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	10/17/2024

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 0690 Level of Harm - Minimal harm or potential for 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** 41392 Based on observation, interview and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 1 resident (Resident#9) reviewed for incontinent care. - CNA A cleaned Resident #9 from back to front instead of front to back during perineal care (cleaning of the area between the anus and genital) on 10/16/24. This failure could place residents at risk of infection and hospitalization . Findings include: Record review of Resident #9's face sheet, dated 10/16/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and initially admitted on [DATE]. Her diagnoses included stroke, ESRD, heart failure, respiratory failure, muscle weakness, depression, anxiety, dementia, diabetes and bipolar disorder. Record review of Resident #9's quarterly MDS, dated [DATE], reflected a BIMS score of 13 out of 15, which indicated intact cognition. She required substantial/maximum assistance with toileting hygiene and personal hygiene. She was frequently incontinent of bowel and bladder. Record review of Resident #9's care plan, with the last review date 09/17/2024, reflected she was verbally aggressive r/t mental illness and ineffective coping skills. She was at risk for alterations in skin integrity and pressure ulcer formation. Interventions included to assist resident for toileting as indicated. She was incontinent of bladder/bowel and at risk for skin breakdown. Interventions included to monitor for incontinence every 2 hours and as needed also to change promptly. On 8/2/24, Resident #9 was on antibiotics for diagnosis of GI: bacterial infection. Interventions included to follow standard precautions to prevent cross-contamination and spread of infection. Resident #9 received dialysis and was at risk of symptoms including infected access site, itchy skin. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/16/24 at 6:30 AM revealed CNA A gathered supplies to provide incontinent care to Resident #9. Resident #9 was lying on her back with her knees bent. CNA A washed her hands, put on clean gloves, unfastened the tabs on the adult brief and using cleansing wipes, cleansed the front peri area from front to back. No issues observed. Resident #9 turned to the left side and CNA A cleansed in the direction starting from the sacral area to the rectum and vagina using three separate cleansing wipes. CNA touched the clean brief and positioned under Resident #9, fastened the tabs and touched the resident's clothing to assist with putting pants on. CNA A removed used gloves and put on clean gloves then assisted Resident #9 into the wheelchair. CNA A gathered the garbage then removed gloves and washed her hands. Interview on 10/16/24 at 6:45 AM, CNA A stated she should have wiped in the direction from the front of the resident to the back when the resident turned to her left side. CNA A stated she forgot, and the resident was demanding by wanting things done quickly. CNA A did not have an answer as to why she did not remove the used gloves after cleaning the resident and before touching the clean brief. CNA A stated she changed her gloves and washed her hands. Interview on 10/16/24 at 2:10 PM, LVN C stated the facility policy and procedure was to cleanse females from front to back even if the resident was lying on one side and the reason was to prevent infection. LVN C stated after incontinent care the gloves would be dirty, should be removed and hands washed prior to touching clean briefs, clothing and beddings to prevent cross contamination. Interview on 10/16/24 at 2:45 PM, LVN E stated the facility policy and procedure for incontinent care was to wipe starting from the front of the peri area towards the back. LVN E stated if wiping from back to front, especially if feces was involved, the feces could get into the urinary tract and cause infection. LVN E stated gloves should be removed and hands washed or sanitized after the dirty part of the procedure was completed. LVN E stated the risk would be infection as dirty gloves could spread germs to the resident and spread germs to the nursing staff's clothing. Interview on 10/17/24 at 8:44 AM, the DON stated when performing perineal care for a female resident, cleansing should begin from front to back due to risk of E.coli infection (a group of bacteria that can cause infection in the gastrointestinal tract and other parts of the body). The DON stated after incontinent care the gloves would be dirty, hand hygiene would be performed, and new gloves put on to decrease the spread of infection. The DON stated everything could get contaminated easily between the dirty procedure and clean procedure, so hands should be washed or sanitized, and new gloves put on. The DON stated most residents already did not have good hand hygiene practices. The DON stated the primary risk was infection. Record review of the facility's policy and procedure for Perineal Care, revised on 12/2023, read in part: .The facility will provide perineal care in a manner that maintains privacy, reduces the risk of infection, and promotes skin integrity .Preparation: wash hands thoroughly and apply gloves .positioning: assist the resident into a comfortable position, usually lying on their back with knees bent and legs slightly apart . Cleaning: for female resident, separate the labia and clean from front to back using a clean wipe for each stroke .Applying clean brief: remove soiled gloves and dispose of them properly. Perform hand hygiene thoroughly. Apply new clean gloves. Assist the resident .place a clean brief under them. Secure the brief . Disposal and cleanup: Dispose of soiled wipes, towels and gloves in the appropriate receptacle. Wash hands thoroughly after removing gloves (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Nursing Policies and Procedures for Activities of Daily Living - Highest Level of Functioning, revised 03/2019, read in part: .The facility is responsible to provide necessary care to all residents who are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392 Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not five percent or greater. The facility had a medication error rate of 7 % based on 2 errors out of 28 opportunities, which involved 1 of 5 residents (Resident #73) and 1 of 3 staff (MA B) reviewed for medication errors. - The facility failed to ensure MA B did not administer Isosorbide and Carvedilol, medications used to treat high blood pressure, to Resident #73 outside of the physicians order when his blood pressure was below 110/60. This failure could place residents at risk of low blood pressure, falls and hospitalization . Findings include: Record review of Resident #73's face sheet, dated 10/16/24, reflected a [AGE] year-old-male who was admitted to the facility on [DATE] and initially admitted on [DATE]. His diagnoses included inflammation of the colon, stroke, heart failure, kidney failure, diabetes, anemia, presence of cardiac pacemaker, bipolar disorder, anxiety, high blood pressure and high cholesterol. Record review of Resident #73's quarterly MDS, dated [DATE], reflected a BIMS score of 9 out of 15, which indicated moderate cognitive impairment. He required supervision with oral hygiene and toileting hygiene. He was independent with other ADLs. He used a walker for mobility. Record review of Resident #73's care plan, last reviewed on 08/30/24, reflected he had a risk for fluctuations in blood pressure values, hypo/hypertension (low blood pressure and high blood pressure) and other complications. Interventions included check blood pressure, observe for increased edema, dizziness, headache, chest pain; give medications as ordered. Resident #73 was at risk for falls and injuries. Resident #73 has a diagnosis of hypertension. Interventions included to give hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (drop in blood pressure when changing positions), increased heart rate and effectiveness. Record review of Resident #73's active physician orders, dated 10/17/24, reflected an order for Carvedilol oral tablet 3.125mg, give one tablet two times a day for high blood pressure. Hold for blood pressure <110/60, heart rate 60. Order date was 07/02/24. Isosorbide Dinitrate-hydralazine oral tablet 20-37.5 mg, give one tablet three times a day for high blood pressure. Hold for blood pressure <110/60, heart rate 60. Order date 07/02/24. Record review of Resident #73's October 2024 MAR reflected MA B documented Resident #73's blood pressure was 107/71, pulse 67 beats per minute and administered Carvedilol and Isosorbide Dinitrate on 10/16/24 at 8:00AM. Observation of medication pass on 10/16/24 at 7:50 AM, MA B checked Resident #73's vital signs. The BP was 107/71 and pulse was 67. MA B prepared Resident #73's 8:00AM medications which included Isosorbide Dinitrate-hydralazine oral tablet 20-37.5 mg 1 tablet and Carvedilol oral tablet 3.125mg 1 tablet then administered to Resident #73. (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/16/24 at 1:30 PM, MA B stated he gave Resident #73 the blood pressure meds Isosorbide and Carvedilol and was not supposed to because the parameters to hold was 110/60 and Resident's actual blood pressure was 107/71. MA B stated he realized his mistake after the State Surveyor left the area. MA B stated he notified his nurse, LVN D and the unit manager LVN E of the error and he rechecked Resident #73's BP. MA B stated he was very nervous and could not even think about what was going on in the unit at the time. MA B stated the risks of giving BP medications outside of ordered parameters was lowered BP and the resident could sleep all day. MA B stated he received training on medication administration a few weeks ago and started working at the facility one month ago. Interview on 10/16/24 at 2:15 PM, LVN D stated MA B notified him that he administered BP meds to Resident #73 outside of the ordered parameters, then he immediately checked Resident #73's BP and notified the MD. When asked what the risks were, LVN D stated there were no risks because he rechecked Resident #73's BP and he was fine. Interview on 10/16/24 at 2:45 PM, LVN E stated MA B reported the BP medications for Resident #73 should have been held and she notified the MD, received orders to recheck the BP and then rechecked a second time. LVN E stated the nurses or anyone administering the medications was responsible to ensure the MD orders were being followed. LVN E stated the risks would be a drop in the BP, drop in HR, dizziness and other adverse reactions. Interview on 10/16/24 at 8:44 AM, the DON stated medication aides or nurses were responsible to following MD orders and BP parameters prior to giving the medication if it was on the MAR and if out of parameters, they were to recheck and call the MD. The DON stated the risks when BP medications were given outside of the ordered parameters was hypotension (drop in BP), dizziness and fall risk. The DON stated that the management team was responsible for ensuring nursing staff were following physician orders for blood pressure parameters and the management team and pharmacists would periodically audit medication administration and then provide reeducation to the staff as needed. Record review of the facility's Nursing Policies and Procedures, Administration of Drugs, revised on 06/2019, read in part: .It is the policy of the facility that medications shall be administered as prescribed by the attending physician. Procedure .2. If a Certified Medication Aide is administering medications, they must do so according to the Texas administrative Code Title 26, Part 1 Chapter 557, rule 557.105 and organization policies and procedures . 3. Medications must be administered in accordance with the written orders of the ordering/prescribing physician .15. Prior to administering the resident's medication, the nurse should compare the drug and dosage schedule on the resident's MAR with the drug label

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392 Based on interview and record review the facility failed to ensure residents were free of significant medication errors for 1 of 5 residents (Resident #73) reviewed for pharmacy services. -MA B failed to ensure Resident #73's Isosorbide and Carvedilol (blood pressure medications) were not administered when the blood pressure (a measure of how forcefully the blood goes through the arteries) and heart rate (the number of times the heart beats in 60 seconds) was outside of the ordered parameters on 10/16/24. This failure could place residents at risk of falls from dizziness and reduced blood flow which could result in stroke or heart attack and hospitalization . Findings include: Record review of Resident #73's face sheet, dated 10/16/24, reflected a [AGE] year-old-male who was admitted to the facility on [DATE] and initially admitted on [DATE]. His diagnoses included inflammation of the colon, stroke, heart failure, kidney failure, diabetes, anemia, presence of cardiac pacemaker, bipolar disorder, anxiety, high blood pressure and high cholesterol. Record review of Resident #73's quarterly MDS, dated [DATE], reflected a BIMS score of 9 out of 15, which indicated moderate cognitive impairment. He required supervision with oral hygiene and toileting hygiene. He was independent with other ADLs. He used a walker for mobility. Record review of Resident #73's care plan, last reviewed on 08/30/24, reflected he had a risk for fluctuations in blood pressure values, hypo/hypertension (low blood pressure and high blood pressure) and other complications. Interventions included check blood pressure, observe for increased edema, dizziness, headache, chest pain; give medications as ordered. Resident #73 was at risk for falls and injuries. Resident #73 has a diagnosis of hypertension. Interventions included to give hypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (drop in blood pressure when changing positions), increased heart rate and effectiveness. Record review of Resident #73's active physician orders, dated 10/17/24, reflected an order for Carvedilol oral tablet 3.125mg, give one tablet two times a day for high blood pressure. Hold for blood pressure <110/60, heart rate 60. Order date was 07/02/24. Isosorbide Dinitrate-hydralazine oral tablet 20-37.5 mg, give one tablet three times a day for high blood pressure. Hold for blood pressure <110/60, heart rate 60. Order date 07/02/24. Record review of Resident #73's October 2024 MAR reflected MA B documented Resident #73's blood pressure was 107/71, pulse 67 beats per minute and administered Carvedilol and Isosorbide Dinitrate on 10/16/24 at 8:00AM. Observation of medication pass on 10/16/24 at 7:50 AM, revealed MA B checked Resident #73's vital signs. The BP was 107/71 and pulse was 67. MA B prepared Resident #73's 8:00 AM medications which included Isosorbide Dinitrate-hydralazine oral tablet 20-37.5 mg 1 tablet and Carvedilol oral tablet 3.125mg 1 tablet then administered to Resident #73. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/16/24 at 1:30 PM, MA B stated he gave Resident #73 the blood pressure meds Isosorbide and Carvedilol and was not supposed to because the parameters to hold was 110/60 and Resident's actual blood pressure was 107/71. MA B stated he realized his mistake after the State Surveyor left the area. MA B stated he notified his nurse, LVN D and the unit manager LVN E of the error. MA B stated the risks of giving BP medications outside of ordered parameters was lowered BP and the resident could sleep all day. Interview on 10/16/24 at 2:15 PM, LVN D stated MA B notified him that he administered BP meds to Resident #73 outside of the ordered parameters, then he immediately checked Resident #73's BP and notified the MD. When asked what the risks were, LVN D stated there were no risks d/t he rechecked Resident #73's BP and he was fine. Interview on 10/16/24 at 2:45 PM, LVN E stated MA B reported the BP medications for Resident #73 should have been held and she notified the MD, received orders to recheck the BP and then rechecked a second time. LVN E stated the nurses or anyone administering the medications were responsible to ensure the MD orders were being followed. LVN E stated the risks would be a drop in the BP, drop in HR, dizziness and other adverse reactions. Interview on 10/16/24 at 8:44 AM, the DON stated medication aides or nurses were responsible to follow MD orders and BP parameters prior to giving the medication if it was on the MAR and if out of parameters, they were to recheck and call the MD. The DON stated the risks when BP medications were given outside of the ordered parameters were hypotension (drop in BP), dizziness and fall risk. Record review of the facility's Nursing Policies and Procedures, Administration of Drugs, revised on 06/2019, read in part: .It is the policy of the facility that medications shall be administered as prescribed by the attending physician. Procedure .2. If a Certified Medication Aide is administering medications, they must do so according to the Texas administrative Code Title 26, Part 1 Chapter 557, rule 557.105 and organization policies and procedures . 3. Medications must be administered in accordance with the written orders of the ordering/prescribing physician .15. Prior to administering the resident's medication, the nurse should compare the drug and dosage schedule on the resident's MAR with the drug label Record review of the facility's Education In-Service for Medication Errors, dated 09/03/24, conducted by the QA Nurse read in part: Medication errors in long-term care facilities are a significant concern because they can lead to adverse drug events (ADEs), compromise patient safety, and increase healthcare costs . Common Types of Medication Errors .4. Administration Errors: The most common type of medication errors in LTCFs involves the incorrect administration of drugs. This can include giving the wrong dose, administering medication at the wrong time or failing to administer a prescribed drug. This type of error can be due to staff shortages, lack of training, or miscommunication among caregivers

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 41469 Based on observation, interview and record review the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for 1 of 2 meals reviewed for palatability. The facility failed to ensure the lunch meal served on 10/15/2024 was not bland. This failure could place residents at risk of experiencing a decreased quality of life and possible malnutrition. Findings include: Record review of the facility's menu, dated October 15th, 2024, reflected residents were served lunch meal consisting of Beef and Macaroni Casserole, Squash Medley, Peach Shortcake and Coffee/Hot Tea. The Always Available menu reflected grilled cheese sandwich as an alternative meal. Observation of the lunch meal test tray on 10/15/24 at 01:57 PM revealed beef macaroni with fruit salad (watermelon and honeydew) was served with a side of yellow squash and red bell peppers and a cup of juice. The State Surveyors tasted the meal and observed the pasta to be mushy and bland, the squash was too chewy and bland and the juice served was diluted and watery. During an confidential interview with 10 residents revealed most of the meals served were subpar and the meal served for lunch on 10/15/2024 was nasty and they did not want to eat it. In an interview with the Assistant Dietary Manager on 10/17/24 at 12:37 PM, she stated she heard the cook overcooked the pasta. She stated she did not hear any complaints about the meals. She stated she was helping on the line because they needed more assistance with the meal service. She stated she believed they needed to add more staff and train the current staff to move faster in the kitchen and serve their meals in a timely manner. In an interview with the Dietary Manager on 10/17/24 at 12:45 PM, she stated she had been working at the facility for two weeks. She stated the cook was new and seemed inexperienced. She stated the cook overcooked the pasta and the quality of the pasta dish, served on 10/15/2024, she had never seen before. She stated although she did not get any complaints directly from the residents about the food, they did have an abnormal influx of residents who requested the alternative meals such as grilled cheese sandwiches for lunch. She stated the quality of their meals needed to be at a higher standard to ensure residents were eating the meals and getting adequate nutrition. She stated she believed they needed more staff to be able to move faster and they needed more training to ensure better quality of food was served and served on time.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41469 Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in one of one kitchen reviewed for dietary services. 1. The facility failed to ensure drinks that were poured into individual cups were stored in the fridge with lids or covers,] and had labels. 2. The facility failed to ensure a pitcher of chopped fruit was dated on labeled. 3. The facility failed to ensure a bin of flour didn't have gaps in the in the cover and was completely sealed. These failures could place residents at risk of foodborne illness. Findings include: Observation of the kitchen on 10/15/2024 at 8:20AM revealed the following: - In fridge #1, a pitcher of chopped fruit was observed without labels or dates. - In fridge #2, two trays of beverages were poured into individual cups without lids/covers and without labels or dates. - a bin of flour had gaps in the in cover and was not completely sealed. In an interview with the Assistant Dietary Manager on 10/15/2024 at 8:30AM, she stated she believed the chopped fruit was used as a garnish but she could not tell how long the fruit had been sitting in the fridge. She stated the fruit should have been labeled. She stated all kitchen staff were responsible for ensuring the drinks in the fridge and the flour bin should both be properly sealed and covered to reduce the risk of contamination and food borne illness. Record review of the facility's policy on food storage, dated 12/01/2011, reflected, .a. To ensure freshness, opened and bulk items are stored in tightly covered containers. All containers are labeled and dated . e. All refrigerated foods are dated, labeled and tightly sealed, including left overs, using clean, nonabsorbent, covered containers t

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Archide, [NAME] Based on observation, interview and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 1 resident (Resident#9) reviewed for incontinent care. - CNA A failed to change gloves and perform hand hygiene after peri care and prior to touching clean items for Resident #9 on 10/16/24. These failures could place residents at risk of infection and hospitalization . Findings include: Record review of Resident #9's face sheet, dated 10/16/24, reflected a [AGE] year-old female who was admitted to the facility on [DATE] and initially admitted on [DATE]. Her diagnoses included stroke, ESRD, heart failure, respiratory failure, muscle weakness, depression, anxiety, dementia, diabetes and bipolar disorder. Record review of Resident #9's quarterly MDS, dated [DATE], reflected a BIMS score of 13 out of 15, which indicated intact cognition. She required substantial/maximum assistance with toileting hygiene and personal hygiene. She was frequently incontinent of bowel and bladder. Record review of Resident #9's care plan, with the last review date 09/17/2024, reflected she was verbally aggressive r/t mental illness and ineffective coping skills. She was at risk for alterations in skin integrity and pressure ulcer formation. Interventions included to assist resident for toileting as indicated. She was incontinent of bladder/bowel and at risk for skin breakdown. Interventions included to monitor for incontinence every 2 hours and as needed also to change promptly. On 8/2/24, Resident #9 was on antibiotics for diagnosis of GI: bacterial infection. Interventions included to follow standard precautions to prevent cross-contamination and spread of infection. Resident #9 received dialysis and was at risk of symptoms including infected access site, itchy skin. Observation on 10/16/24 at 6:30 AM revealed CNA A gathered supplies to provide incontinent care to Resident #9. Resident #9 was lying on her back with her knees bent. CNA A washed her hands, put on clean gloves, unfastened the tabs on the adult brief and using cleansing wipes, cleansed the front peri area from front to back. No issues observed. Resident #9 turned to the left side and CNA A cleansed in the direction starting from the sacral area to the rectum and vagina using three separate cleansing wipes. CNA A did not change gloves or perform hand hygiene and then touched the clean brief, positioned the brief under Resident #9, fastened the tabs and touched the resident's clothing to assist with putting pants on. CNA A removed used gloves and put on clean gloves then assisted Resident #9 into the wheelchair. CNA A gathered the garbage then removed gloves and washed her hands. (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	10/17/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/16/24 at 6:45 AM, CNA A stated she should have wiped in the direction from the front of the resident to the back when the resident turned to her left side. CNA A stated she forgot, and the resident was demanding by wanting things done quickly. CNA A did not have an answer as to why she did not remove the used gloves after cleaning the resident and before touching the clean brief. CNA A stated she changed her gloves and washed her hands. Interview on 10/16/24 at 2:10 PM, LVN C stated after incontinent care the gloves would be dirty, should be removed and hands washed prior to touching clean briefs, clothing and beddings to prevent cross contamination. Interview on 10/16/24 at 2:45 PM, LVN E stated gloves should be removed and hands washed or sanitized after the dirty part of the procedure was completed. LVN E stated the risk would be infection as dirty gloves could spread germs to the resident and spread germs to the nursing staff's clothing. Interview on 10/17/24 at 8:44 AM, the DON stated after incontinent care the gloves would be dirty, hand hygiene would be performed, and new gloves put on to decrease the spread of infection. The DON stated everything could get contaminated easily between the dirty procedure and clean procedure, so hands should be washed or sanitized, and new gloves put on. The DON stated most residents already did not have good hand hygiene practices. The DON stated the primary risk was infection. Record review of the facility's policy and procedure for Perineal Care, revised on 12/2023, read in part: .The facility will provide perineal care in a manner that maintains privacy, reduces the risk of infection, and promotes skin integrity .Preparation: wash hands thoroughly and apply gloves .positioning: assist the resident into a comfortable position, usually lying on their back with knees bent and legs slightly apart . Cleaning: for female resident, separate the labia and clean from front to back using a clean wipe for each stroke .Applying clean brief: remove soiled gloves and dispose of them properly. Perform hand hygiene thoroughly. Apply new clean gloves. Assist the resident .place a clean brief under them. Secure the brief . Disposal and cleanup: Dispose of soiled wipes, towels and gloves in the appropriate receptacle. Wash hands thoroughly after removing gloves Record review of the facility's nursing policy and procedures, Subject Hand Hygiene/Hand Washing revised 06/2019, read in part: .It is the policy of this facility that proper hand washing technique will be used when handwashing is indicated . Hand hygiene/hand washing is the most important component for preventing the spread of infection . Procedures .2. Wash hands .C. Before putting on gloves, when changing into a fresh pair of gloves, and immediately after removing gloves Record review of the facility's Nursing Policies and Procedures for Activities of Daily Living - Highest Level of Functioning, revised 03/2019, read in part: .The facility is responsible to provide necessary care to all residents who are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene