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	04/10/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living (ADL) to maintain good grooming and personal hygiene for 2 (Resident #24 and Resident #100) of 6 residents reviewed for ADLs. - The facility failed to ensure Resident #24 had showers three times a week, throughout February and March 2025. - Resident #100 was not provided nail care. Resident #100's nails were long past the tips of his fingers with a dark substance underneath the nail tip. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life. Findings included: 1. Record review of Resident #24's undated face sheet revealed he was a [AGE] year-old male, admitted to the facility on [DATE], with an original admission date of 4/6/23. His diagnoses included Alzheimer's Disease (disorder that primarily affects memory, thinking, and behavior), Diabetes Mellitus (body does not produce insulin or body resists it), lack of coordination, muscle weakness, malaise (extreme tiredness), extrapyramidal and movement disorder (involuntary movements and motor disturbances that affect body's muscles and coordination), dementia (decline in mental ability severe enough to interfere with daily life), cognitive communication deficit (communication difficulty stemming from impaired cognitive processes), and abnormalities of gait and mobility. Record review of Resident #24's quarterly MDS assessment, dated 2/12/25, revealed a BIMS score of 10/15, which indicated moderately impaired cognition. The resident had impairment on both sides of his lower extremities, impairment on one side of his upper extremities, and used a wheelchair. Resident #24 was dependent (the helper does all of the effort and the resident does none of the effort) with ADLs. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #24's care plan, dated 4/9/23, reflected a Focus of ADL SELF CARE DEFICITS: [Resident #24] has ADL self-care deficits and is at risk for further decline in ADL functioning . The goal was for the resident to be well dressed, groomed, clean, and to have his dignity maintained with no further decline in ADL functioning over the next 90 days. The interventions included: Personal Hygiene: 2:2. The Care Plan did not mention baths/showers. An observation and interview on 3/18/25 at 9:55 AM, revealed Resident #24 was laying in his bed. The resident's hair appeared greasy, he had a gown on, and his sheets were dirty. Resident #24 said that he was not getting showers/baths three times a week like he was supposed to. He was unsure of when his last shower/bath was. Record review of Resident #24's February 2025 and March 2025 shower sheets revealed the resident received a bed bath on 2/5/25, 2/19/25, 2/22/25, 2/25/25, and 3/7/25. According to the sheets, the resident refused on 3/11/25 and 3/15/25. According to these dates, since the resident was supposed to receive baths 3 times a week, he missed 13 baths. In an interview on 3/20/25 at 10:10 AM, with the DON she said showers/baths were performed 3 times a week on residents. She said she was not sure which bed received them at night and which one received them during the day, but A bed would get them on one shift and B bed would get them on the other shift. She said she had not heard of any complaints from residents not receiving showers/baths. The DON said the only problem she heard about showers/baths was that the night shift was receiving clean linens too late and then they had to wake up the residents to give them showers/baths and they would refuse. So, she made sure the linens were coming out earlier. She said they had enough staff and had floating CNAs during the week to help out with the residents who needed more help or took more time, so the regular CNAs could focus on the other residents. The DON said they used paper shower sheets to record the baths/showers and the CNAs filled them out and then gave them to the nurses, so the nurses knew if there were any skin issues or refusals. In an interview on 3/20/25 at 4:36pm, with CNA A he said he gave showers/baths and completed the shower sheets. He said if a resident refused a shower/bath he would report it to the nurse and then the nurse would speak to the resident. In an interview on 3/20/25 at 5:17pm with LVN B he said if a resident refused a shower/bath he would go speak to the resident and try to explain the reasons for it. He said if the resident still refused, he would contact the family. He said if a resident did not get a shower/bath they could be exposed to diseases, skin breakdown, and the resident will begin to smell. 2. Record review of Resident #100's clinical record revealed he was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnosis included other specified abnormal findings of blood chemistry, sepsis unspecified organism, other malaise (feeling of discomfort or illness), bipolar disorder unspecified, other Escherichia coli (E. Coli)(bacteria found in the lower intestine of warm-blooded organisms) as the cause of diseases classified elsewhere, other disorders resulting from impaired renal tubular function (functional unit of the kidney) chronic metabolic acidosis (retention of acid in the body), muscle wasting and atrophy not elsewhere classified multiple sites, and non-pressure chronic ulcer of skin of other sites with fat layer exposed. The resident is [AGE] years old. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #100's Quarterly MDS assessment dated [DATE] revealed his BIMs score was 13 out 15 indicating no cognitive impairment. Resident #100 required supervision or touching assistance throughout the activity or intermittently for toileting hygiene, shower/bath, upper body dressing, and personal hygiene. Resident #100 was frequently incontinent for bowel and had a catheter for urinary continence. Record review of Resident #100's Care Plan revised on 03/11/2024 revealed: -Focus: Resident #100 has an ADL self-care performance deficit and is at risk for further decline. -Interventions: Bathing/Showering; extensive assistance for personal hygiene/grooming. In an observation and interview on 03/18/2024 at 9:42am of Resident #100's fingernails revealed that they were long and extended past fingertips, while sitting up in bed. In an interview with Resident #100 stated he was waiting for a bath and nail cut down. Resident #100 was observed with long, yellow nails with a black substance underneath the nails on both hands. Record Review of Resident 100's Kardex on 03/20/2025 revealed he was hospitalized on [DATE] for further testing after a doctor's appointment. In an interview with ADON on 03/20/2025 at 4:46pm revealed the resident can be hard to bathe/shower or even cut nails. The staff did try to reeducate the resident on nail care and cleanliness. ADON stated that if Resident #100 had an appointment, ADL Care should have been administered before leaving the facility if the resident did not refuse. Record Review of Resident #100 Shower/Bath sheet physical copy, signed off by a nurse on 03/20/2025 revealed the resident last known activity was 03/17/2025, which was blank to verify the activity did not occur. Record Review of Resident #100 Shower/Bathe sheet in Kardex on 03/20/2025 revealed the resident was appointed to have a shower/bath on 03/18/2025 at 04:11am and 12:09pm, but the shower/bathe did not occur at those times. Record review of the facility's policy on Activities of Daily Living-Highest Level of Functioning (revised March 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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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility staff failed to ensure residents received treatment and care in accordance with professional standards of practice to promote healing and prevent infection, for 1 of 7 residents (CR #1) reviewed for wound care. The facility failed to follow wound care orders for CR#1's sacral wound on 11/07/24, 11/12/24, 11/16/24, 11/23/24, 11/24/24, and 11/27/24. CR#1 was transferred to the hospital after family intervention and was diagnosed with a stage 4 pressure injury (full-thickness skin and tissue loss, exposing muscle, tendon, or bone) with infection and severe sepsis. The noncompliance was identified as past non-compliance. The past non-compliance IJ began on 11/28/24 and ended on 2/20/25. The facility corrected the non-compliance before the survey began. This failure could place residents at risk of deterioration of wound, increased infection, decreased quality of life, and hospitalization. Findings included: 1.Record review of CR#1's Face Sheet (undated) revealed, a [AGE] year-old female who was initially admitted to the facility on [DATE] with diagnoses which included Non-ST elevation Myocardial infarction (heart attack that occurs when blood supply to the heart was reduced, causing damage), Acute respiratory failure with hypoxia (lungs failed to adequately oxygenate the blood), Chronic Obstructive Pulmonary Disease (airway obstruction and chronic inflammation of the lungs), Diabetes Mellitus (chronic metabolic disease characterized by high blood sugar levels), and End Stage Renal Disease (kidney failure). Record review of CR#1's admission MDS assessment dated [DATE] indicated a BIMS summary score of 05, which indicated severe cognitive impairment. The resident did not have pressure ulcers as a diagnosis on the entrance MDS. However, there was an indication for a pressure reducing device for her bed. Record review of CR#1's Comprehensive Care Plan, dated 10/03/24, indicated that CR#1 was at risk for pressure wounds related to alteration in skin integrity and pressure ulcer formation. The goal was to be free from alteration in skin integrity/formation of pressure wounds over the next 90 days. CR#1's interventions included assisting with toileting as indicated and performing weekly skin checks. Record review of CR #1 physician's orders on 11/05/24 indicated sacrum: cleanse site with normal saline, wound sacrum cleanser pat dry, skin prep, apply hydrocolloid sheet 3x weekly (Tuesday, Thursday, and Saturday) and prn. That order was discontinued, and a new sacrum wound care order was started on 11/21/24. The new order was for sacrum wound: cleanse site with Vashe pat dry, apply Santyl ointment (Nickel Thick) as topical, cover with calcium alginate as a primary dressing, and cover with bordered gauze daily and PRN every day. Record review of CR #1's treatment administration record for November 2024 revealed wound care was not performed as ordered on 11/07/24, 11/12/24, 11/16/24, 11/23/24, 11/24/24, and 11/27/24. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's weekly wound evaluation summary dated 11/01/2024 revealed a new sacral opening. Record review of CR #1's weekly wound evaluation summary dated 11/05/2024 revealed wound to the sacrum which measured 3x2x0.1cm Record review of CR#1's wound care notes on 11/18/24 by NP F revealed that CR#1's chronic sacral wound was measured at 3.4x7x0 cm. Record review of CR#1's wound care notes on 11/25/24 by NP F revealed that CR#1's chronic sacral wound continued to be unstageable but deteriorating and measured at 5x5x0. Record review of nursing notes dated 11/28/24 revealed CR#1's family member notified EMS to have resident CR#1 transferred from the facility to the hospital due to the condition of CR#1's wound. Record review of local hospital's medical records revealed that CR #1 was brought to the ED on 11/28/24 at 8:34 AM from a nursing facility with a sacral wound. After assessment, the resident was admitted to the hospital with stage 4 pressure injury and severe sepsis (life threatening condition where one or more body's organ is damaged from the inflammatory response). Wound cultures were collected and revealed positive for Escherichia. Coli (bacteria found in the intestines). Attempted to interview with the previous wound care nurse on 03/19/25 at 1:39 PM, but she no longer worked for the facility. During an Interview on 03/20/25 at 12:51 PM with contracted Dialysis RN, she said CR #1 had fluid overload and was on dialysis Monday-Friday. She said CR #1 was alert and oriented with some confusion. She said the resident developed a sacral wound; therefore, they would turn her to her side so she would be off the wound while in dialysis. During an interview on 03/20/2025 at 1:00 PM with the ADON, (who started at the facility on 09/23/24), she said CR#1's family would come to the facility regularly. She said the staff would notify the family member of any changes. She said the resident was in the Geri-chair most of the day and out of the bed per the family's request. She said her expectation was for the staff to follow MD orders. She said the risk of not following MD orders was a concern and that staff should always follow the orders. She said the staff conducted in-services on following MD orders recently but could not to provide a date. The ADON said the risk of not following MD orders could worsen the condition/diagnoses or wound. During an interview on 03/20/2025 at 3:24 PM with the DON, she said CR#1 was admitted to the facility without pressure ulcers but developed a pressure wound while at the facility. She said the resident was being treated as ordered, but the staff did not document her treatment. The DON said she could not confirm wound care was perfomed due to insufficient documentation. She said the wound care nurse who performed the treatment was terminated and no longer work at the facility. The DON said there was a new wound care nurse. She said she expected the staff to follow MD orders and document all treatments . The DON said the risk of not performing wound care as ordered could lead to deterioration of the wound. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Attempted to interview wound care Nurse Practitioner F on 03/20/25 at 3:51 PM, but she no longer worked for the wound care company. During an interview on 03/20/25 at 4:09 PM, the current wound care nurse, Nurse Practitioner L said Nurse Practitioner F assessed and provided treatment to CR#1, who no longer work for the company. Nurse Practitioner L said her expectation was that the nursing staff followed MD orders. She said some residents were placed on hydrocolloid, which can last up to 7 days; however, the staff should not deviate from the orders. She said if the order said to provide treatment every 3 days, the staff should follow that order. The Wound Care Nurse Practitioner L said the risk of not following the MD's orders was deterioration of the wound. During an interview on 03/20/25 at 5:13 PM with LVN T, wound care nurse, (who started at the facility on 2/24/25), she said her expectation was for staff to follow MD orders for wound care. She said the wound care doctor comes to the facility once a week, and if there were a change or deterioration to the wound, she would assess the wound to include measurements and notify the charge nurse and wound care MD. She said she conducted an in-service on skin assessments last week. She said she educated the CNAs on what to look for on the resident's skin. She said the risk of not following the physician's orders was the wound/ulcer could worsen. During an interview on 03/20/25 at 5:45 PM with the administrator, she said her expectation was the staff follow MD orders. She said she was unaware of what could happen if the staff did not cleanse the wound as ordered by the MD. During an interview on 04/07/25 at 2:12PM, CR#1's family member said she called EMS because CR#1's wound was large and had an odor. She said when she arrived at the local hospital the doctor admitted CR#1 her aunt because she was septic. She said she had E. Coli in her wound. She said after acquiring the wound and becoming septic, CR#1 was never the same. CR#1's family member said they had to perform colostomy (surgical procedure that creates an opening in the abdomen to allow stool to pass out the body) on 12/12/24, and she was discharged to another nursing facility on 12/14/24. During an interview on 04/07/25 at 4:48 PM, the Chief Medical Officer for the wound care company said NP F no longer worked there. She said, based on the photos, CR #1 had a chronic unstageable sacral wound. She said the wound had not significantly changed between the initial visit on 11/18/24, measuring 23.8 cm, and the 2nd visit on 11/25/24, measuring 25cm. She said the interventions, including the dressing that was ordered, were appropriate for wound care. She said the resident had significant comorbidities and was incontinent to bowel and bladder, which could also deteriorate the wound quickly. The chief medical officer said the resident was declining, and based on the appearance of the wound, this skin failure was a phenomenon that was recognized in residents with a terminal condition. During an interview on 04/07/25 at 5:01 PM, LVN M said nurses perform weekly skin assessment on the residents. She said the nurses were responsible for providing wound care if the wound care nurses were unavailable. She said the staff was in-serviced last week on wound care. She said the risk of not performing wound care could lead to further breakdown of the skin or worsen the wound. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/07/25 at 5:36 PM, RN O said nurses perform wound care when the wound care nurse was not available. She said they also have a wound care MD that comes once a week to provide care. RN O said they perform skin assessments on every new admission and conduct weekly skin assessments. She said a wound consult was requested for every resident with a wound, and the MD was contacted if there was a change in the wound. RN O said the last in-service on wound care was conducted last week. She said the risk of not providing wound care was infection. Attempted telephone interview with Dr. T on 04/08/25 at 12:54 PM, left a voicemail message. During an observation of Resident #2's wound care on 04/09/25 at 2:40 PM, the wound care nurse sanitized hands and applied PPE (personal protective equipment), including gown and gloves. She cleaned the bedside table and applied barrier to bedside table. She doffed gloves and washed her hands. She donned gloves, cleaned the unstageable sacral wound with wet gauze, and patted it dry. The wound care nurse doffed gloves, washed her hands, and donned new gloves. She applied Medihoney, calcium alginate, and dressing as ordered. She doffed her gown and gloves and washed her hands. She repositioned the resident to her right side and removed discarded items. During an interview on 04/09/25 at 2:51 PM, RN S said she does wound care as needed. She said she noticed an increase in training in January and February by the wound care nurse. She said she cannot remember the date of her last wound care training. She said in training, the staff was educated on change of condition (odor, increase drainage, increase pain, and increase temperature) and the notification process. She said when providing wound care, the staff should document changes in the wound and notify the MD, RP, and DON. She said staff should reposition residents every 2 hours and change wet and soiled briefs frequently to prevent skin breakdown. Review of the facility's policy titled Wound Evaluation, with a revision date of 06/ 2019, read in part . Procedures: 2. Document all treatments performed and resident response in Point Click Care. 6. Evaluation results are communicated to the members of the interdisciplinary care team through documentation, care plan meetings, and care planning . The noncompliance was identified as past non-compliance. The IJ began on 11/28/24 and ended on 02/20/25. The facility corrected the non-compliance and implemented the following interventions prior to the surveyors entering the facility on 03/18/25: -Record review of QA meetings, with facility clinical staff and regional nursing staff, regarding facility skin system and wound care on 12/06/24, 12/20/24, 01/10/25 and 02/07/25. -Record review of Wwound care nurses were terminated on 12/17/24 and 12/23/24. -Record review of skin sweeps conducted 12/23/24 through 12/31/24. Results indicated no other residents were found to have new or worsening wounds. -Record review of QA Nurse and DON followed-up on all wound care audits and skin assessments. -Outside Wound Care physician rounded on all residents on 02/06/25-02/07/25. -Interviews with staff they who stated they have been in-serviced to report any changes or anything different for the resident. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Record review of in-services and re-education provided to facility staff on 01/06/25, 01/14/25, 01/15/25, 02/05/25, and 02/14/25. Topics included: Wound care; change in conditioning; incontinent care and repositioning for residents with wounds. -Observations during annual recertification 03/18/25-03/20/25 revealed no concerns.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 of 6 residents (Resident #41 and #495) reviewed for respiratory care. The facility failed to ensure resident #41's had oxygen ordered by the physician. The facility failed to ensure Resident #495's oxygen was set to the 2 LPM indicated in her physician's order. These failures could place residents who receive oxygen at an increased risk for hypercapnia (too much carbon dioxide in the blood), pulmonary oxygen toxicity (damage to the lung lining tissues and air sacs), hypoxemia (low levels of oxygen in the blood, decreasing the oxygen supply to vital organs), and shortness of breath. Findings Included: Record review of Resident #41's undated face sheet, revealed she was a [AGE] year old female admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included: COPD (group of lung diseases that cause ongoing breathing problems), dependence on supplemental oxygen, Type II Diabetes Mellitus (body does not make insulin or resists it), repeated falls, severe obesity, depression, insomnia, anxiety, pressure ulcer of the sacrum (buttocks), fracture of upper end of right humerus (upper arm), and fracture of upper end of left humerus. Record review of Resident #41's quarterly MDS assessment, dated 3/10/25, revealed a BIMS score of 15/15 which indicated normal cognition. The resident had an impairment on both sides of her lower extremities and used a wheelchair. Resident #41 was dependent (the helper does all of the effort and the resident does none of the effort with all ADLs). According to the MDS, the resident was on oxygen therapy. Record review of Resident #41's comprehensive care plan, dated 5/22/24 revealed a Focus: The resident had COPD and was on O2 dependent @ 4L/min per NC. The goal was to be free of s/sx of respiratory infections through the review date. Interventions included oxygen settings at 4L/min continuously via nasal cannula. Record review of Resident #41's February 2025 and March 2025 pulse ox records revealed the resident was on oxygen since she was readmitted to the facility on [DATE]. During an observation and interview on 3/18/25 at 11:17am with Resident #41, she had oxygen via nasal cannula on and the oxygen concentrator was set at 3L. The resident said she used the oxygen continuously. Record review of Resident #41's March 2025 Physician Orders revealed no orders for oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #41's discontinued/completed orders revealed the last order for oxygen was on 8/25/24 at 11:34am for Oxygen @ 4 LPM via nasal cannula as needed. During an interview on 3/20/25 at 10:15am the DON said there should have been an order for the oxygen, and she did not know why there was not one. She said the order should have been put in when she was readmitted because she was on oxygen before. She said she would make sure to get an order. The DON said it could negatively impact the resident if there were no order and the resident was receiving treatment. 2. Record review of Resident #495's undated face sheet revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease with (acute) exacerbation (inflammation of lung tissue due to non-infectious causes, which results in cough without mucus or phlegm, shortness of breath, and fatigue), and Congestive heart failure (chronic condition in which the heart muscle fails to pump blood as it should), and shortness of breath. Record review of Resident #495's admission MDS assessment on 03/17/25 revealed a BIMS summary score of 9, indicating moderate cognitive impairment. Further review of the MDS assessment revealed Resident #495 was on oxygen therapy. Record review of Resident #495's care plan revealed Resident #495 required supplemental oxygen via nasal cannula related to: COPD exacerbation and congestive heart failure. The goal was to maintain adequate oxygen saturation levels and respiratory comfort through the review date. The interventions included to follow physician orders for oxygen therapy delivery. Record review of Resident #495's physician's orders dated 03/12/25, Oxygen at 2 LPM via nasal cannula continuously. Record review of MAR/TAR and vital signs for Resident #495's oxygen saturations from 03/12/25 to 03/19/25 revealed oxygen saturations were at or above 94%. Record review of Resident #495's progress notes indicated no signs or symptoms of respiratory distress (difficulty breathing). During an observation and interview on 03/19/25 at 10:33 AM Resident #495 was in her room, seated in her wheelchair, receiving O2 via NC at 3.5 LPM. She said she had been on O2 continuously for her diagnosis of COPD. When asked if she moved the dial to adjust the flow rate of the O2 she said the nurse set the flow rate and she did not touch the dial. She said the CNA informed her that her oxygen was supposed to be set between 2-4 lpm. During an observation on 03/19/25 at 11:24 AM Resident #495's O2 concentrator was set at 3.5 LPM. During an interview on 03/19/25 at 1:36 PM, CNA J said nurses were responsible for setting flow rates for O2. She said she does not touch the resident's oxygen flow rate and if the resident was having any respiratory distress, she would notify the nurse immediately. (continued on next page)

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	675085	A. Building B. Wing	04/10/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 03/19/25 at 1:38 PM, RN H (Unit Manager), the Unit manager and surveyor observed that Resident #495's O2 concentrator was set at 3.5 LPM. The Unit manager said nurses were responsible for setting oxygen flow rates; however, there was a standing order to increase the O2 from 2-4 lpm if the resident had shortness of breath or oxygen saturations lower than 90%. During an observation and interview on 03/19/25 at 1:49 PM, LVN B and surveyor observed that Resident 495's O2 concentrator was set at 3.5 LPM said nurses were responsible for setting flow rates on O2. He said nurses knew what level to set O2 flow rate by referring to physician's orders. LVN B looked on his computer and found Resident #495's order was for O2 at 2 lpm. He said the risk of receiving too much oxygen could cause the resident natural breathing to be suppressed. During an interview on 03/20/25 at 1:10 PM, the ADON said the regional respiratory therapist comes to the facility to conduct in-services on respiratory therapy. She said the nurses set O2 flow rates and know what rate to set by looking at physician's orders. She said if O2 was set higher than the order the resident could have too much carbon dioxide and could cause the resident to be hospitalized due to an exacerbation. During an interview on 03/20/25 at 1:37 PM, the DON said the residents' O2 flow rate should reflect the MD orders. She said we have standing orders, and the staff can titrate between 2-4 lpm based on nursing judgement. She said there should be documentation based on the oxygen saturations and signs of respiratory distress. She said there could be a negative outcome if oxygen was administered at lower or higher rates than ordered. The DON said the risk of getting too much oxygen was breathing suppression in residents with COPD. During an interview on 03/20/25 at 2:21 PM, the QA nurse said he does on-boarding training with all new hires to include infection control, abuse and neglect, HIPAA, and generalized standards of care. He said the regional respiratory therapist conducted trach care in-services with return demonstration for all new staff. The QA nurse said oxygen therapy was covered during on-boarding which was verified by the shadowing floor nurses. He said there was no paper checklist available to review. During an interview on 03/20/25 at 2:26 PM, the administrator said her expectation was for nursing staff to follow all physician orders. She said the staff does ongoing training and in-services on following MD orders and Respiratory care to include O2. She said the risk of not following orders could lead to a potential for negative outcome. Record review of the facility's oxygen therapy policy, dated 4/2021, read in part, .it is the policy of this community to ensure all oxygen administration is conducted in a safe manner . Procedure: 1. Verify there is an order for oxygen administration to include: a. method of delivery b. flow rate, c. oxygen saturation parameters if indicated .3. Assess resident's respiratory status . 6. Start oxygen flow of rate as ordered. 7. Document resident's response to prn oxygen therapy: a. date and time of oxygen administration b. type of delivery c. oxygen rate d. assessment of resident's respiratory status to include oxygen saturation via pulse oximetry (a quick, noninvasive test that measures the oxygen saturation levels in the blood)

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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** 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 8% based on 3 errors out of 35 opportunities, which involved 2 of 4 residents (Resident #58 and Resident #8) reviewed for medication errors in that: - LVN B administered Sennoside 8.6 mg (a stool softener) instead of Sennoside 8.6 with Docusate 50 mg and Multivitamins with minerals instead of Multiple Vitamins (without minerals) as ordered by the physician to Resident #58 on 3/19/25. - MA B applied a new Rivastigmine patch (used to treat dementia) to Resident #8 prior to removing the old one on 3/19/25. These failures could place residents at risk of inadequate therapeutic outcomes. Resident #58 Record review of Resident #58's Face Sheet dated 3/19/25 revealed a [AGE] year-old female who readmitted to the facility on [DATE]. Her diagnosis included in part, dementia, protein-calorie malnutrition, and constipation. Record review of Resident #58's annual MDS dated [DATE] revealed a BIMS score of 99 which indicated the resident was unable to complete the interview. The staff assessed her mental status as severely impaired. She was dependent on staff for ADL care. Record review of Resident #58's Care Plan last reviewed 3/17/25 indicated she had a diagnosis of constipation and was at risk for impactions and bowel obstructions. 2/15/23 docusate sodium as ordered. Interventions were to give medications per order. Resident also had an alteration in hematological status related to vitamin deficiency. Intervention was to give medications as ordered. Record review of Resident #58's MD order revealed orders for: Multiple vitamin give 1 tablet via g-tube one time a day for wound, order date 1/23/25, Senna-Time S 8.6 - 50 mg give 1 tablet via g-tube every 12 hours for constipation, order date 1/23/25. Record review of Resident #58's MAR for March 2025 revealed Multiple Vitamin was scheduled for 8:00 a.m. and Senna-Time S 8.6-50 mg (sennosides-docusate) was scheduled for 9:00 a.m. In an observation on 3/19/25 at 9:34 a.m. LVN B prepared Resident #58's medication for administration via g-tube (a surgically placed device used to give direct access to stomach for supplemental feeding, hydration or medicine). He prepared Multivitamins with minerals 1-tablet, Senna 8.6 mg 1-tablet, Vitamin D, Zinc, Tetrabenazine, and Valproic acid and administered them to Resident #58. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/19/25 at 10:14 a.m. LVN B said the facility had the multivitamin with minerals in stock and there was no significant difference between the ordered multiple vitamins and multivitamin with minerals. He said the Sennosides 8.6 mg with Docusate 50 mg was what presented on the eMAR, but he had not seen that medication in the facility and had previously requested it. He said the medication he administered, Senna, did not contain the docusate ingredient. He said he could not say the medications were similar but that is what the facility had in stock. He said when administering medications he verified the MD order, patient, location, dose, direction, and route. He said there was a possibility of risk to the patient. In an observation and interview on 3/19/25 at 2:31 p.m. of the medication supply room revealed there were bottles of Multiple Vitamins available. Central supply staff said Senna plus (sennosides with docusate) was on back order since last week but would hopefully arrive at the facility today. She said she was informed today (3/19/25) to go to the store and purchase Senna plus. In an interview on 3/20/25 at 12:09 p.m. the DON said nursing staff should compare the bottle to the order to ensure the right medication is administered. She said if the medication was running low, staff should be notified so they could go and purchase it. She said nursing staff should verify the name of the medication, dosage, route, and all the resident rights. She said the risk to the resident was that something was given that was not ordered. Resident #8 Record review of Resident #8's Face Sheet dated 3/19/25 revealed a [AGE] year-old female who readmitted on [DATE]. Her diagnosis included dementia. Record review of Resident #8's discharge assessment-return anticipated MDS dated [DATE] revealed the staff assessed her cognitive skills for daily decision making as modified independence. She required assistance from staff with ADL care. Record review of Resident #8's Care Plan dated 3/3/25 revealed the resident had a diagnosis of dementia and was at risk for increased confusion and decline in ADLs as the diseases progressed. Interventions were to administer medications as ordered by the MD. Record review of Resident #8's MD orders revealed an order for Rivastigmine transdermal patch 9.5 mg/hr apply 1 patch transdermally one time a day for psychosis and remove per schedule. Record review of Resident #8's MAR for March 2025 revealed Rivastigmine transdermal patch 9.5 mg/24 hr was scheduled to remove at 7:59 a.m. and apply at 8:00 a.m. In an observation on 3/19/25 at 9:06 a.m. MA B prepared Resident #8's medication for administration including Rivastigmine 9.5 mg patch and 13 additional oral medications. MA B entered Resident #8's room and searched for her old Rivastigmine patch. She identified the old patch on her upper left back. She placed the new patch on her upper right back and then removed the old patch. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/19/25 at 9:26 a.m. MA B said when applying patches, she ensured to date the patch and apply it to a different area. She said she placed the new patch on prior to removing the old one. She said the new one should be placed first so it would not be contaminated by the old one. She said she did not think there was any risk of having two patches on at the same time if she did not leave the old patch on and removed it right away. She said she had patch administration training a long time ago. In an interview on 3/19/25 at 12:09 p.m. the DON said nursing staff should remove the old patch prior to placing a new one to ensure it is not placed in the same location and to ensure multiple patches were not on at the same time. She said that was best practice. In an interview on 3/20/25 at 12:25 p.m. the Administrator said she expected nursing staff to follow all the rights of medication administration and follow the MD recommendations. Record review of the facility's Oral medication Administration policy revised 8/2020 read in part, .2. Review and confirm medication orders for each individual resident on the MAR prior to administering medications to each resident . Record review of the facility's Transdermal Drug Delivery System (Patch) Administration policy revised 8/2020 read in part, .Medications will be administered in a safe and effective manner. The guidelines in this policy detail how to properly place patches and care for application sites . Procedures: 3. Remove the old patch from the body. Fold the old patch in half with the adhesive sides together. Discard the patch according to facility policy . 5. Cleanse the area where the new patch will be placed using a gauze pad wet with clean water and pat dry with another gauze pad . 8. Apply the new patch firmly to the skin . Record review of the undated Highlights of Prescribing Information for Exelon (Rivastigmine) patch from www.accessdata.fda.gov read in part, .Patient Counseling: . How to use the Exelon Patch: . you must remove the previous day's Exelon Patch before applying a new one