on [DATE] at 07:34 PM. Record review of CR #1's Baseline Care Plan dated [DATE] revealed, Focus: Urinary Incontinence, Bowel Incontinence, Behaviors (resident has episodes of behaviors and is at risk for further increased episodes and injury), Falls (resident is at risk for falls and injuries). Social Services Code Status: Full code. Record review of CR #1's EMR revealed, no admission packet or agreement on record. Family #1 was appointment CR#1's healthcare agent and had the POA was notarized on [DATE]. Record review of CR #1's Hospitalist Service Progress Note dated [DATE] at 02:20 PM revealed, Code Status: DNR. Record review of CR #1's facility provided Hospital Medicine Service Progress Note signed [DATE] at 08:21 AM revealed, Code Status: DNR. Record review of CR #1's facility provided Hospital Medicine Service Progress Note signed [DATE] at 08:03 AM revealed, Code Status: DNR. Record review of CR #1's admission portal Summary Report uploaded [DATE] revealed, during her hospital stay, she demonstrated significant physical deconditioning and impaired cognition, characterized by damage to the small blood vessels in the brain due to reduced blood flow and worsening memory/organization. Advance Directives: Code Status: DNR (Do Not Resuscitate). Living Will: Received. Record review of CR #1's BIMS Assessment Completed [DATE] revealed the resident had moderately impaired condition as indicated by a BIMS score of 12 out of 15. Record review of CR #1's Physicians Orders dated [DATE] revealed, ADC: Full code. The order was discontinued on [DATE]. Record review of CR #1's Physician's Progress Note dated [DATE] at 08:15 AM revealed, code status: Full code. Advance Directives DNR. Record review of CR #1's Change of Condition form (continued on next page)

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	04/28/2026

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	dated [DATE] signed by LVN A revealed, Code Status: full code; Assessment: Resident was unresponsive during rounds and shift change and resident was unresponsive to verbal stimuli with no pulse. The NP and Family Member #1 were notified on [DATE]. Record review of CR #1's Progress Notes dated [DATE] at 07:21 AM and signed by LVN A revealed, between 05:30-05:58 AM the resident was rounded on by this nurse and an aide at two separate times. Provided peri care, a brief change and assessed for pain and the need of repositioning. The resident was stable, alert and talking. At 06:20 AM during morning rounds at shift change the oncoming nurse reported to this nurse that the resident was unresponsive and not easily aroused to painful stimuli. No pulse was palpable (felt) and the resident was pale in the face and her skin was warm. Code status confirmed by another nurse on duty that the resident was a full code. CPR was initiated by this nurse after confirmation. The aide called 911 and another nurse assisted with the use of the Ambu bag for breaths in between. During pulse checks there was no pulse. CPR continued. At 06:35 AM EMS arrived and took over compressions. They continued CPR while attempting to start an IV line which was unsuccessful. At 06:45 AM EMS verbally confirmed that there was no blockage in the resident's airway then intubated (tube placed in the throat to help breathing) the resident at bedside and continued to bag. At 06:49 AM the free hand CPR machine was used and the resident still had no pulse. Blood sugar was checked at 06:51 AM by EMS and it was 110. At 07:00 AM EMS left the facility with the resident via stretcher continuing CPR. Family Member #1 was called and no answer. A VM was left for a retuned call. Two minutes later the family member returned the phone call and was notified of the change in condition and she stated, I have noticed that something was wrong with her for a few days now. She was also informed that the resident was sent to the hospital. The DON and NP were notified. Record review of CR #1's ED Hospital Notes dated [DATE] revealed, Medical Decision Making: [AGE] year-old female with cardiac arrest (heart stopped beating) PEA (a form of cardiac arrest where the heart monitor shows an organized rhythm, but the heart muscle does not contract, resulting in no pulse. It is a life-threatening, non-shockable rhythm requiring immediate CPR and identification of underlying causes) on scene, multiple shocks and then recurrent PEA. Greater than 45 minutes total downtime. Following about 10 minutes of CPR in the emergency department, CR #1 did not regain pulses. Next of Kin/POA was contacted who stated CR #1 should be DNR but there was no paperwork on file with the new facility where the patient was currently located. They requested cessation of resuscitative efforts. These efforts were ceased and the patient remained pulseless. Her time of death was 07:28 AM. Disposition: the patient has a disposition of expired. In an interview on [DATE] at 02:35 PM, Family Member #2 said CR #1 wished to be a DNR and her wishes were documented in the records sent to the facility when she was accepted. She said on [DATE], CR #1 was found unresponsive and the facility initiated CPR. Family Member #2 said CPR continued until CR #1 was in the hospital and the family notified them of the residents wishes to be DNR. Family Member #2 said the hospital she discharged from to the facility took care of the DNR paperwork. In an interview of [DATE] at 04:10 PM, Family Member #2 said CR #1 had documents with 2 different code status (full code and DNR) but the facility never reached out to get clarification for the resident's code status. In an interview on [DATE] at 09:14 AM, the Hospital Case Manager said she sent CR #1's clinical records to the facility on [DATE], [DATE] and [DATE] after she received notification that the facility would accept her and could meet the CR #1's needs on [DATE]. The Case Manager would not confirm CR #1's code status and said it was documented in the resident records that were sent to the facility In an interview on [DATE] at 11:13 AM, LVN A said the night of [DATE] was the first day she worked with CR #1. She said the resident was sleepy and didn't want to eat dinner because she was up all night. LVN A said on the night of [DATE] CR #1 was fine, talkative during the night, and when she saw her she was alert. She said when she and the on-coming nurse were performing walking rounds around 06:20 AM on [DATE], CR #1 was found unresponsive. LVN A said after the staff confirmed she was full code in her EMR (banner located in EMR), she initiated CPR. LVN A said a resident's DNR status could be verified through the documents in the miscellaneous tab of the EMR but she did not look in CR #1's (continued on next page)

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	04/28/2026

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	miscellaneous tab to verify if there was DNR paperwork. She said facility staff continued CPR until the EMS arrived. She stated she communicated the resident's full code status to the EMS and they continued to perform CPR until the resident discharged from the facility. On [DATE] at 01:37 PM, an attempt was made to contact CR #1's attending physician (MD A), and a message was left. On [DATE] at 02:23 PM, the DON notified surveyors that MD A was unavailable in an email that read [MD A] is not in office I have been told she is out with a family emergency however, the office states that if you want to speak with our medical Director that would be okay Resident #1 Record review of Resident #1's Face Sheet dated [DATE] revealed, an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of: sepsis (blood infection), UTI, elevated white blood cell count, chest pain, high cholesterol, kidney failure, Parkinsonism (group of diseases with symptoms of tremors), and blood clots. Record review of Resident #1's admission MDS dated [DATE] revealed the resident was severely impaired cognition as indicated by a BIMS score of 3 out 0f 15. Record review of Resident #1's undated Care Plan downloaded [DATE] at 10:00 AM revealed, Focus- FULL CODE: Resident #1/Responsible party have requested a code status of FULL CODE Date Initiated: [DATE] revision on: [DATE]. Interventions/Task- If resident's heart stops, initiate CPR and call 911 for transfer to the hospital; Date Initiated: [DATE]. Record review of Resident #1's OOH- DNR Form dated [DATE] revealed, the form was completed with the signature of the legal guardian, two witnesses and notarized on [DATE]. The facility Medical Director did not sign the form until [DATE]. Record review of Hospital Nephrology Progress Notes dated [DATE] revealed, Code Status: DNR. Record review of Hospital Nephrology Progress Notes dated 0321/26 revealed, Code Status: DNR. Record review of Resident #1's Hospital Transfer Cover Page dated [DATE] revealed Code Status: DNR Record review of Resident #1's Physician's Orders revealed:- [DATE] at 03:17 AM, ADC: Full code; Order type: Advance Directive; Advanced Directive Status: Verified by Medical Record Only. Discontinued on [DATE].- [DATE] ADC: Do Not Resuscitate- DNR- [DATE] ADC: Full Code, Order type: Advance Directive; Advance Directive Status: Verified by Medical Record Only.- [DATE] ADC: Do Not Resuscitate- DNR Record review of Resident #1's Progress Notes revealed,- [DATE] signed by the Social Worker- Call placed to Family Member #3 to verify code status. No answer and was unable to leave a voice message.- [DATE] signed by the Social Worker- Follow up call placed to Family Member #3. The RP wishes for the resident to remain a DNR. There was no documentation prior to [DATE] that addressed the resident's advance directives. In an interview on [DATE] at 11:23 AM, the Administrator said her date of hire was within the last 2 weeks. She said resident admissions started with communication through the admissions portal and when the information was sent to the facility, the DON reviewed the clinical information. The Administrator said she expected the admitting nurse to review the resident's clinical documentation when they arrived, and the review included upcoming appointments and code status (advance directives), and if there were discrepancies in the code status in the records she expected the admitting nurse and the Social Worker to get clarification. In an interview on [DATE] at 11:41 AM, the DON said there was no specific staff responsible for ensuring the resident's admission process included wishes and code status were transcribed or entered accurately. She said it was a multi-staff process but the Social Worker was responsible for entering and verifying a resident's code status during the 72 hour care plan, but normally when a resident is not full code the hospital sends the documentation to the facility. The DON said there was no review of advance directives after the Social Worker entered the information during the 72 hour care plan. The DON was unable to identify who was responsible for ensuring advance directives were accurate and verified before the 72 hour care plan. The DON said she did not review any resident clinicals before or after admissions. She said the Marketer was responsible for clinical review of the residents' charts to ensure the facility could meet their needs . The DON said after she was made aware of concerns regarding CR #1's code status, she did not investigate what happened, and the facility had not performed any audits of resident advance directives She said the marketing team was responsible for verifying the resident's code status prior to admission and if there was a discrepancy (continued on next page)

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	04/28/2026

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	the marketing team was responsible for identifying the issue and alerting nursing. The DON said the marketing team was responsible for clinical review of the discharge documents for advance directives. The DON said accurate advance directives were important because it was violation of the resident's rights, and if a resident didn't want to go through CPR, they shouldn't have to. In an interview on [DATE] at 11:57 AM, the Admissions Coordinator said her responsibility during the admissions process was to get the resident's room ready and ensuring the resident had a good stay. She said she was not responsible for reviewing any admissions documentation. In an interview on [DATE] at 12:01 PM, the Social Worker said she confirmed the resident's code status/advance directives during the 72 hour care plan meeting and she did not know who was responsible to ensure a resident's advance directives were respected, or who was responsible for verification of the advance directives before the 72 hour care plan meeting. The Social worker said when she confirmed a resident's advance directive was a DNR, she was expected to facilitate the completion of the OOH-DNR, and ensure the form was signed by the physician. She said if a discrepancy was identified and the facility did not have the OOH-DNR then she was expected to contact the resident, POA, and their family and request the document. The Social Worker said she was unaware of a discrepancy with CR #1's advance directives because she did not perform the clinical review of the resident's admission documentation and never spoke to the resident's POA. The Social Worker said she was scheduled to talk to Family Member #1 on [DATE] but the resident expired on [DATE]. The Social Worker said failure to verify a resident's advance directives placed them at risk of not receiving services in line with what their wishes were. In an interview on [DATE] at 12:27 PM, Family Member #1 said CR #1 admitted to the hospital on [DATE] and 2 days after her admission, the hospital staff had a meeting with the resident and herself to address her advance directives and CR #1 decided she did not want to be resuscitated, so her code status was changed to DNR. She said she was CR #1's POA and she arrived shortly after the ambulance dropped the resident in the facility on [DATE]. She said at admission CR #1 was very confused, yelling that they tried to kill her and rape her in this truck (the ambulance). The resident kept saying people were trying to kill her and beat her so Family Member #1 should not leave her at the facility. Family Member #1 said the facility called her on [DATE] and notified her that CR #1 was found unresponsive, CPR was in progress and emergency services had transported her to the hospital. Family Member #1 stated the family immediately started to call the hospital because CR #1's advance directive was a DNR. She said when she got in touch with the hospital, she notified the doctor that CR #1's advance directive was a DNR, so CPR was stopped and her time of death was called at 07:28 AM. Family Member #1 said she never received an admission packet, and no one ever talked to her or gave her any documentation of their rights or anything else. She said no staff discussed the resident's advance directives or wishes and if they did she would have notified them of her DNR status. In an interview on [DATE] at 12:50 PM, the Admissions Coordinator said she was responsible for the admission packet and it was usually completed after the resident admitted to the facility. She said the packet was provided to the resident or RP via email or presented in person and it as usually completed within 48 hours of admission. The Admissions Coordinator said the packet addressed the resident's wishes, laundry and consent to take pictures. She said she did not go through the admissions packet with the resident or their RP, and she only emailed the packet after the resident admitted to the facility. The Admissions Coordinator said she did not have an admissions packet for CR #1, and Family Member #1 (CR #1's POA) did not receive the admissions packet. She said Family Member #1 was with CR #1 when she arrived with the resident, but she never received the admission packet, there were no communication about the residents rights or anything contained in the packet. The Admissions Coordinator said she intentionally did not send Family Member #1 the admission packet because she had to confirm she was the POA, and the executed POA was provided to the facility with admission documentation that came before and after the resident admitted but she didn't know it was at the time. The Admissions Coordinator said she had no obligation to communicate the contents of the admission packet to the (continued on next page)

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	04/28/2026

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	resident or their designee and she did not know the packet contained acknowledgement of a residents advance directives. In an interview on [DATE] at 09:14 AM, Family Member #3 said Resident #1 had wishes to be a DNR for several months before she admitted to the facility, and the facility was made aware of her wishes during admission. He said he provided the OOH- DNR to the facility when she admitted and no facility staff had contacted him in the last 48 hours seeking clarification of Resident #1's advance directives and DNR wishes. Family Member #3 said he was never notified of Resident #1's being a full code. In an interview on [DATE] at 01:48 PM, the Marketer said he only functioned as a liaison between the hospital and the facility. He said the hospital used an admission portal to communicate the resident's clinical information prior to admission. The Marketer said the admission portal combed through the resident's clinical record and generated a summary report that was sent to the facility, and to his knowledge the resident's code status was communicated to the facility through the report. In an interview on [DATE] at 10:10 AM, the NP said when a resident admitted to the facility she expected nursing to review the clinical documentation but most patients admitted with advance directives of full code. She said if there was a discrepancy in which records reflected both full code and a DNR she would expect the provider to be notified and clarification to be made. The NP said she was unaware of any discrepancies with CR #1's code status but failure to clarify discrepancies caused confusion and left the resident with an unknown advance directive. The NP said changes to a resident's code required physician and family notification, and a resident could not be changed from full code to a DNR, or vice versa without notification and approval. The NP said she had not given any approval to change Resident #1's code status from full code to DNR on [DATE], or back to full code on [DATE]. She said failure to send notification prior to changes in advance directives would place residents at risk of not being provided the level of care that was in line with their wishes. The NP said if there were issues with a resident's advance directives they need to call them and let them figure it out. In an interview on [DATE] at 11:27 PM, the Medical Director said when a resident arrived at the facility and discrepancies were identified in the clinical records facility staff must reach out and get clarification. He said nursing staff were expected to notify providers of discrepancies in advance directive so they could work on it. The Medical Director said a resident's advance directive was not only physician driven but required conversations with the resident and/or qualified family member. He said once the facility was notified of a resident's wish to be a DNR, the nurses and providers initiated the appropriate paperwork and got it signed. The Medical Director said failure to identify and clarify discrepancies in a resident's advance directive placed them at risk of death if they were incorrectly documented as a DNR, or conversely a resident received CPR when their wishes were to be a DNR. He said clarification of a resident's DNR advance directives and completion of the appropriate documentation should be done as soon as possible. He said he signed off on Resident #1's OOH-DNR today but was unaware that the facility had the completed form prior to [DATE] and he was notified the facility switched Resident #1's code status to full code on [DATE] but he was not informed about failure to notify the family. In an interview on [DATE] at 12:00 PM, the DON said her date of hire was [DATE]. The DON said when a resident arrived to the facility the admitting nurse was expected to review the clinical packet to ensure accuracy of resident information. The DON stated after the admitting nurse reviewed the chart, the nurse manager reviewed the documentation, if they were in the building, or the next day if they were not in the building when the resident arrived. The DON said once a discrepancy was identified, nursing was expected to reach out to the provider or applicable person for clarification and documented their efforts in the residents chart. She said failure to seek clarification of identified discrepancies including advance directives could result in failure to follow physician's orders or care being provided contrary to the resident's rights. In an interview on [DATE] at 12:00 PM, the Administrator said her date of hire was [DATE]. The Administrator said there was an issue with the admission process regarding advance directives. She said verification of the advance directive was a shared responsibility, and DNR documentation was given to the nursing department who then took care of it. She said Resident #1's OOH-DNR should never have been given (continued on next page)

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	04/28/2026

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	to the Admissions Coordinator, and she expected everyone to document all efforts made regarding advance directives but obviously we (DON/Administrator) were not here when the system was put into place. She said there was failure in communication and documentation, and the facility was aware as of yesterday that there was a broken system and they were putting things in place going forward. The Administrator said, there are processes that are broken and they are fixing it. She said there was a failure in the timing of the formulation of residents' advance directives, and when a resident arrived staff should have pulled an order recap to review the admission, but apparently they were not pulling the order recap to review changes to a resident's status. The Administrator said after questions arose from surveyors regarding CR #1's advance directives, the facility completed an audit and identified Resident #1, Resident #2 and Resident #3's advance directives for a DNR could not be confirmed, so they changed them to full code yesterday, [DATE], while they verified their paperwork and consulted their RP. Record review of the facility provided Order Listing Report dated [DATE] at 01:40 PM generated by the DON revealed, Status: Current, Order Status: Active, Order Type: Advance Directive. Resident #1, Resident #2 and Resident #3's Order Summary were ADC: Do not Resuscitate-DNR. Record review of the facility provided Order Listing Report dated [DATE] at 02:24 PM generated by the DON revealed, Status: Current, Order Status: Active, Order Type: Advance Directive. Resident #1, Resident #2 and Resident #3's Order Summary were ADC: Full Code with revision dates of [DATE]. In an interview on [DATE] at 12:00 PM, the Admissions Coordinator said Family Member #3 sent her Resident #1's OOH-DNR so she printed it and handed it to the nurse on [DATE]. She said that was why her advance directives were changed to DNR. The Admissions Director said neither the DON nor Administrator were notified of her communications with Family Member #3 or the change in advance directives. In an interview on [DATE] at 12:00 PM, the Social Worker said the resident's EMR had a tab that indicated the resident's advance directive and she did not know how she was expected to review the resident's documentation/chart to verify their advance directive. Record review of a blank facility TX admission Packet revealed, Advance Directive Acknowledgement- Does the Resident have an existing Advance Directive regarding life-sustaining treatment? Select one of the following: YES. You confirm that the Resident has an existing advance directive and will provide a copy to the Resident's physician and the Facility. You understand that the Facility cannot implement the Advance Directive until it is fully executed and received.Select which documents are currently executed and provide to the Facility: ___ Living Will ___ Healthcare Power of Attorney___ Do-Not-Resuscitate (DNR) Order NO. You confirm that the Resident does not have an existing advance directive andunderstand that you may contact the Facility to discuss this matter further. Even if you do not have an Advance Directive, you have the right to provide the name of one or more people that you want your treating physician to consider appointing your surrogate should you lose the ability to make health care decisions for yourself. In the absence of an Out-of Hospital Do Not Resuscitate Order (OOH-DNR), the undersigned acknowledges that it is the wish of the Resident to receive Cardiopulmonary Resuscitation (CPR). By signing below, the understanding acknowledges and understands that should cardiac arrest occur, the Resident will be considered a FULL CODE and CPR may be performed. You may change your designation at any time. Please contact the Facility to discuss this matter, change your designation, or to complete the necessary documentation. Record review of the undated facility policy titled Admissions Process, Resident Rights, and Timely Completion of admission Packet revealed,Record review of the facility policy Resident Rights revised 04/2024 revealed, Policy- The facility protects and promotes the rights of each resident. The facility staff will uphold the resident's dignity and individuality, providing care that fosters their quality of life in a respectful environment. Procedure: A written copy and oral review of State and Federal Resident Rights are provided to the resident upon admission; The residents will be informed of their rights and responsibilities in a language they can understand. Legal Representative: Should a resident be declared incompetent per state law or be medically incapable of understanding their rights, this policy will apply to the legal representative as indicated. The legal representative supports the resident in: (continued on next page)

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	04/28/2026

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	decision-making, accessing medical/ social/or other personal information of the resident, managing financial matters, or receiving notifications.The decisions of a legal representative are treated as the decisions of the resident to the extent required by the court or applicable law, or delegated by the resident. The facility may not extend additional rights to the legal representative that were not delegated by the resident, the court, or applicable law. Record review of the facility policy titled Texas OOH DNR revised 05/2025 revealed, The Facility respects the rights of residents to make advance directives, including the choice to execute a valid Out-of-Hospital Do Not Resuscitate (OOH-DNR) order. The facility will comply with all applicable state laws regarding OOH-DNR orders. This was determined to be an Immediate Jeopardy (IJ) on [DATE]. The Administrator, DON, Regional Clinical Nurse and Director of Operations were notified of the IJ on [DATE] at 02:22 PM and the Administrator was provided with the IJ template. The following Plan of Removal submitted by the facility was accepted on [DATE] at 09:02 PM. Plan of Removal - F578 [DATE]Deficient Practice:The facility failed to have a system in place to clarify discrepancies in residents' advance directives immediately upon admission.Corrective Actions Taken:The Administrator and Director of Nursing (DON) notified the Medical Director of the Immediate Jeopardy on [DATE] during an ad hoc QAPI meeting.Resident #1's code status was immediately corrected on [DATE] to reflect verified wishes following direct confirmation with the POA and physician notification.On [DATE], the Regional Nurse Consultant provided education to the Administrator, Social Worker and DON regarding:Verification of advance directives upon admissionEnsuring emergency procedures align with the resident's code statusThe DON initiated education on [DATE] for licensed nursing staff on:CPR policy and DNR policyVerification of code status upon admission with nursing documentationEnsuring emergency interventions align with resident code statusEducation for newly hired staff will be incorporated into orientation. Staff will not be allowed to provide direct resident care until training has been completed.Education will be completed on [DATE] .The Social Worker and MDS completed a 100% audit of all current residents' code statuses on [DATE] to ensure accuracy and consistency across medical records and physician's orders. 1 resident was identified with an incomplete DNR not signed by the physician but was immediately corrected and verified by POA.Systemic Changes Implemented:All new admissions will be reviewed during the daily clinical morning meeting with the interdisciplinary team (IDT) to:Verify code statusEnsure accurate and consistent documentation, including:Physician's ordersVerified consent from resident/POANursing documentation of confirmationAll new physician's orders will be reviewed in the clinical morning meeting to ensure:Any changes in code status are verified o Supporting documentation is complete and consistent within the medical record No changes were added to the facility policy.No changes to facility clinical admission checklist were noted or added.Monitoring Plan:The Director of Nursing (DON) and/or Unit Managers will conduct daily audits Monday through Friday on new admission, while the Weekend Supervisor will review admissions occurring on Saturdays and Sundays for a period of two weeks and randomly thereafter to ensure that code status is verified and accurately documented. No changes to the policy were needed.Audit findings from the daily new admission audits will be reviewed by the DON and Administrator and discussed during QAPI meetings monthly x3 months.Any identified issues will result in immediate corrective action and staff re-education.Policy Review:The Administrator reviewed the facility policy on CPR, DNR, and Clinical admission checklist on [DATE]. No revisions were required at this