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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administering of all drugs and biologicals) to meet the needs of 3 of 8 residents (Residents #32, #70 and #60) and failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation for 2 of 5 medication carts (LEC MA cart and East Front Nurse cart) reviewed for pharmacy services.The facility failed to ensure the LEC medication aide's cart had accurate narcotic counts for Residents #32 and #70 on 8/14/25.MA W stored Resident #32's Lorazepam (a narcotic used to treat anxiety) on the medication cart incorrectly after not immediately wasting it with a nurse on 8/14/25. The facility failed to ensure the East Front Nurse's cart had accurate narcotic counts for Resident #60 on 8/14/25.These failures could place residents at risk for medication errors, drug diversion, and delay in medication administration.Findings included:1. Record review of Resident #32's face sheet dated 8/14/25 revealed an [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included Alzheimer's disease, restlessness and agitation, and generalized anxiety disorder.Record review of Resident #32's quarterly MDS assessment dated [DATE] revealed a BIMS score of 0 out of 15 which indicated severe cognitive impairment. She required supervision or touching assistance with most ADLs.Record review of Resident #32's care plan dated 5/19/25 indicated she had a diagnosis of alteration in mood or exhibition of behavioral symptoms related to anxiety, depression. Interventions were to administer medications as ordered.Record review of Resident #32's MD order dated 8/14/25 revealed an order for Ativan 1 mg (Lorazepam) give 1 tablet by mouth at bedtime, order date 12/12/23.Record review of Resident #32's MAR for August 2025 revealed Lorazepam 1 mg was scheduled for 8:00 p.m. and was last documented as administered on 8/13/25 at 8:00 p.m. Record review on 8/14/25 at 10:41 a.m. of Resident #32's Controlled Drug Administration Record for Lorazepam 1 mg indicated there were 8 pills remaining with the last administration recorded on 8/13/25 at 8:00 p.m.Observation and interview on 8/14/25 at 10:42 a.m. of LEC MA's cart with MA W revealed Resident #32's Lorazepam 1 mg blister pack contained 7 pills. MA W retrieved an unlabeled medication cup that contained 1 Lorazepam pill from the top drawer of the medication cart (which was under one lock) and said it belonged to Resident #32. She said around 9 a.m. she administered Resident #32's medications and pulled the Lorazepam 1 mg in error. She said she was supposed to call the nurse and waste (destroy) it when she pulled it, but the nurse was down the hall. She said the medication was not supposed to stay in the cart because she could accidently give it to someone else. Observation at 10:45 a.m. revealed MA W and LVN E destroyed the Lorazepam 1 mg. She said she had not documented or signed off in the narcotic book on any of the narcotics administered that morning.In an interview on 8/14/25 at 3:05 p.m. LVN E said if the narcotic was accidently popped you could not wait and store it on the cart because it was a narcotic. She said it had to be wasted, and two signatures obtained. She said MA W did not ask her previously to waste the Lorazepam 1 mg. 2. Record review of Resident #70's face sheet dated 8/14/25 revealed a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included unspecified severe (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dementia, heart disease, and anxiety.Record review of Resident #70's admission MDS assessment dated [DATE] revealed a BIMS score of 0 out of 15 which indicated severe cognitive impairment. She required assistance with ADL care.Record review of Resident #70's care plan revised on 5/26/25 indicated she used anti-anxiety medications related to anxiety disorder. Interventions were to administer anti-anxiety medications as ordered by physician.Record review of Resident #70's MD order dated 8/14/25 revealed an order for Lorazepam 1 mg give 1 tablet by mouth two times a day for anxiety, order date 5/14/25.Record review on 8/14/25 at 10:43 a.m. of Resident #70's Controlled Drug Receipt/Disposition Form for Lorazepam 1 mg indicated there were 6 pills remaining with the last administration recorded on 8/13/25 at 5 p.m. Observation and interview on 8/14/25 at 10:43 a.m. of the LEC MA's cart with MA W revealed Resident #70's Lorazepam 1 mg's blister pack contained 5 pills. MA W said she was supposed to document after administering the narcotic but had not documented or signed off on any of the narcotics administered that morning because there was a lot going on in the LEC (Memory care unit). 3. Record review of Resident #60's face sheet dated 8/14/25 revealed a [AGE] year-old female who readmitted to the facility on [DATE]. Her diagnoses included dementia, schizophrenia, and other chronic pain.Record review of Resident #60's quarterly MDS assessment dated [DATE] revealed her cognitive skills for daily decision making were severely impaired. She required assistance from staff with ADL care.Record review of Resident #60's care plan dated 6/9/25 indicated she had the potential for pain related to chronic disease process. Interventions were to administer analgesics as ordered.Record review of Resident #60's MD order dated 8/14/25 revealed an order for Tramadol 50 mg give 1 tablet enterally every 8 hours as needed for moderate and severe pain, order date 1/23/25.Record review of Resident #60's MAR for August 2025 revealed Tramadol 50 mg was documented as administered on 8/14/25 at 11:20 a.m. by LVN J.Record review on 8/14/25 at 11:49 a.m. of Resident #60's Controlled Drug Administration Record for Tramadol 50 mg indicated there were 33 pills remaining with the last administration recorded on 8/11/25 at 8:30 a.m.Observation and interview on 8/14/25 at 11:49 a.m. of the Front East Nursing cart with LVN J revealed Resident #70's Tramadol 50 mg blister pack contained 32 pills. LVN J said he administered one Tramadol pill to Resident #70 around 11:20 a.m. and had not signed yet. He said he was trained to sign the narcotic book after administering and as soon as he got back to the cart. He said there was a risk of forgetting to sign if not done right away. In an interview on 8/14/25 at 1:26 p.m. the DON said nursing staff should sign the narcotic sheet as soon as the narcotic is popped and given because in the event of an emergency, other staff need to know exactly what was given. She said if the narcotic was not signed off, another person could administer an extra dose to a resident. She said if a resident refused a narcotic, it should be wasted and documented immediately. She said narcotics needing to be wasted could not just sit around in the cart because it was illegal. She said narcotics should be stored under double lock on the medication cart (in the locked narcotic box located in the locked cart) She said the Consultant Pharmacist reviewed narcotic sheets at the facility monthly and staff were trained on narcotic protocol. Record review of the facility's Controlled Substance Prescriptions policy, revised 8/2020, reflected the following, . Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances and medications classified as controlled substances by state law are subject to special ordering, receipt,and recordkeeping requirements in the facility, in accordance with federal and state laws and regulations. Security and Recordkeeping. 2. Controlled substance medications are stored at the facility under double lock or as required by state regulations, separate from all other medications and counted at each change ofcustody or in accordance with facility policy.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain and effective pest control program, so the facility was free of pest and rodents for 1 of 1 kitchen and 2 of 2 dining rooms reviewed for environment. - Flies were witnessed on residents dining plates, before food was placed on the plate.- Flies were sitting on residents' food, as they were eating.- A roach was identified in the dining area while residents were eating. These failures could place residents at risk of infection, skin irritation, allergies, which could result in unsanitary living conditions and decline in health and well-being. Findings include:In an observation on, 08/13/2025 at 11:48am, in kitchen 1 of 1, revealed flies on the plates that were prepped for serving resident's lunch. In an interview and observation with DM on 08/13/2025 at 11:49am, where the surveyor showed the DM flies that were on the plates. The DM removed 2 plates and took them to the kitchen. The DM stated that she removed the plates and did not cover any additional plates from flies. The DM stated the risk to the flies being left on residents' plates was, it could lead to the resident being sick or possibly a bacterial infection. The DM stated there was also risk the flies could cause bacterial infection if the flies were flying around the food and plates as it was being prepared for the resident. The DM stated the kitchen was being treated by pest control on weekly basis. In an observation on 08/14/2025 in kitchen 1 of 1 at 10:43am, the flies were flying around while food was being prepared for lunch, which was witnessed by the kitchen staff. In an observation on 08/14/2025 in dining room [ROOM NUMBER] of 2 at 12:42pm a roach was identified on the floor while residents were having lunch.In an interview with LVN S on 08/14/2025 at 12:43pm stated she has been working at the facility since February 2025. She was assigned to the dining room for today to monitor residents and ensure there was no choking. LVN S stated that they will remain in the dining room until the last resident. LVN S stated that she has not seen any roaches in the dining area or throughout the building since she has been employed at the facility. LVN S said if there were roaches or flies in the dining room while residents were eating, it could cause infection or even make the resident sick. In an observation on 08/14/2025 in dining room [ROOM NUMBER] of 2 at 12:55pm, flies were seen flying around and landing on the resident's food while the residents were eating.In an interview with CNA B on 08/14/2025 at 12:58pm stated she has been at the facility since July 2024. CNA B stated that she has not seen any flies or roaches in the dining room or in the vicinity of the residents while eating, although it was pointed out of the flies and residents waving their hands to keep the flies from getting on their food. CNA B stated that if she did see a fly or roach, she would kill it and report it to maintenance and remove the resident from the area. The risk to the resident when it comes to roaches and flies around their food during mealtimes was, the resident could develop a rash. In an interview with the ADMN on 08/14/2025 at 1:14pm stated she has been working at the facility for 5 days. The expectation for pest control was there should be none, but they should be on a routine schedule. Communication with herself and the maintenance department should be done with pest control if a situation was identified to ensure the issues were rectified immediately. Since being in the building, she has not witnessed any pest control issues or concerns from the residents or through observation. If flies or roaches were to be identified, they do carry diseases and it's a problem and a safety concerns with cleanliness. Record review of the facility pest control log dated for 08/01/2025, reflected the facility was on weekly service. The facility was treated with replacing 15 fly lights, with unknown sights of treatment. Record review of the facility pest control log dated for 08/08/2025, reflected replacing the fly lights in the dining area and replaced a fly light in the kitchen along with a liquid application in the dishwasher area. Record review of the facility pest control log dated for 08/14/2025, reflected flies in the memory care area and replacement of fly light device in areas throughout the building, including the kitchen. Liquid residual applied in the kitchen near the back door. Record review of the facility's contract with pest control, revised on 04/2024, reflected pest sightings will be documented and communicated to the (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pest control provider for follow-up. The pest control provider will determine the appropriate treatment method for any identified pest activity. The maintenance director will maintain documentation of all pest control services, treatment, and pest sighting reports for review.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care -plan for the resident, consistent with the resident rights that include measurable objects and timeframes to meet the residents medical, nursing, and mental psychosocial needs that are identified in the comprehensive assessment for 1 of 9 residents (Resident #8) reviewed for comprehensive care plans. The facility failed to: - Update the comprehensive care plan to resident #8 having a 1/4 right rail on the right side of the bed.This failure could place the resident at risk for not obtaining/maintain their highest practicable wellbeing.Findings include:Record review of Resident #8's undated face sheet, revealed she was a [AGE] year-old female with an initial admission date of, 04/20/2024, with the most recent admission on , 06/10/2025. Resident #8 has diagnosis of, other lack of coordination, Alzheimer's disease with late onset, altered mental status, repeated falls, unspecified lack of coordination, and other symptoms and signs involving cognitive functions and awareness. Record review of Resident #8's Quarterly MDS assessment dated , 06/16/2025 revealed a BIMS score of 7. Resident #8 has mild cognitive impairment when it comes to making decisions. Resident #8 does require assistance with mobility devices, using a wheelchair. Resident #8 does require total dependency for a helper and is unable to complete any mobility functions on her own.Record review of resident #8's physician order dated 08/14/2025 from MD F, revealed an order for right quarter rail.Record review of resident #8's care plan dated 06/29/2025 did not reveal the 1/4 side rail on the right side of the resident bed. Record review of resident #8' consent form for the 1/4 side rail was signed on, 06/12/2025.Observation of resident #8 on, 08/12/2025 at 10:24am revealed bed rail on right side of the bed.In an interview on 08/14/2025 at 9:59am with LVN E stated, the rail on the resident bed was used for positioning. LVN E stated the orders of the resident was checked along with the care plan before assisting the resident and the bed rails should be care planned. The risk of the bed rails not being care planned could cause something to happen and the facility could be in trouble by the state or the family. In an interview on 08/14/2025 at 1:05pm with the DON stated, the MDS team update care plans when needed, but there were other nurses, such as themselves can make updates to the care plan and then put interventions into place. The DON stated that the nurses will write notes on the resident chart to update the care plan, to provide the best possible details for updating a resident's care plan. The DON then stated the care plan for resident #8 was updated today, 08/14/2025 with the consent of the family and physical therapy notes/recommendations to include why a 1/4 right rail would be in the best interest for resident #8. The DON stated the risk to resident #8's care plan not being updated was a mis form of communication on how to care for the resident.In an interview on 08/14/2025 at 1:37pm with LVN W stated, the MDS team was responsible for updating care plans. LVN W stated the risk of the care plan not being updated was the resident not receiving proper care or treatment. LVN W stated that care plans were updated daily by running the order listing which will state if the doctor has new orders for treatment or changes. LVN W stated the care plan for resident #8 was updated after learning there was a 1/4 right rail on the resident bed 08/12/2025. LVN W stated the 1/4 right rail on the bed was used for positioning/assistance for the resident who is bedbound. Record review of Care Plan Revisions Policy revised 05/2022 reflects .1. The comprehensive care plan will be reviewed and revised every quarter, when a resident experiences a status change and as deemed necessary. 2. (a) upon identification of a change in status, the nurse will notify the MDS coordinator, the physician, and the resident representative, if applicable. (c) The care plan will be updated with the new or modified interventions. 3. The MDS coordinator will determine whether a significant change in status assessment is warranted. If so, the assessment will be completed according to established procedures.