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	06/05/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that drugs and biologicals were stored in locked compartments under proper temperature controls, limited access, for 1 of 2 (Hall A) medications storage rooms reviewed for proper medication storage.-Medication storage room on Hall A had 4 bags of 50ml normal saline mixed with the antibiotic medication daptomycin 500mg sitting out on the countertop. The label on the outside of the bag read to refrigerate upon arrival. This failure could place residents at risk for infection, IV contamination, and treatment of the medication not being effective. Record review of Resident #71 face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] and again on 05/12/26. Resident #71's diagnoses included sepsis (life threatening response to an infection in the body), metabolic encephalopathy (when the brain is not function properly due to a chemical imbalance or organ failure {one or more of the body's vital organs can no longer do its job to keep a person a live} in the body), and acute kidney failure (sudden loss of kidney function to filter waste from the blood). Record review of Resident #71's MDS dated [DATE] reflected a BIMS score of 0 indicating that Resident #71's cognition was severely impaired. Record review of Resident #71's Comprehensive Care Plan dated 04/13/26 revealed that resident was being care planned for antibiotic therapy and being at risk adverse reactions: Antibiotic Daptomycin until 06/24/26.Dx: sepsis. An intervention included to follow standard precautions to prevent cross contamination and spread of infection. Record review of Resident #71's Physician Order Summary included the following order: -Dated 05/19/26 Daptomycin intravenous 500mg one time a day for sepsis secondary to post-op (period of time after a surgical procedure) surgical site infection left hip until 06/24/26. Record review of Resident #71's MAR for the month of June 2026 revealed that the facility was administering the medication as ordered by the physician. Record review of the pharmacy delivery date for the medication daptomycin 500mg IV dated 06/01/26 reflected that LVN A signed the delivery form at 8:55PM. Observation on 06/03/26 at 9:30AM of the medication storage room on the [NAME] Wing revealed four 50ml bags of normal saline mixed with the medication daptomycin 500mg sitting on top of the countertop labeled with Resident #71's name on bags. These bags were inside of large clear plastic bag. The date delivered on bags read 06/01/26. On the outside of the plastic large clear bag was a green sticker label reading in bold black print that read refrigerate upon arrival. Interview on 06/03/26 at 9:45AM with RN I said whoever accepted the medication from the pharmacy was responsible for storing the medication daptomycin 500mg IV in the fridge. RN I said daptomycin IV was supposed to be stored in the fridge at a certain temperature to be effective when administered. RN I said he had been working at the facility full time for 2-1/2 months from 6AM-6PM and was never told who was responsible for checking the medication room to ensure that medications were stored appropriately. RN I said when medications were not stored correctly, the medication may not be effective in treating what it was supposed to treat. Interview on 06/03/26 at 9:50AM with LVN O he said he was Resident #71's nurse. LVN O said the medication daptomycin 500mg IV had been placed on hold and did not know why. LVN O said he was not aware that the medication daptomycin IV had (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been placed on the countertop in the medication room. LVN O said he worked at the facility full time from 6AM-6PM for 4 or 5 months. LVN O said all the nurses were responsible in checking the medication room to ensure medications were stored properly daily. LVN O said when IV antibiotic medication daptomycin is not stored properly, it placed the resident at risk for increase in infections. LVN O said he had checked the medication storage room earlier but did not completely check the medication storage room. Interview on 06/03/26 at 10:10AM with LVN NT she said she was the unit manager for the [NAME] Wing. LVN NT said she had been working at the facility since April of 2026. LVN NT said it was her and the nurses on the unit that were responsible for checking the medication storage room to ensure all medications were stored appropriately every day. LVN NT said the medication daptomycin 500mg IV should not be sitting out on the countertop in the medication room and that it placed the resident at risk of not receiving effective treatment. Interview on 06/03/26 at 10:22AM with the DON said she had been the DON at the facility for 2 months. The DON said it should be the unit manager that should be checking the medication storage room to make sure medications were being stored properly. The DON said she was responsible to ensure that this was being done. The DON said by not storing the medication daptomycin 500mg IV in the fridge as instructed could affect the efficacy (desired results or the intended effect) of the medication placing the resident at risk of not receiving the therapeutic results of what the medication was ordered for. The DON said even if the medication daptomycin 500mg IV had been placed on hold, the medication should still be stored in the fridge because it just on hold, not discontinued, meaning the medication could be resumed. Further interview with the DON, she said after reviewing the pharmacy delivery of the medication daptomycin 500mg IV, it was LVN A that signed and accepted the medication on 06/01/26. Attempted interview on 06/03/26 at 1:00PM via phone with LVN A, no answer, left a voicemail with a call back number. Interview on 06/04/26 at 10:37AM with the pharmacist revealed the medication daptomycin 500mg IV needed to be refrigerator per manufactured instructions. The pharmacist said if not stored in fridge, the medication daptomycin IV would lose its stability in being effective. Record review of the facility policy on Storage of Medication revised in August 2020 revealed in part: . Medications and biologicals are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier.Medications requiring storage in cool place are refrigerated unless otherwise directed on the label.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to ensure that food was prepared, distributed, and served food in accordance with professional standards for food service safety in one of one kitchen in that. _The facility failed to ensure that equipment was cleaned.The facility failed to ensure that plates, bowls, and cups with dried food particles, and glasses with water spots and stains were not stored with clean plates, bowls and glasses._The facility failed to ensure that menu items on the steam table were maintained at 135 degrees F and above.-The facility failed to ensure that chicken salad was on ice and served for lunch at the correct holding temperature of 41 degrees F and below.-The facility failed to ensure that pans with food particles on them were not stored with clean pans.- The facility failed to ensure that foods in the freezer were labeled and dated. - The facility failed to ensure that the dry storage room had no expired food items. These failures placed all residents who ate food prepared by the kitchen at risk of foodborne disease and other illnesse Observation on 6/2/2026 between 8:30- 9:30 am revealed the following: [NAME] J was observed plating resident's food for breakfast. [NAME] J touched the stove knob, the frying pan, pick plates, touched the counter of the steam table and without changing gloves picked up bread and cooked bacon and placed them on the resident's plate. Observation also revealed chipped plates, and bowls were stored with unchipped plates and bowls. Regular plates and divided plates with food particles were stored with clean plates and divided plates. The oven doors and racks had an accumulation of grease and burnt food particles on them. The deep fat fryer had brown oil with burnt food particles in it. The casing (holder) for the table mounted can opener had an accumulation of black stuff and grease on it. In the freezer were fries, spinach, Tator tots, squash in plain plastic bags not labeled or dated. Collard greens with no date. Pots and pans had grease and dried food particles in them. Muffin pans with dried food particles in them. Coffee cups with white power looking stuff in them. Water jugs with plastic, glue from the tapes use to secure the labels on the water jugs and paper on them. In an interview on 6/2/26 at 9:00 am the Dietary Manager said the deep fat fryer and the oven were on the schedule to be cleaned that day. The DM said she will have to find another way of labeling water jugs, because of the glue from the tapes that were left on the jug when they were removed to be washed. Observation on 6/3/2026 at 12:10 pm of the steam table for lunch revealed menu items not at the correct holding temperature: Pureed pork at 120.7 degrees F and chicken salad at 45.6 degrees F. Observation 6/3/2026 at 12:15 pm revealed [NAME] J plating food and touching the stove knob and touching the food and not changing gloves. [NAME] J was observed at that time plating chicken salad for a resident. The pan with the chicken salad was on the counter not on ice. The temperature was taken at that time, and it was 45 degrees. The Dietitian was about to put the chicken in the cooler, but the DM told her to discard the chicken salad. Observation of the dry storage room on 6/3/2026 at 12:30pm revealed 4 cases of thick and easy water with best used date of 4/30/2026. The DM discarded the water when the surveyor brought it to her attention. In an interview on 6/3/26 at 12:55 pm with the DM she said that if food was not at the correct temperature residents could get sick. She said ready to eat food should be served with a tong and not be touched with bare hands. She said if gloves were used, they should be changed after each task. Regarding the thickened water she said she had just started working at the facility and was in the process of changing and putting polices in order. She said staff should be checking for expired foods and food that are closed to be expired using the fist in first out method (FIFO), (a storage method where the oldest was used first). Interview with [NAME] J on 6/5/2026 at 8:30 am she said ready to eat food should not be touched with bare hands. She said she should be using tongs to pick up ready to eat food. She said touching the food after doing multiple tasks could cause residents to get sick. She said she will be using tongs to pick up ready to eat food. Further interview on 6/5/2026 at 8:35 am with [NAME] J she said she was in-serviced on the use of tongs to pick up ready-to-eat food. She said she did not (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	remember being in-serviced on ready to eat foods before this in-service. She said not changing gloves or using tongs could cause residents to get sick due to cross contamination. In an interview on 6/5/26 at 8:40 am the DM said the staff had been in-serviced, and she will continue to in-service staff until they learn the correct ways to do things in food service until they are in compliance. She said she would be in-servicing staff on using tongs and if gloves were used, they should be changing them after each task. She said moving forward she was going to ensure that all staff know how to handle ready-to-eat food and the proper use of gloves. Record review of the facility's Nutrition Services Policies and Procedures dated 06/2019 read in part.Subject: Safe Food TemperaturesPolicy:It is the policy of this facility that food temperatures be maintained at acceptable levels during food storage, preparation, holding, serving, delivery, cooling and reheating. The steamtable may not be used to reheat food.Minimum safe internal cooking temperatures for some high-protein foods that require special handling are as follows:A Poultry, stuffed meats, fish, poultry and stuffed pasta: 165F for at least 15 seconds. Stuffing made from potentially hazardous foods should be cooked separately to a minimum internal temperature of 165F for at least 15 seconds.Note: Appearance in meat is not a reliable indicator of safety or risk. Only by using a food thermometer can you determine if meat has reached a sufficient temperature to destroy pathogens of public health concern.Procedures:1. Minimize the time that time/temperature control for safety (TCS) food is in the temperature danger zone (41 to 1350 F) throughout the food handling process to no more than 4 hours.2. [NAME] whole cuts of meat to at least 145F internal cooking temperature then allow it to rest 3 minutes before carving or consuming. Foods can be cooked to higher temperatures if the quality is not sacrificed.3. Reheat all previously cooked TCS food so that all parts of the food reach an internal temperature of at least 165F for 15 seconds.5. When hot pureed, ground, or diced food drops into the danger zone (below 135 F), it must be reheated to 165 F for 15 seconds.6. Hold hot foods at 140 F or higher during meal service (on the tray line). Hold cold foods at 40F or lower during meal service (on the tray line). Maintain and serve hot beverages at 140F or higher.7. Check and record tray line food temperatures on the food temperature record before each meal. If the food temperatures are not within acceptable parameters, reheat the food to at least 165F for 15 seconds (for hot foods) or discard it.9. Cooling: Improper cooling is a major factor in causing food borne illness. The ideal bacterial incubation temperature range is 70-125 F and is to be avoided. TCS food is cooled to 41 F or lower within 4 hours after reaching 135 F. (For example a cooked food is put into the refrigerator at 165 F. The clock starts when the food reaches 135 F.)11. When preparing a TCS food from ingredients at room temperature (e.g. tuna or chicken salad), cool it to 41 F within 4 hours.Guidelines for Checking Food Temperatures:1. Make certain the thermometer is clean and has been sanitized with an appropriate sanitizer (100 ppm [parts per million] bleach solution or 25 ppm iodine solution). The use of individual, foil wrapped alcohol pads also is acceptable for sanitizing probes; however, allow time for the alcohol to evaporate before inserting the probe into the food. Another method is to utilize the coffee urn making sure water temperature is 180 F.Note: The thermometer must be cleaned and sanitized between each product that is tested.2. Insert the stem of the thermometer into the thickest portion of the food being tested, so that the sensing area (usually a line or staking dimple etched into the thermometer stem) is covered approximately 1/8 to 1/4 inch above the staking dimple with the food being tested. Allow to stabilize for 15 - 20 seconds and record the temperature.3. To attain accurate readings, never insert the probe next to a bone, or allow the thermometer to touch the bottom or side of the pan.4. If temperatures do not meet requirements, notify the Nutrition Services Director (NSD) for direction.5. Stir hot foods from the middle of the pan outward during the meal service to maintain an even temperature.Calibrating the Thermometer:1. Check the thermometer for proper calibration at least weekly or more often if it has been dropped. Record on the Calibration Record form.2. For the cold temperature method, insert the sensing area of the thermometer into an equal mixture of crushed ice and water until the indicator stabilizes, and then turn the calibration nut so the indicator reads 32F.3. The hot temperature method: place the thermometer in boiling water; the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature should be 212F.4. If the thermometer is not accurate, the NSD repairs or replaces the thermometer. Record review of the facility's Nutrition Services Policies and Procedures dated 6/2029 read in part.SUBJECT: WAREWASHING USING DISHWASHING MACHINEPOLICY:Utensils and dishes washed by a mechanical dishwasher will be clean and sanitized.PROCEDURES:1. Check the cleanliness of the machine. Fill wash and rinse tanks with clear water. Check the temperature of the wash and rinse cycles, verifying that both meet the temperatures posted on the dishwashing machine. (If the manufacturers' temperatures are not posted on the machine, request from vendor). If using a low temp machine, check the sanitizer level at contact times specified in accord with the product label. Record data on the Temperature and Sanitizer Log Form # CP1906.2. Notify Maintenance if required temperatures are not reached. Discontinue warewashing and use disposable dishes and flatware until the issue is resolved.3. Bus trays and dishes. Throw paper and disposable items in trashcan.4. Scrape food into garbage disposal.5. Separate glasses, flatware and china; stack trays.6 Presoak flatware and dishes to soften dried foods; do not soak longer than 15 minutes; long soaking may cause pitting of some items.7 Place glasses, china, and trays in dish racks with all sides of china, glasses and trays exposed to the water; do not crowd into dish racks.8 Spray dishes and flatware thoroughly with overhead spray to remove food particles.9 Wash dishes in dish machine according to equipment directions.10 Wash flatware, following these steps:A. Place flatware in a flat dish rack (no more than 60 pieces per rack).B. Run the dish rack through the dish machine.C. Sort knives, forks, and spoons.Revised 6-2019D. Place the flatware in cylinders with the handles down in the basket and send back through the dish machine (no more than 30 pieces per cylinder).E. Once the flatware has been washed the second time, use an empty cylinder to place over the full cylinder containing the clean flatware.F. Invert the cylinders so the eating end is now in the bottom of the cylinder.11. Wash hands between handling soiled and clean dishes to prevent cross contamination.12. Store clean sanitized dishes and utensils in a clean, dry location not exposed to splash or other contamination.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 establish and 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 infection for 2 of 6 residents (Resident #7 and Resident #4) and 2 of 2 staffs (CNA T, CNA B) reviewed for infection control.-The facility failed to ensure CNA B donned PPE including gloves and gown before preforming incontinent care to Resident #7 with EBP sign posted on the entrance door on 6/3/2026. -The facility failed to ensure CNA T donned PPE including gloves and gown before performing incontinent care to Resident #4 with EBP sign posted on the entrance door on 6/3/2026. These failures could place residents at risk for spread of infection and cross contamination to residents causing resident illness and/or distress. Record review of Resident #7s face sheet dated 06/03/2026 revealed he was a [AGE] year-old female who was admitted to the facility on [DATE]. His medical diagnoses included reduced mobility , mild protein-calorie malnutrition, other sequelae of cerebral infarction (consequences of stroke), secondary hypertension (blood pressure), hyperlipidemia (high fat in the blood) unspecified hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (paralysis or partial paralysis following stroke affecting left non-dominant side), other lack of coordination, cognitive communication deficit, dependence on supplemental oxygen, need for assistance with personal care, muscle weakness (generalized), other abnormalities of gait and mobility and pressure ulcer of sacral region (a large, triangular bone at the base at the of the spine that connects the vertebral column to pelvis), stage 4, pressure ulcer of right hip, stage 4, pressure ulcer of left hip, stage 3 (Full thickness tissue loss with exposed bone, tendon muscle), Record review of Resident #7's admission MDS assessment, dated 12/25/25, reflected a BIMS score of 3 out of 15, which indicated severe cognition impaction. She required assistance from staff with ADL care. Record review of Resident #7's care plan, dated 10/04/25, reflected, . The resident had an ADL self-care deficit .Interventions.Personal Hygiene and Toilet use- Resident is totally dependent . Resident #7 was also care-planned for incontinent care, with interventions including changing brief in a timely manner preventing skin break down. During observation on 6/3/26 at 2:59 PM, Resident #7 had an Enhanced Barrier Precaution sign posted on her door. Resident #7 was lying in bed; CNA B did not don (put on) gloves and gown before entering Resident #7's room and set up the supplies to perform incontinent care for Resident #7.In an interview with CNA B on 6/3/26 at 3:45 p.m., she said she forgot to wear PPE before entering Resident #7's. She said she did have in-services about using PPE to prevent infection to her and the residents on EBP.Resident #4Record review of Resident #4's face sheet last captured 06/03/2026, revealed she was a [AGE] year-old female originally admitted on [DATE]. Her medical diagnoses were gastronomy status (has a gastrointestinal tube to provide nutrition and medication from opening straight into stomach), muscle weakness (generalized), muscle wasting and atrophy, not elsewhere classified, multiple sites, dysphagia (difficulty), cognitive communication deficit, moderate protein-calorie malnutrition, other lack of coordination, need for assistance with personal care, sepsis, unspecified organism, altered mental status, unspecified, type 2 diabetes mellitus with hyperglycemia (high sugar in the blood), acute respiratory failure with hypoxia (low oxygen in the blood).Record review of Resident #4 's significant change MDS, dated [DATE], reflected the BIMS score was 00 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #4 was incontinent of bladder and bowel. Record review of Resident's #4's care plan, dated 12/24/2025, reflected the following: I have ADL self-care performance deficit and totally dependent on staff for all ADLs and requires assistance with activities of daily living due to decreased physical and functional mobility secondary to weakness and multiple medical comorbidities. During observation on 6/3/2026 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 3:29 PM, Resident #4 had an Enhanced Barrier Precaution sign posted on her door. Resident #4 was lying in bed; CNA T did not don (put on) gloves and gown before entering Resident #4's room to perform incontinent care.In an interview with CNA T on 6/3/2026 at 4:33 p.m., she said she forgot to wear PPE before entering Resident #4's. She said she did have in-services about using PPE to prevent infection every month at least bi-weekly. CNA T said using PPE was to prevent infection to her and the residents on EBP.Interview with the Administrator on 6/3/26 at 5:00 PM, regarding expectations for Resident #4 and Resident #7 on EBP during care. The Administrator said his expectation was for all residents with EBP signs posted on their doors, the staff were supposed to don PPE before entering their room to perform any care, to prevent infection.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.oEBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; oroWounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO. ˆ Wounds generally include chronic wounds, not shorter-lasting wounds: skin breaks/skin tears/or similar areas.oˆ Examples of chronic wounds: pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.oˆ Examples of indwelling medical devices: central lines, urinary catheters, feeding tubes, and tracheostomies.oWhen 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. 1.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.2.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.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents have a right to a dignified existence and treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 2 (Resident #4 and Resident #7) of 8 residents reviewed for dignity.- C NA B did not knock on the residents' door prior to entering and did not provide Resident #7 privacy during incontinent care with Resident #116 (roommate) in the room on 06/03/2026.- C NA T did not knock on the residents' door prior to entering and did not provide Resident #4 privacy during incontinent care with Resident #25 (roommate) in the room on 06/03/2026.These deficient practices could lead to psychosocial harm due to feelings of low self-esteem and/or embarrassment regardless of resident cognition. Findings:Record review of Resident #7s face sheet dated 06/03/2026 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her medical diagnoses included reduced mobility, mild protein-calorie malnutrition, other sequelae of cerebral infarction (consequences of stroke), secondary hypertension (high blood pressure), hyperlipidemia (high fat in the blood), unspecified hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (paralysis or partial paralysis following stroke affecting left non-dominant side), other lack of coordination, cognitive communication deficit, dependence on supplemental oxygen, need for assistance with personal care, muscle weakness (generalized), other abnormalities of gait and mobility and pressure ulcer of sacral region (a large, triangular bone at the base of the spine that connects the vertebral column to pelvis), stage 4, pressure ulcer of right hip, stage 4, pressure ulcer of left hip, stage 3 (Full thickness tissue loss with exposed bone, tendon muscle). Record review of Resident #7's admission MDS assessment, dated 12/25/25, reflected a BIMS score of 3 out of 15, which indicated severe cognitive impairment. She required assistance from staff with ADL care. Record review of Resident #7's care plan, dated 10/04/25, reflected, . The resident had an ADL self-care deficit .Interventions.Personal Hygiene and Toilet use- Resident is totally dependent . Resident #7 was also care-planned for incontinent care, with interventions including changing brief in a timely manner preventing skin break down.Observation on 6/3/26 at 2:59PM revealed CNA B entered Resident #7's room without knocking before entering room for incontinent care. She did not pull the privacy curtain between Resident #7 and roommate Resident #116 during incontinent care.Interview on 6/3/26 at 3:39 PM CNA B said she forgot to pull the privacy curtain and knock on the door, and she will be careful.Resident #4Record review of Resident #4's face sheet last captured 06/03/2026, reflected she was a [AGE] year-old female originally admitted on [DATE]. Her medical diagnoses were gastronomy status (has a gastrointestinal tube to provide nutrition and medication from opening straight into stomach), muscle weakness (generalized), muscle wasting and atrophy, not elsewhere classified, multiple sites, dysphagia (difficulty swallowing), cognitive communication deficit, moderate protein-calorie malnutrition, other lack of coordination, muscle wasting and atrophy, not elsewhere classified, unspecified site, need for assistance with personal care, sepsis, unspecified organism, altered mental status, unspecified, type 2 diabetes mellitus with hyperglycemia (high sugar in the blood), acute respiratory failure with hypoxia (low oxygen in the blood).Record review of Resident #4 's significant change MDS, dated [DATE], reflected the BIMS score was 00 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on bed repositioning and personal hygiene. Further record review of the MDS indicated Resident #4 was incontinent to bladder and bowel. Record review of Resident's #4's care plan, dated 12/24/2025, reflected the following: I have ADL self-care performance deficit and totally dependent on staff for all ADLs and requires assistance with activities of daily living due to decreased physical and functional mobility secondary to weakness and multiple (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675085	A. Building B. Wing	06/05/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical comorbidities.Observation on 6/3/26 at 3:29PM revealed CNA T entered Resident #4's room without knocking before entering room for incontinent care. She did not pull privacy curtain between Resident #4 and roommate (Resident #25) during incontinent care.Interview on 6/3/26 at 4:33 PM CNA T said she forgot to pull the privacy curtain and knock on the door, and she will be careful. CNA T said not pulling the privacy curtain and not knocking on their door was disrespectful to the residents.Interview with the Administrator and DON on 06/3/26 at 5:35pm, the Administrator said that privacy curtains should be utilized during procedures. Residents having procedures done without them could have made them feel uncomfortable and not have privacy. Record review of the facility's policy on resident rights, undated, read in part, A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.Privacy and confidentiality .1. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits.

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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 that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #77) of 5 residents reviewed for comprehensive care plans. Resident #77's comprehensive care plan did not include all care areas triggered on the resident assessment. This failure could place all residents in the facility at risk of not receiving proper care to develop and improve their mental, physical and psychosocial well-being.Record review of Resident #77's admission face sheet revealed Resident # 77 was a [AGE] year-old male who was admitted on [DATE]. Resident #77's diagnoses included acute respiratory failure (a condition that makes it difficult for the lungs to breathe in oxygen and breathe out carbon dioxide), hypertension (high blood pressure), hyperlipidemia (high level of fat in the blood), depression (a mood disorder that causes persistent sadness, and loss of interest activities), anxiety (worried thoughts and emotions), and bipolar (is a mental condition that causes extreme mood changes). Record review of Resident #77's admission MDS dated [DATE] revealed the resident was coded for B1000 as impaired for vision and uses corrective lens, C0500 as having a BIMS score of 11 indicating the resident has moderate cognitive impairment: For Bowel and bladder he was coded as occasionally incontinent of bowel and bladder. Record review of Resident #77's MDS dated [DATE] reflected these CAAs triggered: cognitive loss/dementia, visual function, communication, urinary incontinence/indwelling catheter, psychosocial well-being and falls. Review of Resident #77's comprehensive care plan initiated 4/29/2026 revealed it did not include cognitive loss, visual function, urinary incontinence/indwelling catheter, psychosocial well-being and falls. Observation on 06/04/2026 at 10:15 am of Resident #77 revealed he was in bed, alert and oriented clean and groomed with no odor. His call light was within reach. During an interview on 06/04/2026 at 10:15 am Resident #77 said he was never abused since being admitted at the facility. He said his only problem was not getting his blood thinner medication for his blood clots. During an interview on 06/04/2026 at 12:55 pm with MDS Coordinator N she said it was an oversight why all triggered areas were not addressed on Resident #77's care plan. She said when completing the care plans, she interviews and observed residents, reviewed activities of daily living notes and nurse's notes. She said she also interviewed the CNAs and nurses to ensure all areas were addressed on the care plan. She said moving forward she was going to ensure all triggered areas of the CAAS were addressed. She said she was going to update the care plan. In an interview on 06/04/2026 at 2:20pm the DON said her expectation of the MDS nurse was to complete comprehensive care plans that address all triggered areas of the MDS. She said the MDS nurse was to ensure that care plans were accurate and complete. She said if care plans were not accurate then that could prevent residents from getting the care and treatment they need. She said they were talking about looking at the MDS and the skilled charting and how they could do better charting and care plans. She said they will continue to look at the MDS by reviewing the baseline care plan and change in conditions and then update the care plan. Record review of the facility's policy titled, Care Plan Revisions, with revision date 5/2022, revealed, Care plans will be modified as needed by the MDS Coordinator or other designated staff member.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one resident (Resident #99), of four residents reviewed for ADLs.The facility failed to provide nail care to Resident #99.This deficient practice could place residents at risk of skin breakdown and reduced feelings of self-worth.Findings include:Record review of Resident #99's face sheet dated 06/03/26 revealed he was initially admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. Resident #99 had diagnoses which included heart failure (heart not pumping blood efficiently to meet body's needs for oxygen), diabetes mellitus (high blood sugar), and hypertension (high blood pressure).Record review of Resident #99's quarterly MDS assessment dated [DATE] revealed a BIMS score of 14, indicating intact cognition. Further review of the MDS revealed the resident needed supervision with minimum assistance.Record review of Resident #99's care plan initiated on 07/22/23 revealed the resident had a self-care deficit and was at risk for further decline in ADLs. Intervention: provide assistance of 1 staff member for personal hygiene/grooming.Record review of Resident #99's POC(point of care) response history shower record for May 2026 did not reveal whether the resident's fingernails were cut.During an observation on 06/02/2026 at 9:43 a.m., Resident #99 had three fingernails on the left hand which were about 1.75 cm long and had dark brown substances under the fingernails. He also had four fingernails on the right hand which were about 1.5 cm long and also had brown substances under the nails.During an interview on 06/02/26 at 9:43 a.m., Resident #99 said he wanted his fingernails cut. He said the aides gave him showers three times a week and when the aides asked him if he wanted his fingernails cut, he would say yes. He said he did not ask the aides because the aides were supposed to ask him. Resident #99 said the staff did not clean his fingers after meals and that was why he had dirt in his fingernails. He said he did not feel groomed because of the dirt under his fingernails.During an interview on 06/02/26 at 10:05 a.m., CNA T said Resident #99's fingernails were cut two times a week and as needed by the aides and shower technician. She said Resident #99's fingernails were supposed to be cleaned daily and as needed. CNA T said she did not notice Resident #99's fingernails were long and had substances under the fingernails until then. She said Resident #99 could scratch himself, which could cause skin tears, and the areas could become infected.During a telephone interview on 06/02/26 at 4:41 p.m., RN O said she did not look at Resident #99's fingernails when she made rounds, but when she observed Resident #99's fingernails now it revealed both hands had long fingernails and some of the fingernails were dirty. She said resident fingernails were cut whenever the fingernails were long and the fingernails were cleaned daily, and it was the responsibility of all nursing staff. She said the resident could scratch himself when his fingernails were long and he could get an infection from the germs under the dirty fingernails.During an interview on 06/04/26 at 8:20 a.m., the DON said CNA T should have cut Resident #99's fingernails and if the resident was diabetic, then the nurse would cut the resident's fingernails. The DON said if the facility staff could not cut Resident #99's fingernails, then the podiatrist would cut the resident's fingernails. She said Resident #99 could have skin breakdown and infection if Resident #99's fingernails were dirty. She said the resident's fingernails were cleaned as soon as the staff noticed the nails were dirty.Record review of the facility policy on activities of daily living revised 1/2026 did not contain instructions on fingernail care, but the definition revealed, .activities of daily living include personal care tasks such as bathing.grooming.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 2 of 6 residents (Resident #7 and Resident #4) reviewed for incontinent care. -The facility failed to ensure CNA B cleaned Resident #7's buttocks before putting on a clean brief during incontinent care on 6/3/26. -The facility failed to ensure CNA T cleaned Resident #4 's buttocks before putting on a clean brief during incontinent care on 6/3/26. This failure could place residents at risk for pain, infection, injury, and hospitalization. Finding included Record review of Resident #7's face sheet dated 06/03/2026 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. Her medical diagnoses included reduced mobility, mild protein-calorie malnutrition, other sequelae of cerebral infarction (consequences of stroke), secondary hypertension (high blood pressure), hyperlipidemia (high fat in the blood), unspecified hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (paralysis or partial paralysis following stroke affecting left non-dominant side), other lack of coordination, cognitive communication deficit, dependence on supplemental oxygen, need for assistance with personal care, muscle weakness (generalized), other abnormalities of gait and mobility and pressure ulcer of sacral region (a large, triangular bone at the base of the spine that connects the vertebral column to pelvis), stage 4, pressure ulcer of right hip, stage 4, pressure ulcer of left hip, stage 3 (Full thickness tissue loss with exposed bone, tendon muscle). Record review of Resident #7's admission MDS assessment, dated 12/25/25, reflected a BIMS score of 3 out of 15, which indicated severe cognitive impairment. She required assistance from staff with ADL care. Record review of Resident #7's care plan, dated 10/04/25, reflected, . The resident had an ADL self-care deficit .Interventions.Personal Hygiene and Toilet use- Resident is totally dependent . Resident #7 was also care-planned for incontinent care, with interventions including changing brief in a timely manner preventing skin break down. Observation of incontinent Care on 6/3/26 at 2:59 PM, performed by CNA B, revealed CNA B did not wash hands then donned clean gloves. CNA B picked up clean and wet wipes, unfastened the soiled brief, and using wet wipes cleaned the groin. Resident #7 was repositioned on her left side. Resident #7 was soiled of urine and feces. CNA B cleaned in between the buttocks several times using wet wipes. She did not clean around the buttocks, changed gloves, she then placed a clean brief on and fastened it.Interview on 6/3/26 at 3:45PM with CNA B, regarding incontinent care, she said she did a good job, C NA B was asked why she did not cleaned around buttocks, she said she was nervous and she did not want to mess up the dressing to the sacral area Oh, I forgot CNA B said she had in-services on incontinent care, and she knew not cleaning the buttocks could cause more skin breakdown, odors and urinary tract infection.Resident #4Record review of Resident #4's face sheet last captured 06/03/2026, reflected she was a [AGE] year-old female originally admitted on [DATE]. Her medical diagnoses were gastronomy status (has a gastrointestinal tube to provide nutrition and medication from opening straight into stomach), muscle weakness (generalized), muscle wasting and atrophy, not elsewhere classified, multiple sites, dysphagia (difficulty swallowing), cognitive communication deficit, moderate protein-calorie malnutrition, other lack of coordination, muscle wasting and atrophy, not elsewhere classified, unspecified site, need for assistance with personal care, sepsis, unspecified organism, altered mental status, unspecified, type 2 diabetes mellitus with hyperglycemia (high sugar in the blood), acute respiratory failure with hypoxia (low oxygen in the blood).Record review of Resident #4 's significant change MDS, dated [DATE], reflected the BIMS score was 00 out of 15, which indicated the resident had severe cognitive impairment. Further record review of the MDS revealed the resident was totally dependent on bed repositioning and personal hygiene. Further record review of the MDS indicated (continued on next page)

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	675085	A. Building B. Wing	06/05/2026

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 was incontinent to bladder and bowel. Record review of Resident's #4's care plan, dated 12/24/2025, reflected the following: I have ADL self-care performance deficit and totally dependent on staff for all ADLs and requires assistance with activities of daily living due to decreased physical and functional mobility secondary to weakness and multiple medical comorbidities. Observation of incontinent Care on 6/3/26 at 3:29 PM, performed by CNA T, revealed CNA T washed her hands and then donned clean gloves. CNA T picked up clean and wet wipes, unfastened the soiled brief, and using wet wipes cleaned the groin. Resident #4 was repositioned on her right side. Resident #4 was soiled of urine and feces. CNA T cleaned in between the buttocks several times using wet wipes. She did not clean around the buttocks, changed gloves, she then placed a clean brief on and fastened it.Interview on 6/3/26 at 4:33PM with CNA T regarding incontinent care, she said she did a good job, she was asked why she did not clean around buttocks, she said she did not want the dressing to come off the sacral area. CNA T said she had in-services on incontinent care weekly, and she knew not cleaning the buttocks could cause more skin breakdown, odors and urinary tract infection.In an Interview with the DON -RN on 6/3/26 at 5:00pm, she said that she was in charge of doing the in services for incontinent care. She said she randomly went into rooms to observe staff to ensure they were doing care properly. She said she checked to see their technique, hand washing and customer service. She said her last in-service on incontinent care was on 3/4/26. She said that all C NA's were checked off and trained. DON said she was going to do more frequent skill check offs with staff.Interview with the Administrator on 6/4/26 at 5:00 PM, regarding expectation for incontinent care, she said her expectation was for incontinent care to be done in a manner to prevent urinary tract infection. 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.

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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 residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 2 of 11 (Residents #42 and #110) residents reviewed for respiratory care. -The facility failed to ensure Resident #42's oxygen was administered at the correct setting of 2-3 liters per minute on 06/02/2026.-The facility failed to ensure Resident #110's oxygen was administered at the correct setting of 2-3 liters per minute on 06/03/2026. These failures could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care.Resident #42 Record review of Resident #42's face sheet dated 06/03/26 revealed he was initially admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. Resident #42 had diagnoses which included dementia (a loss of memory, language, and thinking abilities that were severe enough to interfere with daily life), COPD (lung disease that made it hard to breathe), and acute respiratory failure (a sudden life-threatening condition where the respiratory system failed). Record review of Resident #42's quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, indicating intact cognition. Further review of the MDS revealed the resident was on oxygen. Record review of Resident #42's care plan initiated on 04/20/25 and revised on 06/02/26 revealed the resident had oxygen via nasal cannula or mask related to respiratory failure, COPD, SOB(shortness of breath), and Hypoxia (the body did not get enough oxygen to function properly). Intervention: follow physician orders for oxygen therapy. Record review of Resident #42's order dated June 2026 revealed Oxygen at 2-3 LPM via nasal cannula as needed for shortness of breath. Monitor O2 sat per shift and as needed for shortness of breath. The order was initiated on 01/17/26 and discontinued on 06/02/26 at 7:53 p.m Record review of Resident #42's order dated June 2026 revealed oxygen at 0.5 LPM via nasal cannula for shortness of breath. Monitor O2 sat per shift. The order was initiated on 06/02/26 at 7:53 p.m. Record review of Resident #42's O2 sat summary for May 2026 revealed the resident's oxygen saturation was 96% with oxygen via nasal cannula. Observation on 06/02/26 at 9:16 a.m. revealed Resident #42 was lying on his back in his bed and had the nasal cannula in his nostrils. The nasal cannula was connected to the oxygen concentrator. The setting on the oxygen concentrator read 0.5 L the observation was before the oxygen order was changed on 06/02/26 at 7:53 p.m. During an interview on 06/02/26 at 9:16 a.m., Resident #42 said he was not having SOB because he had his oxygen. He said a nurse told him the setting on the oxygen concentrator was 1 L, but he could not remember the nurse's name. Resident #42 said he did not change the setting on the concentrator. During an interview on 06/02/26 at 9:22 a.m., RN O said Resident #42's oxygen was set at 0.5 L on the concentrator. She said the oxygen setting on the concentrator should have been between 2 to 3 L. She said Resident #42 stated he did not touch the oxygen setting on the concentrator. RN O said nurses were responsible for making sure the setting on the oxygen concentrator was what the physician prescribed to prevent Resident #42 from having any SOB. She said Resident #42 was not getting the required oxygen. She said she made rounds at least three times during her shift and did not check the setting on the concentrator when she made her initial round during shift change. RN O said she did not know why Resident #42 oxygen was set on 0.5 L. During an interview on 06/04/26 at 8:30 a.m., the DON said if the oxygen was not set on the concentrator as ordered by the physician, RN O did not follow the physician's orders. She said Resident #42 needed oxygen for SOB. The DON said RN O should have called the physician to obtain an order that reflected where Resident #42 wanted the oxygen to be set. She said she was not aware Resident #42 was changing the oxygen setting on the concentrator and, if she had known he was changing the oxygen setting on the concentrator, she would have called the physician and care planned it. She said Resident #42 was receiving some oxygen but was not receiving oxygen as (continued on next page)

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	675085	A. Building B. Wing	06/05/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescribed. She said the nurses should have been monitoring the setting on the concentrator during rounds. She said there was no set time for rounding, but it should have occurred at least every 2 hours. Resident #110Record review of Resident #110's face sheet dated 06/03/2026, reflected he was an [AGE] year-old male originally admitted on [DATE] and last re-admitted on [DATE]. His medical diagnoses included obstructive sleep apnea (this occurs when the throat muscles relax and block the airway), weakness and paralysis following stroke affecting right dominant side, and chronic kidney disease and dementia (declining brain function related to thinking and judgement that is severe enough to impact daily life). Record review of Resident #110's active orders list dated 06/05/2026, reflected he had an order for oxygen @ 2-3 LPM via nasal cannula continuously. Monitor 02 sat with a start date of 05/21/2026 every shift for shortness of breath.Record review of Resident #110's care plan dated 05/06/2026, reflected he had a focus area of oxygen use and required supplemental oxygen via nasal cannula related to SOB with interventions including following physician orders for oxygen therapy delivery, routinely monitoring the resident's oxygen saturation levels, assessing for signs of hypoxia (such as turning blue, confusion, restlessness) and respiratory distress and report to MD as needed.Record review of Resident #110's oxygen readings from 01/03/2026 to 06/04/2026, reflected his readings were within normal range for all dates except for 05/19/2026 when his oxygen reading was at 87% and he was sent to the ER.Observation and interview on 06/03/2026 at 8:23a.m., Resident #110 was in bed and appeared comfortable and not under respiratory distress. Resident #110's oxygenator reading showed he was getting 1.5 L/min. Resident #110 said he did not need anything else. RN I was called into Resident #110's room on 06/03/2026 at 8:43a.m. and RN I read the oxygenator and said it was a little under 2L and turned the knob up to 2L/min. RN I said he had not checked the oxygen level and he was making his way down the hall to Resident #110's room. RN I said the previous shift nurse should have checked the oxygen to make sure it was at the right level. RN I said that residents not getting enough oxygen could negatively affect them and possibly lead to hospitalization. RN I said Resident #110 had previously declined in health and had to get on oxygen and hospice. At the time of the interview with RN I, Resident #110 appeared comfortable and in no distress. Resident #110 said he had no difficulty breathing. Record review of the facility's policy on oxygen last revised 8/2019, it read, Policy: It is the policy of this facility that the facility will provide oxygen therapy by means of various administration devices. Procedures: 1. Review physician's order on the chart for completeness. 5. Assess the resident. Establish baseline respiratory rate and heart rate. 8.Start O2 flow rate at the appropriate flow for administration device.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to assist residents in obtaining routine and 24-hour emergency dental care and in making appointments for 1 of 4 residents (Residents #36) reviewed for dental care. -The facility failed to assist Resident #36 in making their respective follow-up dental appointments. These failures could place residents at risk of oral complications, dental pain, and diminished quality of life. Findings: Record review of Resident #36's face sheet dated 06/05/2026, revealed she was a [AGE] year-old female originally admitted on [DATE] and last re-admitted on [DATE] with medical diagnoses including Alzheimer's Disease with early onset (a progressive brain disease that cause memory loss), dementia (declining brain function related to thinking and judgement that is severe enough to impact daily life), hypertension (high blood pressure), major depressive disorder (a mental illness characterized by prolonged periods of sadness and feelings of worthlessness), and age-related physical debility (decline in ability). Record review of Resident #36's Comprehensive MDS dated [DATE], revealed she was coded as having no dental concerns, including no obvious or likely cavity or broken natural teeth and no mouth or facial pain, discomfort or difficulty with chewing. Record review of Resident #36's Quarterly MDS dated [DATE], revealed she had a BIMS score of 8, indicating moderate impairment related to thinking and memory. She required substantial assistance with oral hygiene related to dentures and ability to use suitable items to clean teeth. Resident #36 was coded as having no broken or loosely fitting full or partial dentures nor did she have mouth or facial pain, discomfort or difficulty with chewing. Resident #36 had no pain and did not have regular pain medications. Record review of Resident #36's Order Summary dated 06/05/2026 revealed she had an active order for regular texture, regular/thin consistency with an order date of 01/02/2025. Record review of Resident #36's care plan last dated 06/05/2026 revealed she had a focus area of requiring a regular diet with thin liquids for nutritional support and being at risk for unplanned weight loss and nutritional complication dated 06/30/2024 with interventions including assisting resident with eating as indicated, serving diet as ordered and have the DM monitoring and discussing her food preferences. There were no areas documented on oral pain or damaged natural teeth. Record review of Resident #36's most recent dental visit on 12/03/2025 revealed the resident presented for initial exam with a complaint of wanting dentures. Remaining teeth were non-restorable with recommendations to ext. (extract) all remaining teeth and fabrication of CD/CD (complete dentures) to aid in function and mastication (chewing). Resident #36 was documented at being at high risk for caries (cavities) and teeth condition was written as ?poor, asymptomatic; general breakdown. The document wrote that the next actions required by nursing home staff included obtaining signature from responsible party on consent form for extractions. Record review of the dental company's emails revealed the company sent the following email to the SSW:-On 12/08/2025, the company sent an inquiry into Resident #36's applied income. Record review of Resident #36's progress and psychiatric visit notes since December 2025 revealed resident was not documented as having any complaints for oral pain. Record review of the dental company's schedule for the visit on 06/24/2026 revealed Resident #36 was not on the list. Record review of Resident #36's dental insurance information revealed Resident #36 did not have any gaps in dental insurance care. Record review of Resident #36's weights revealed she had no weight loss from 12/10/2025 to 05/08/2026. Record review of Resident #36's meal percentages revealed she ate 75-100% of her meals in the last 30 days from 05/06/2026 to 06/05/2026. Record review of emails related to Resident #36's dental care revealed the Administrator sent an email on 06/05/2026 at 10:28a.m., she said the SSW had no additional documentation for Resident #36's dental care or insurance concerns. Observation and interview on 06/03/2026 at 11:46a.m., Resident #36 was observed during activities in the secured unit with three teeth on her lower right side with white enamel and blackened center when viewed from the top. When asked about her teeth, Resident #36 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675085	A. Building B. Wing	06/05/2026

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said that she could not eat hard foods like sausage and some meats, but she could eat softer foods and she got plenty of it and that her teeth only hurt when she ate hard foods. Resident #36 said she ate her breakfast and was getting ready for lunch. Resident #36 said she did not tell her nurse or aides about her food preferences and pain in her teeth. In a later observation and interview on 06/04/2026 at 9:58p.m., Resident #36 was sitting on her bed in her room eating cheese puffs. Resident #36 reiterated that she had no pain now and only had teeth pain when eating hard things like sausages. Interview on 06/03/2026 at 3:13p.m., LVN C said she did not know about Resident #36's teeth and that neither Resident #36 nor CNAs told LVN C about Resident #36's teeth. LVN C said she expected staff to tell her about black teeth. LVN C said she was going to tell the SSW about Resident #36's teeth so she could be placed on a dental list for the next visit by the dental contractor with the facility. In a later interview with LVN C on 06/04/2026 at 10:05a.m., she said staff not informing LVN C of Resident #36's black teeth could have prolonged treatment and that black teeth were a sign of possible infection or could affect the ability to eat. Interview on 06/03/2026 at 3:20p.m., CNA C said that she did not usually work with Resident #36 but knew she was pretty independent with her ADLs. CNA C said that she did not know when she noticed Resident #36's black teeth but that everyone knew about it. Interview with CNA L on 06/04/3026 at 9:23a.m. via phone, CNA L said that Resident #36 required setup only with toothbrush and toothpaste set out and never complained about teeth pain and did not see blackened teeth and that CNA L would report black teeth to Resident #36's nurse. CNA L said black teeth could affect residents by causing infection and other negative outcomes. CNA L could not specify what other negative outcomes. Interview with the Administrator and DON on 06/03/2026 at 7:02p.m., the DON said that black teeth should trigger dental services. The Administrator and DON said they will check if Resident #36 was admitted with dental concerns but that she had never complained about it. In a later interview on 06/04/2026 at 3:41p.m., the Administrator said that if Resident #36 was not able to get her procedures done, she would not be able to get dentures but there was no negative outcome because she was not losing weight and was eating 100% of her meals. Interview with the SSW on 06/04/2026 at 10:52a.m., she said she submitted documents through the dental company portal. Staff would assess pain and let the SSW know. Appointments would depend on when the company was scheduled to come to the facility. The SSW said the process for dental appointments was that after an initial exam, the dental company would make recommendations, and the dentist would notify the resident or resident's RP on the cost. The facility would check the insurance and if the insurance did not cover the recommended procedures, then the facility would let the RP decide if they wanted to proceed with the procedure or not. The SSW was given the initial exam date for Resident #36 was 12/03/2025 and that she would look into Resident #36's history of dental work. The SSW denied anyone complaining about dental pain. The SSW said black teeth should be shared between aides and nurses and herself because it could lead to teeth decay, gingivitis and other oral concerns. The SSW said she would provide the list of residents on active dental services. In a later interview on 06/04/2026 at 12:54p.m., the SSW said she would need to check on Resident #36's dental work as she had not had time to review it. She said that the dental company was solely responsible for communicating any procedures with the family and that the SSW had reviewed the insurance at the time and confirmed that Resident #36 had insurance to complete the procedure. When asked if she was responsible for checking in and ensuring the family received the documentation from the dental company, the SSW responded that it was the dental company's responsibility and that the dental company did not even send documentation to the facility and it was out of the facility's hands. The SSW said she would not know what the family agreed on. In a follow up interview on 06/04/2026 at 2:41p.m., SSW said she was not in charge of appointments and that the dental company would schedule visits and let her know about dates and also if residents refused services. The SSW said she talked to Resident #36's RP recently and said the RP did not mention any concerns with teeth and that he was pretty active and visited Resident #36 weekly. The SSW said she just found out this morning that the dental company had not contacted the family. When (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked what could happen if referrals were not followed up on by her, the SSW responded that she wasn't sure how to answer that. Interview with the dental company representative on 06/05/2026 at 11:40a.m., he said that Resident #36 was seen on 12/03/2025 and the company sent the facility her proposed treatment plan on 12/08/2025. The company inquired about Resident #36's applied income to complete the payment portion by email and phone, but no one reached back out so the company could not move forward with the treatment plan. The representative said his supervisor sent the email to several facility staff including the SSW and he was going to ask his supervisor to forward the email. The representative said the company made appointments and always kept the facility in the loop by forwarding information by email to the residents, the RP and facility in case the resident is their own RP. Interview with CNA P on 06/04/2026 at 1:22p.m., CNA P said she was the aide in Resident #36's hall. CNA P said Resident #36 did her own dental care and brushed her own teeth. CNA P said she did not notice black teeth. Interview with Resident #36's FM on 06/04/2026 at 1:45p.m., he said when he talked to a facility staff in December 2025, they did not mention any blackened teeth. The FM said he had issues with Resident #36's dental insurance and was waiting for the facility to update him on Resident #36's insurance status. The FM said he did not know who he talked to about her insurance but that it was a case worker. The FM said that Resident #36 lost her dentures before she transferred to this facility but that even though Resident #36 did not like to use her removable dentures, the facility still should have taken care of her blackened teeth. The FM said he did not receive any messages or phone calls from the dental company. The FM was aware Resident #36 had a hard time eating hard food. Interview with the regional DON on 06/04/2026 at 1:57p.m., she said that from what she was able to find out, Resident #36 had not responded to the dental company's consent form and that Resident #36 never complained of pain and the family did not want to downgrade the diet. The regional DON said even if teeth were decaying, it did not mean that the person was in pain. At her exam on 12/3/2025, Resident #36 denied pain. The regional DON said the dental company did not send copies of the dental consent form to the facility. The regional DON said the dental company would only see her on emergency basis if she complained of pain and that staff would notice if Resident #36 was not eating as much. Interview with the Administrator on 06/04/2026 at 3:41p.m., the Administrator said that the SSW should have followed up to check on the referral for Resident #36. A negative outcome would have been Resident #36 did not get her dentures, but there was no negative outcome since she was not losing weight and eating 100%. Record review of the facility's policy on ancillary services, it read, The facility staff will work to assist and/or coordinate services, such as, but not limited to, the following: Routine dental, vision, audiology and podiatry services. Identify residents who require prompt referral. Examples include but are not limited to: Damaged or broken dentures, hearing aids, glasses, or other assistive devices. Lost dentures, hearing aids, glasses, or other assistive devices .Schedule an appointment and arrange transportation, as needed .Document referrals, coordination efforts, appointments, and resident or representative notifications in the resident's medical record, as applicable.