

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Paradigm at Woodwind Lakes		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that each resident received adequate supervision to prevent accidents for 2 of 8 residents (Resident #60 and Resident #134) reviewed. The facility failed to ensure adequate supervision to prevent accidents for Resident #60 and Resident #134 when they were smoking outside without staff supervision. This failure placed the residents at risk for burns, injury, and fire hazards. Findings included: Record review of Resident #60's undated face sheet revealed he is a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE]. His diagnoses were lack of coordination, muscle weakness, falls, difficulty in walking, schizoaffective disorder (hallucinations and delusions), dementia, and transient ischemic attack (a temporary blockage of blood flow to the brain). Record review of Resident #60's MDS annual assessment dated [DATE] revealed a BIMS score of 10 out of 15 which indicated moderate cognitive impairment and the resident may need support with decision-making or understanding instructions. Record review of Resident #60's Smoking assessment dated [DATE] revealed resident was to not wear a smoking apron, but was educated on the following: designated smoking area, designated smoking times, staff will store smoking materials, residents may not smoke outside of designated smoking times or designated smoking areas, and noncompliance with smoking policies and procedures may lead to involuntary/immediate discharge. The IDT determination was that the resident was safe to smoke with supervision. Record review of Resident #60's Care Plan dated 12/29/2025 revealed he has the potential for injury related to being a smoker. The interventions put into place indicated that staff members will store and distribute the residents' smoking materials, safe smoking will occur during safe smoking times and in the designated smoking areas, routinely complete safe smoking assessments to assess for safe smoking, supervision required, and any assistive devices needed. Record review of Resident #134's undated face sheet revealed he was a [AGE] year-old male who admitted on [DATE] and readmitted on [DATE]. His diagnoses were respiratory failure, muscle weakness, dementia, cognitive communication deficit, repeated falls, lack of coordination, and presbyopia (loss of eyes ability to focus on nearby objects). Record review of Resident #134's Smoking assessment dated [DATE] revealed resident was to not wear a smoking apron, but was educated on the following: designated smoking area, designated smoking times, staff will store smoking materials, residents may not smoke outside of designated smoking times or designated smoking areas, and noncompliance with smoking policies and procedures may lead to involuntary/immediate discharge. The IDT determination was that the resident was safe to smoke with supervision. Record review of Resident #134's Care Plan dated 01/06/2026 revealed resident was a tobacco smoker and refused to give his cigarettes to staff. The interventions put into place were staff to perform smoking assessments according to facility policy and explain where designated smoking areas were and smoking times. During an observation on 01/06/2026, at 12:49 pm two residents were observed smoking outside, unsupervised. Residents were observed sharing 1 cigarette, putting it out, and came back into the building. The residents identified were Resident #60 and Resident #134. Both residents refused to be interviewed. In an interview with LVN T on (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 0689 Level of Harm - Actual harm Residents Affected - Few	01/06/2026 at 12:51 pm she stated she was only monitoring the residents in the dining room, which was beside the facility's designated smoking area. LVN T denied seeing the residents outside smoking and unsure of how residents would have smoking supplies, as it was normally locked in the Activities Coordinator's office. The risk of the residents smoking unsupervised could result in the residents burning themselves. In an interview with ADMN on 01/06/2026 at 12:57pm ADMN stated the facility staff were assigned to supervise smokers by the department throughout the day. ADMN stated they have two residents who do what they want to do, and they searched the residents' rooms prior and found cigarettes and lighters, which they refused to give to staff. Smoking paraphernalia was locked in a box in the Activity Director's office, which only staff have access to. Staff were trained to use the fire extinguisher and fire blanket, should there be a fire while smoking. The risk of residents smoking unsupervised was the residents burning themselves. Record review of Electronic Healthcare Records on 01/07/2026 at 9:04 am revealed Resident #60 and Resident #134 have been discharged from the facility on 01/06/2026. In an interview with AD H on 01/07/2026 at 11:07 am stated the designated times for smoking were 8:30am, 11am, and she is unsure of the rest, but it is posted on the wall by the designated smoking area. She is responsible for locking all smoking supplies for each resident who is a smoker. At times the resident's family will ask her to purchase resident cigarettes, and she will. The lighter is provided by the facility to ensure the safety of the resident when lighting the cigarette, which she does or any staff that is designated for that smoking time. Residents are to not be left unsupervised when smoking as it is a risk of the residents having a fall, burning themselves, or someone else. She stated she does not know any residents that have separate allotted smoking times outside of the times already allotted for the residents. The reason for having allotted smoking times is to ensure the residents will be supervised by staff and if anything changes it will come from the ADMN or DON. In an interview with HSK D on 01/08/2026 at 1:35 pm stated her allotted smoking time is 1:30 pm when she's working and no residents are to have any smoking supplies. She has not witnessed any residents smoking unsupervised, if she did, she would notify the Administrator and stay with the residents to ensure they are safe. All smoking supplies are kept in a lock box in the activities director's room. She is trained to use the fire extinguisher if there is a fire during the smoking times. The risk of the residents being unsupervised while smoking could be dangerous because it could cause a fire. Record review Staff Smoking Schedule on 01/09/2026 at 7:30 am revealed the allotted smoking times are 8am (Laundry Staff), 11am (Activities Director), 1:30pm (Housekeeping Staff), 4pm (Floor Technician), and 6pm (Maintenance Staff). The schedule also displays staff that are assigned when others may be out. In interview with FT P on 01/09/2026 at 8:29 am stated his allotted smoking time to supervise residents while smoking outside is 4 pm. He does walk around the smoking area to ensure the right residents are outside smoking and he is trained to know what to do in case of a fire. He keeps all the smoking materials with him and lights the cigarette for the resident. If he witnessed a resident outside smoking with no supervision, he would stay with the resident while requesting a nurse to come, as no resident should be outside smoking without supervision. All smoking materials are left in the activity director's office, locked. The risk of a resident smoking unsupervised could cause harm by burning themselves. In interview with LR M on 01/09/2026 at 8:35 am she stated her allotted smoking time to supervise residents while smoking outside is 8 am. When outside with smoking residents, she is verifying the correct residents are outside by the folders in the smoking lock box. In the morning, she only has four residents that she is monitoring while smoking. In case of a fire, she has been trained to use the fire blanket and the fire extinguisher. All the supplies were kept with her, and they do assist the residents with lighting the cigarette because they cannot have a lighter. The risk of the residents smoking unsupervised is being burned or hurting someone outside. In an interview with LVN K on 01/09/2026 at 10:18am she stated she does complete the smoking assessments for the residents, which is completed quarterly. The reason for Resident #60 and Resident #134 being discharged was due to violating the smoking policy. Any resident that is a smoker has been assessed and cannot be left unsupervised, as that is their (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	policy for the safety of the residents. Both residents identified outside smoking were safe smokers and the only time the assessment will change between the quarters is if the residents develop the shakes or they are unable to hold the cigarette on their own. At that time, residents will need to wear a smoking apron to prevent any ashes from burning the resident. The risk of a resident smoking unsupervised could result in burning themselves or someone else. Record review of the facilities Safe Smoking policy dated 03/2024 read. We are committed to providing a safe, healthy, and comfortable environment for all residents, staff, and visitors. Our policy is designed to ensure residents are aware of their privilege when it comes to smoking but also following guidelines in which smoking may occur in our setting. This policy applies to facilities that permit smoking (including the use of e-cigarettes/vape pens). The facility may permit smoking for certain individuals at designated times in designated areas based upon the findings of the resident's Smoking - Safety Screen. The Smoking Policy Notification is outlined in the admission Agreement. Staff members maintain all smoking materials as appropriate for the resident. Staff members will distribute smoking materials to residents at designated smoking times in the designated smoking area. Residents who require supervision while smoking will be supervised by an employee throughout the designated smoke break.		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 10 residents (Resident #12) reviewed for incontinent care. 1. CNA AA failed to ensure Resident #12's indwelling Foley catheter tubing was below the bladder while assisting LVN CC during pressure ulcer treatment on 01/7/26. 2. The facility failed to ensure Resident #12's indwelling catheter was secured on 1/7/26. Resident #12 had a slit on his penis measuring 0.3 cm length by 0.1 cm width that was identified by the Surveyor on 1/7/26. These failures could place residents at risk for pain, infection, injury, and hospitalization. Findings included: Record review of Resident #12's face sheet dated 1/7/26 reflected a [AGE] year-old male originally admitted on [DATE] and was re-admitted on [DATE] with medical diagnoses of Pneumonia (is a lung infection that inflames the air sacs (alveoli), causing them to fill with fluid or pus, which makes it hard to breathe) unspecified organism, acute respiratory failure with hypoxia (low oxygen in the body), essential (primary) hypertension (high blood pressure) schizophrenia (is a serious, long-term brain disorder that causes people to interpret reality in an abnormal way, making it difficult to distinguish between what is real and what is imaginary), pressure ulcer of sacral region, stage 3 (is a deep, crater-like wound where the skin has broken down through all layers, revealing the fatty tissue underneath but not muscle, tendon or bone) other malaise, obstructive and reflux uropathy (obstructive uropathy is a condition where urine flow is blocked, causing a damming effect that can damage the kidneys, while reflux uropathy is a condition where urine flow backward (the wrong way) in the urinary tract, also potentially damaging the kidneys, muscle weakness (generalized), pressure ulcer of other site, (stage 3), type 2 diabetes mellitus without complications, type 2 diabetes mellitus with other specified hemiplegia and hemiparesis (weakness on one side of your body) following cerebral infarction (Stroke) affecting right dominant side, functional quadriplegia (a complete inability to move due to severe disability or frailty caused by another condition without physical injury or damage to the spinal cord), vitamin d deficiency, malignant neoplasm (Cancerous tumor, an abnormal growth of cells that divides uncontrollably, invades surrounding healthy tissue, and can spread (metastasize) to distant parts of the body, unspecified kidney, except renal pelvis infection and inflammatory reaction due to indwelling urethral catheter (a common type of thin, flexible tube that a doctor or nurse puts into the bladder to continuously drain and collect urine acute respiratory failure (is when your lungs suddenly can't do their job of getting oxygen into your blood and removing carbon dioxide). Record review of Resident #12's Comprehensive MDS dated [DATE], revealed his BIMS score was 10, indicating moderate cognitive impairment. He required total assistance with toileting. He was continent for bladder and incontinent of bowel. He had an indwelling catheter. Record review of Resident #12's care plan dated 04/18/2025, interventions were to follow physician orders for catheter insertion, changes, and maintenance. Monitor site for signs and symptoms of infection or skin breakdown - report any noted to MD. Notify the Physician of any adverse findings/changes. Record review of Resident #12's order summary dated 1/7/26 revealed he had orders for: use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Rotate site of securement daily. (order date 10/10/25). Monitor for potential complications of indwelling urinary catheter use such as redness, irritation, s/s of infection, obstruction, urethral erosion. (start date 12/8/2025). Record review of Resident #12's skin assessments dated 12/10/2025, 12/18/2025, 12/25/2025, and 01/01/2026 did not address the slit on the penis. Record review of care plan dated 10/10/25 reflected Resident #12 was on Antibiotic: Meropenem Intravenous Solution Reconstituted 1 GM (Meropenem) Use 1 gram intravenously every 8 hours for UTI for 2 WEEKS Observation and interview of Resident #12's incontinent and foley care on 01/07/2026 at 10:32 am with CNA AA and (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	CNA BB, there was no leg strap or Statlock (stabilization device for a foley catheter) to secure the catheter. There was small redness to the top side of the penis near a slit. Resident #12 did not verbalize he was in pain or displayed any facial grimacing while staff cleaned indwelling catheter. The slit was measured by the ADON RN and was 0.3 cm in length and 0.1 cm in width. CNA AA and CNA BB said they had not seen the slit on the resident's penis before. Interview with the interim treatment nurse, LVN CC, on 01/07/2026 at 10:57 am, she stated she was not aware of the slit on Resident #12's penis. LVN CC stated this was her first time working with Resident #12. While performing pressure ulcer treatment to Resident #12's sacral area, LVN CC handed the indwelling catheter tubing to CNA AA and it was placed on the bed with cloudy urine along the tubing while performing treatment to sacral area. The tubing was not below Resident #12's bladder. Interview with LVN CC on 01/07/26 at 11:05 am, regarding having the indwelling catheter placed on the bed while performing pressure ulcer treatment, she said she was very sorry, it should be below the resident's bladder. Interview with ADON RN on 01/07/2026 at 11:10 am he stated he was not aware of the slit on Resident #12's penis. He said he had not checked if Resident #12's Statlock was in place because he was just called in to work. He said he would normally check placement every shift. Attempted to contact the treatment nurse LVN DD on 01/07/2026 at 2:33 pm and left a voicemail message. The call was not returned. Interview with DON on 01/07/2025 at 4:05 pm she stated she was not made aware of Resident #12 having a slit on the penis. Now that she has been made aware, the facility staff immediately conducted audits of every resident and started an in-service on Statlocks and foley care. DON stated that it could cause tension and tear on the penis if the Statlock is not in place. The expectation is all nurse aides with notify the nurse to place the Statlock in the right position. DON said F/C should be hung below Resident #12's bladder and this is to prevent back flow of urine to the bladder and could result in Resident #12 acquiring a UTI. DON said she would be monitoring the CNAs randomly now. DON said she does have monthly in-services on F/C and incontinent care. Interview with Resident #12's MD she said she was notified on 1/7/26 of the slit to Resident #12's penis. She said she expected the skin to be protected by using the Statlock to anchor the foley and prevent injury. Interview with Resident #12's NP she said she was notified of Resident #12's slit to the penis on 1/8/26. She said it was not normal for the resident to have a slit to the penis but said the penile area looked good and was not infected. Interview with CNA AA, CNA JJ, CNA KK and CNA ZZ on 01/08/26 at 9:43 AM and at different times regarding recent in-services, CNA's said they had in-services on securing F/C, checking for any skin change, slits, PPE, and notify the nurse. Interview with LVN AA and LVN ZZ on 01/09/26 at 10:45 AM, they said they had in-services to monitor and document F/C every Statlocks each shift and head to toe assessments done each shift and notify ADON and the doctor. Record review of the facility's policy for Catheter Care revised 2/2024: Indwelling, straight, reflected. Catheter Management. Kinks: Ensure the catheter tubing remains free from any kinks that might obstruct urine flow. Securement: Rotate the catheter securement device regularly, and change it when it becomes visibly soiled to prevent skin breakdown or irritation Positioning: ensure the catheter bag is positioned below the level of the bladder to allow for proper drainage and avoid reflux of urine.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 8 (Resident #54) residents reviewed for comprehensive assessments. The facility failed to ensure that Resident #54's care plan documented interventions for hand contractures. This deficient practice could place residents at risk of not receiving proper care and services. Findings Included: Record review of Resident #54's face sheet dated 01/07/2026 revealed a [AGE] year-old admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease (a progressive brain disorder that slowly destroys memory and eventually the ability to carry out simple tasks), parkinsonism (a nervous system disorder), stroke, muscle weakness and need for assistance with personal care. Record review of Resident #54's quarterly MDS assessment dated [DATE] revealed a BIMS score of 9 out of 15 indicating he had moderately impaired cognition. He had impairment to the upper extremity one side and impairment on both sides of the lower extremities. Record review of Resident #54's physician orders revealed an order for Baclofen 10mg tablets, start date was 07/20/2025. Record review of Resident #54's January 2026 MAR revealed he was receiving Baclofen 10mg every 8 hours for muscle spasms. Record review of Resident #54's follow-up progress note written by the MD on 12/08/2025 revealed past medical history included bilateral wrist contractures. The physical exam included musculoskeletal - contractures bilateral upper extremities, left wrist severely contracted, greater than right wrist. Further review revealed the assessment and plan included to continue Baclofen 10mg three times daily for management of muscle spasms and contractures. Record review of Resident #54's care plan downloaded from the electronic health record on 01/07/2026 at 9:28 AM revealed a care plan that was last reviewed on 12/15/2025. Focus - Resident #54 had ADL self-care deficits and was at risk for further decline and ADL functioning and injury. Interventions included: provide PROM (passive range of motion) during ADL cares as needed by RCS (resident care staff). The date initiated was 10/24/2025. The care plan did not specifically address interventions for hand contractures including administration of Baclofen for contractures as ordered by the MD. Observation on 01/06/2026 at 10:30 AM, Resident #54's left hand was severely contracted, and arm was bent at the elbow. Resident #54's right hand was also bent at the elbow. The resident was able to open and close the right hand upon command. Both hands did not have palm protectors or hand braces. In an interview on 01/09/2026 at 1:10 PM, the MDS nurse was asked how Resident #54's hand contractures were addressed in the care plan. The MDS nurse stated she was aware of the resident's hand contractures and that interventions should be included in the care plan. The MDS nurse then stated that she updated Resident #54's care plan to address contractures on 01/08/2026. In an interview on 01/09/2026 at 2:25 PM, the DON stated the nursing team was responsible for updating the care plan. The DON stated the charge nurse, MDS nurse and even the DON can update the care plan. The DON stated the purpose of the care plan was to provide information on how to care for residents, so all staff know how to meet the residents' needs. The DON stated Resident #54's contractures should be in the care plan and did not know why his care plan was not updated prior to 01/08/2026.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 (Resident #10) of 2 residents reviewed for enteral nutrition. The facility failed to always provide the abdominal binder as a supportive device per physician orders to help prevent dislodgment of Resident #10's G-tube (Gastrostomy feeding tube). These failures could place residents with G-tubes at risk of injuries, hospitalization, and death. Record review of Resident #10's face sheet dated 01/08/2026 revealed a [AGE] year-old admitted to the facility on [DATE] and initially admitted on [DATE]. Her diagnoses included dementia, severe malnutrition, , , gastrostomy status (the presence of a G-tube which is a hollow device inserted through the abdominal wall to create a passageway into the stomach to provide long-term access for delivering nutrition), and adult failure to thrive. Record review of Resident #10's quarterly MDS dated [DATE] revealed a BIMS score of 00 out of 15 indicating severe cognitive impairment. Resident #10 had no impairment to upper and lower extremities. Resident #10 was dependent on staff assistance for all ADLs. She had a feeding tube for nutritional approaches. Record review of Resident #10's care plan last reviewed on 01/06/2026 revealed: Focus - Resident #10 requires the use of a feeding tube for nutrition and is at risk of nutritional complications. Goal - Resident #10's feeding tube will remain patent (clear and open for use) and resident will receive nutrition as ordered without evidence of aspiration, dehydration or nutritional compromise. Interventions included: ABD (abdominal) binder at all times. Focus - Resident #10 requires tube feeding r/t dysphagia (difficulty with swallowing). Interventions included - monitor/document s/sx of aspiration, fever, tube dislodgement Record review of Resident #10's physician orders revealed an order dated 10/14/2025 at 9:56AM for the device: abdominal binder - every shift for monitor placement: skin check donning/doffing for bathing/showers (check skin when removing and replacing the binder when bathing the resident). Record review of Resident #10's change of condition progress note dated 10/14/2025 at 11:18 AM and written by RN F revealed the resident's G-tube was found to be dislodged and the hospice nurse was notified. Further review of the progress note revealed a 16-French foley catheter (a flexible tube used for urinary drainage) was inserted into the stoma (a surgical opening created in the abdomen for placement of a g-tube) and balloon (the flexible drainage tube has a balloon inflated to maintain the position of the tube) was inflated to maintain tract patency (the passage of the stoma being clear and unobstructed). Continued review of the progress note revealed the resident was subsequently transferred to the hospital for further evaluation and management. Record review of Resident #10's progress note dated 10/14/2025 at 2:06 PM and written by the MDS nurse revealed the resident returned and a G-tube was in place. Observation on 01/09/2026 at 8:00 AM, revealed Resident #10 was receiving patient care at the time by the hospice aide. Observation on 01/09/2026 at 9:40 AM, revealed LVN CC pulled back the covers over Resident #10 to view the G-tube site. The resident did not have an abdominal binder on. The resident was observed moving her arms and hands freely without restrictions. Attempted interview of Resident #10 on 01/09/2026 at 9:40 AM, revealed did not answer when asked if she was in any pain. Resident #10 was alert, pleasant, cooperative, smiled at those around her and did not appear in distress. In an interview on 01/09/2026 at 12:00 PM, LVN AA stated he was taking care of Resident #10 and stated he received a report in the morning that the ABD binder was put into laundry because it became wet. LVN AA stated Resident #10 should always have the binder on and that without it there is a chance she could pull The g-tube out. LVN AA stated he was unsure, but she may have a history of G-tube dislodgement but was less likely to pull at it because she is less active. LVN AA stated if dislodged, the risk is that the resident would have to leave the facility to get it replaced as this is not done at the bedside. LVN AA stated the binder is probably dry now and that he will make (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sure the clean/dry binder is on the resident. LVN AA was asked why she had only one binder and he did not say why but stated he had been monitoring her every hour. In an interview on 01/09/2026 at 2:20PM, the DON stated the nurses were responsible to follow orders for ABD binder if the physician places the order. The DON stated nurses and aides can place the binder on the resident and that if the ABD binder becomes soiled, she would expect it to be put into the wash and for nursing to get a clean one from laundry or central supply. The DON state the ABD binder should always be on Resident #10 due to her history of pulling out G-tubes. The DON stated the risk to the resident was complete dislodgement, trauma to the stoma site, the stoma could close, and the resident would have to be sent out to get it replaced. If the ABD binder is not on the resident, she expected nursing staff to closely monitor and maybe place something in front of the abdomen in the time being to deter resident from handling the tubing until the ABD binder is replaced. Record review of the facility policy and procedure for Enteral Feedings, revised on 09/2023 read in part: The facility will provide adequate care for residents with enteral feeding tubes to prevent complications. Types - Gastrostomy Tube, Jejunostomy Tube.		

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NAME OF PROVIDER OR SUPPLIER Paradigm at Woodwind Lakes		STREET ADDRESS, CITY, STATE, ZIP CODE 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	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 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of one residents reviewed for Tracheotomy care (Resident #1) The facility failed to ensure LVN AA used sterile technique and checked oxygen saturation before and during tracheostomy suctioning for Resident #1 on 01/09/26. These failures placed residents with tracheostomy requiring suctioning at risk for respiratory infections, hospitalizations, and a decline in their quality of life. Findings included:Record review of Resident #1's face sheet revealed she was a [AGE] year-old female who was originally admitted on [DATE] and was readmitted [DATE]. Her medical diagnoses included tracheostomy status (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck), sepsis (a life- threatening medical emergency where the body's extreme, over-the-top reaction to an infection damages its own tissues and organ), unspecified organism, other muscle spasm, essential (primary) hypertension (high blood pressure), anxiety disorder (a mental health condition characterized by persistent excessive fear and worry) and unspecified, metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance or metabolic problem in the body not a direct injury or confusion or memory loss and persistent vegetative state, other speech and language deficits following nontraumatic intracerebral hemorrhage (stroke). Record review of Resident #1's quarterly MDS dated [DATE] revealed the BIMS was blank indicating the resident was rarely or never understood. Further review revealed the staff assessed Resident #1 on mental status and found he had short-term, long-term and memory/recall ability problems. Further review revealed that Resident #1 was dependent on staff for care, which means the resident does none of the effort to complete the activity. Record review of Resident #1's Physician Orders reviewed 05/05/2023 revealed the following: 1. Tracheostomy Care every shift and PRN. Clean or change inner cannula when needed Shiley (flexible trach tube) 4.5 x7 days2.Tracheostomy site dressing change every DAY and PRN if soiled.3. Suction tracheostomy tube as needed to clear airway. Document results in Progress notes4. Trach suctioning Q shift and PRN5. Oxygen at 4-6L/min via Tracheostomy Record review of Resident #1's Care plan revised 10/24/2025 revealed resident was care-planned for: 1. Resident #1 has a Tracheostomy r/t respiratory failure-Interventions: Suction as necessary, use Universal Precautions as appropriate Interview and observation of Resident #1 on 01/06/2026 at 7:30am revealed the resident was observed lying in bed with the head at a 30-degree angle. She was unable to answer yes or no to all questions asked by the surveyor. Resident #1's oxygen concentrator read 5L/min via trach mask. Observation of Resident #1 on 01/09/2026 at 10:30am, revealed resident was observed lying in bed with the head at a 30-degree angle. Resident #1's oxygen concentrator read 5L/min. The resident had foam coming out of her mouth but did not appear to be in distress. Observation on 01/09/2026 at 10:30 AM revealed Resident #1 was in bed with dry crusted phlegm to side of the mouth. LVN AA washed hands, donned cleaned gloves, opened the sterile suction kit, doffed the dirty gloves without washing hands, donned the sterile gloves from the suction kit, picked up the sterile suction catheter, then picked up the connecting suction tube to the suction machine at Resident#1's bedside. LVN AA then connected it to sterile tubing and was using both hands then removed the oxygen neck mask, then suctioned. LVN AA did not check oxygen saturation before and during suctioning. LVN AA then washed hands. At 10:42AM, LVN AA opened the trach kit, donned sterile gloves, picked up the drape and placed it on the bed side table, then picked up the inner cannula on the bedside in the drape, picked up 4x4 gauzes and placed them in the drape, then picked up a normal saline bottle with the sterile gloves. Using sterile gloves, LVN AA undid the neck mask and took out the inner cannula and replaced the new cannula. LVN AA did not change the gloves when going from a dirty field to sterile (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	field. LVN AA checked oxygen saturation after tracheostomy care. In an interview with LVN AA on 1/9/26 at 10:56AM about the trach care, he said he did a great. He said he did forget to maintain a dominant hand and was trained that changing the inner cannula was aseptic technique. He said he forgot to check oxygen saturation before starting the suction. He said he had in-service on tracheostomy about 2 months ago. In an interview with the Respiratory Therapist on 01/09/26 at 11:15 AM, she confirmed that changing the inner cannula was aseptic technique, and she was following the facility technique, and the suctioning was a sterile technique. She said LVN AA should have a dominant hand and should not use both hands during suctioning, and not performing suctioning in a sterile technique could result in infection and death. She said she does tracheostomy in-service any time the facility has a resident with a tracheostomy. In an interview on 01/09/2026 at 12:45 PM, the DON stated sterile technique should be used throughout tracheostomy care and not suctioning tracheostomy with sterile technique could result in infection or cardiac arrest. Record review of the facility policies and procedures Tracheostomy care, revised 9/2025 reflected:Policy: The facility will ensure that tracheostomy care is performed aseptically for cleaning of the tracheostomy tube and stoma site, to prevent plugging of the tracheostomy tube, to prevent airway obstruction, to prevent infection of trach site, and to maintain a patent airway for suctioning. Equipment: Procedure . 10. Open trach care kit. 11. Aseptically DON sterile gloves. 16. With a non-dominant hand, pick up new inner cannula and with the dominant hand, replace inner cannula.21. Note: Monitor O2 saturation throughout procedure.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records were kept in accordance with professional standards and practices and were complete and accurately documented for 1 of 5 residents (Resident #125) reviewed for accuracy of records. The facility failed to ensure Resident #125's bath or shower was documented as given on 1/1/26, 1/3/26 and 1/6/26 in her electronic chart. These failures could place residents at risk for improper care due to inaccurate records. Findings included: Record review of Resident #125's admission Record dated 1/9/26 revealed a [AGE] year-old female who admitted on [DATE] and readmitted on [DATE]. Her diagnoses included encephalopathy (damage or disease that affects the brain), schizoaffective disorder depressive type (a mental health condition that is marked by a mix of schizophrenia symptoms such as hallucinations and delusions, and mood disorder symptoms), Alzheimer's disease with early onset, and morbid obesity. Record review of Resident #125's 5-day MDS assessment dated [DATE] revealed a BIMS score of 11 out of 15 which indicated moderate cognitive impairment. She was dependent on staff for showering/bathing. Record review of Resident #125's care plan dated 12/29/25 indicated her ADL functions were extensive to total assistance with 2 staff members (total assistance requires hands on help throughout the entire task, significant assistance: the individual can perform some parts of the task but requires substantial help from a caregiver). Interventions were to set-up, assist, give shower, shave, oral, hair, nail care per schedule and PRN. Record review of Resident #125's undated electronic POC (the point in time when staff deliver healthcare products and services to patients at the time of care) response history revealed her bathing schedule was Tuesday, Thursday, and Saturday on the 7 a.m. - 7 p.m. shift. N/A was documented by CNA I for showers on 1/3/26 and 1/6/26. CNA B marked N/A for a shower on 1/1/26. (N/A indicated not applicable). There was no documentation on the electronic chart to indicate Resident #125 had a shower or bed bath on those days. Record review on 1/7/26 of Resident #125's paper shower sheets for January 2026 revealed one shower was documented on 1/3/26. The shower sheet was signed and dated by CNA H. It did not indicate the cleansing activity or expected resident grooming received. In an interview on 1/7/26 at 10:42 a.m. Resident #125 said the staff did not pay attention to her and sometimes did not give her a shower. She said she never turned down a shower, and her last shower was last week. In an interview on 1/7/26 at 4:00 pm CNA H said Resident #125 was total care with showers (total assistance requires hands on help throughout the entire task). She said her shower days were Tuesday, Thursday, and Saturday during the day shift. She said she last showered Resident #125 on Saturday 1/3/26. She said she also gave her a bed bath on Thursday 1/1/26 but forgot to document it. In an interview on 1/7/26 at 4:15 pm CNA I said she gave Resident #125 a bed bath on Tuesday 1/6/26 but forgot to document it on the shower sheet. She said the resident gets her baths. In an interview on 1/7/26 at 4:30 p.m. CNA I said she must have clicked the wrong button while documenting Resident #125's showers on the POC. In an interview on 1/8/26 at 3:00 p.m. the DON said staff needed to document the shower/bath to show that the care was done. She said she conducted in-services with the staff on general documentation and said if the care was not documented it was not done. She said she monitored the shower documentation through spot checks. In an interview on 1/9/26 at 2:16 p.m. the Administrator said she expected documentation to be complete to ensure residents received the proper care needed. Record review of the facility's Clinical Documentation policy dated 11/2025 read in part, .The facility maintains accurate, timely, and resident-centered clinical documentation within Electronic Medical Records (EMR) to reflect care provided in accordance with physician orders and the resident's plan of care. Documentation supports continuity of care, clinical decision-making, and communication among the interdisciplinary team. Routine care is documented through assigned tasks. Procedure: CNAs document care in Point of Care (POC) within Electronic Medical Records (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(EMR). Paper documentation is used only during approved downtime and entered into Electronic Medical Records once systems are restored. General Documentation Expectations: Documentation should be: Completed as close to the time of care as possible, Accurate and reflective of care provided.		

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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** Based on observation, interview, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 11 residents (Resident #12 and Resident #6) observed for infection control. 1. The facility failed to ensure C.NA AA and C.N A BB used the required PPE for Resident #12, who was on enhanced barrier precautions while performing incontinent/indwelling Foley catheter care on 01/07/26. 2. CNA E failed to perform hand hygiene with glove changes during perineal care on Resident #6. 3. CNA E donned gloves from out of her pocket during perineal care on Resident #6. These failures could place the residents at risk of cross-contamination and development of infection. Findings included: Record review of Resident #12's face sheet reflected a [AGE] year-old male originally admitted on [DATE] and re-admitted on [DATE] with medical diagnoses pressure ulcer of sacral region, stage 3 (is a deep, crater-like wound where the skin has broken down through all layers, revealing the fatty tissue underneath but not muscle, tendon or bone,) other malaise, obstructive and reflux uropathy (obstructive uropathy is a condition where urine flow is blocked, causing a damming effect that can damage the kidneys, while reflux uropathy is a condition where urine flow backward (the wrong way) in the urinary tract, also potentially damaging the kidneys, pressure ulcer of other site, stage 3), unspecified kidney, except renal pelvis infection and inflammatory reaction due to indwelling urethral catheter (a common type of thin, flexible tube that a doctor or nurse puts into the bladder to continuously drain and collect urine). Record review of Resident #12's Comprehensive MDS dated [DATE], reflected his BIMS score was a 10, indicating moderate cognitive impairment. He required total assistance with toileting. He was continent for bladder and incontinent of bowel. He had an indwelling catheter. Record Review of Resident #12's care plan dated 11/27/2025 reflected I have ADL self-care performance deficit and totally dependent on staff for all ADLs. I will remain clean, dry, without odor and comfortable every shift daily, with all needs to be anticipated and met by staff over the next 90 days. Record review of Resident #12's physician's order dated 10/10/25 revealed enhanced Barrier Precautions - PPE: Gloves/Gown during high contact resident care activities, every shift related to Foley Catheter. Observation on 01/07/26 at 10:30 AM of Resident #12 lying in bed crooked needing help repositioning in bed, and incontinent/ indwelling Foley catheter care. Resident #12 had EBP was posted by the head of bed. CNA A and CNA B entered Resident #12's room without wearing PPE gowns. Both CNAs put on gloves once they entered the room. During an interview with CNA AA on 01/08/26 at 12:30 PM, when asked why she didn't gown up with PPE when she repositioned the resident in bed and Foley Catheter, CNA AA said she forgot. When asked if she knew what EBP was for: CNA AA stated it was for those residents that have GTube, wounds, and indwelling catheter and it's to prevent infection. She said she had in-services on the use of PPE and contact isolation. Interview with CNA BB on 1/8/26 at 1:00 PM regarding not using the PPE while repositioning Resident #12 and assisting with indwelling catheter/incontinent care. CNA BB said she forgot to do PPE. In an interview with the DON on 01/07/26 at 4:35 PM she stated any resident who had a Foley catheter was placed on Enhanced Barrier precautions to help reduce the spread of MDRO's. She stated signage was posted outside to the door, which explains what PPE was to be worn and for what task the PPE is to be worn for. She stated any contact with a resident with a catheter required the use of gown and gloves. She stated the staff had received trainings on the use of Enhanced Barrier Precautions and hand washing. Record review of Resident #6's face sheet revealed a [AGE] year-old admitted to the facility on [DATE] and originally admitted on [DATE]. Resident #6's diagnoses included diabetes, Hemiplegia (one sided paralysis or severe loss of strength on one side) and malnutrition. Record review of the quarterly MDS assessment dated [DATE] revealed Resident #6 had a BIMS score of 10 out of 15 indicating moderate cognitive impairment. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 required substantial assistance of staff for toileting hygiene. Resident #6 was occasionally incontinent of bowel and bladder. Record review of Resident #6's care plan report last reviewed on 12/15/2025 revealed in part; -Focus: Resident #6 has bladder incontinence. Goal: Resident at risk for septicemia (an infection that occurs when bacteria enter the bloodstream and spread. It can lead to sepsis, the body's reaction to the infection, which can cause organ damage and even death) will be minimized/prevented via prompt recognition and treatment of symptoms of UTI. Interventions included clean peri-area with each incontinent episode, monitor/document for signs and symptoms of UTI. Observation on 01/07/2026 at 8:30 AM, revealed CNA E and CNA KK provided perineal care to Resident #6. CNA E and CNA KK washed their hands and put on clean gloves. Both CNAs unfastened the brief. CNA E separated the labia and cleaned Resident #6 from front to back using a clean wipe for each stroke. CNA KK assisted the resident in turning onto the left side. CNA E wiped the buttocks and anal area, from front to back using a clean wipe for each stroke. CNA E removed the soiled brief and deposited into a trash bag, removed gloves, disposed of the used gloves into the trash bag, removed a pair of gloves from her pocket and put them on. CNA E did not perform hand hygiene after removing used gloves. CNA E then touched the clean briefs and applied the brief to the resident. CNA E touched the bed linen to cover the resident. CNA KK removed gloves after CNA E completed the dirty portion of the pericare. CNA KK washed her hands at the sink prior to putting on a new pair of gloves retrieved from the glove box before assisting with repositioning the resident. In an interview on 01/07/2026 at 8:45 AM, CNA E stated she was nervous and should have washed her hands after removing the dirty gloves before touching the clean briefs and touching the bed linens. CNA E stated it was important to wash hands after removing used gloves to prevent cross contamination. In an interview on 01/07/2026 at 1:15 AM, CNA E stated she should not have used the gloves from her pocket for patient care due to infection control. CNA E stated she grabbed gloves to put into her pocket not being sure if there would be gloves in the room when CNA E asked for assistance with peri care. In an interview on 01/07/2026 at 4:17 PM, the DON stated she expected the CNAs to wash hands after disposing of used gloves, and before putting on new gloves when performing perineal care for infection control and to prevent cross contamination. The DON stated it was not ok to keep gloves in pockets and use them on residents as there could be dirt and debris in the pocket. Record review of Resident #6's care plan report last reviewed on 12/15/2025 revealed in part; -Focus: Resident #6 has bladder incontinence. Goal: Resident at risk for septicemia (infection spread through the bloodstream) will be minimized/prevented via prompt recognition and treatment of symptoms of UTI. Interventions included clean peri-area with each incontinent episode, monitor/document for signs and symptoms of UTI. Observation on 01/07/2026 at 8:30 AM, revealed CNA E and CNA KK provided perineal care to Resident #6. CNA E and CNA KK washed their hands and put on clean gloves. Both CNAs unfastened the brief. CNA E separated the labia and cleaned Resident #6 from front to back using a clean wipe for each stroke. CNA KK assisted the resident in turning onto the left side. CNA E wiped the buttocks and anal area, from front to back using a clean wipe for each stroke. CNA E removed the soiled brief and deposited into a trash bag, removed gloves, disposed of the used gloves into the trash bag, removed a pair of gloves from her pocket and put them on. CNA E did not perform hand hygiene after removing used gloves. CNA E then touched the clean briefs and applied the brief to the resident. CNA E touched the bed linen to cover the resident. CNA KK removed gloves after CNA E completed the dirty portion of the pericare. CNA KK washed her hands at the sink prior to putting on a new pair of gloves retrieved from the glove box before assisting with repositioning the resident. In an interview on 01/07/2026 at 8:45 AM, CNA E stated she was nervous and should have washed her hands after removing the dirty gloves before touching the clean briefs and touching the bed linens. CNA E stated it was important to wash hands after removing used gloves to prevent cross contamination. In an interview on 01/07/2026 at 1:15 PM CNA E stated she should not have used the gloves from her pocket for patient care due to infection control. CNA E stated she grabbed gloves to put into her pocket not being sure if there would be gloves in the room when CNA (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	KK asked for assistance with peri care. In an interview on 01/07/2026 at 4:17 PM, the DON stated she expected the CNAs to wash hands after disposing of used gloves, and before putting on new gloves when performing perineal care for infection control and to prevent cross contamination. The DON stated it was not ok to keep gloves in pockets and use them on residents as there could be dirt and debris in the pocket. Record review of the facility policies and Procedures revised 3/24 on Enhanced Barrier Precautions reflected: Policy: Enhanced barrier precautions (EBPs) is utilized to prevent the spread of multi-drug resistant organisms (MDRO). Enhanced Barrier Precautions is an infection control intervention designed to reduce the transmission of multidrug-resistant organisms and employs targeted gown and glove use during high-contact resident care activities for targeted residents. Guidance/Procedure: Enhanced Barrier Precautions (EBP) are used in conjunction with standard precautions and expands the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO. ^ Wounds generally include chronic wounds, not shorter-lasting wounds: skin breaks/skin tears/or similar areas. ^ Examples of chronic wounds: pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. ^ Examples of indwelling medical devices: central lines, urinary catheters, feeding tubes, and tracheostomies. When EBP are indicated, EBP should be employed for the following high-contact resident care activities: Dressing, bathing/showering, transferring, providing hygiene, changing briefs, assisting with toileting, device care, and wound care. In general, gowns and gloves would not be recommended when performing transfers in common areas such as dining or activity rooms, where contact is anticipated to be shorter in duration. Therapy consideration: if close contact is required to perform therapy functions, gown and gloves are recommended. Residents are not restricted to their rooms or limited from participation in activities. The facility has discretion in how they choose to communicate these precautions to the staff. PPE for EBP is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. The facility has discretion in using EBP for residents who do not have wounds or indwelling medical devices and are infected or colonized with an MDRO that is not currently targeted by CDC. Record review of the facility's policy 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. Procedure: .wash hands thoroughly and apply gloves. Gather necessary supplies: .clean gloves. Applying Clean Brief: Remove soiled gloves and dispose of them properly, perform hand hygiene thoroughly and apply new clean gloves.		