STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455544	A. Building B. Wing	09/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at Stevens	204 Walter St Yoakum, TX 77995

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain comfortable temperature levels for 2 of 5 residents (Residents #1 and #2) reviewed for environment. The facility failed to ensure the temperature in the room shared by Residents #1 and #2 was cooled to a comfortable level in September 2025. This failure could lead to decreased quality of life for residents. Findings included:Record review of Resident #1's face sheet dated 9/6/2025 reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included schizophrenia (a mental health disorder in which a person has difficulty distinguishing their own thoughts/delusions from reality), depression, and generalized anxiety disorder. Record review of Resident #1's admission MDS, submitted 8/14/2025, reflected a BIMS score of 15, indicating intact cognition. Record review of Resident #2's face sheet dated 9/6/2025 reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included hypertensive (elevated blood pressure) and schizoaffective disorder (a mental health disorder with similar presentations as schizophrenia). Record review of Resident #2's admission MDS, submitted 8/14/2025, reflected a BIMS score of 13, indicating intact cognition. In an observation and interview on 9/6/2025 at 10:55 AM, the room shared by Residents #1 and #2 had a recorded temperature of 75.5 degrees F. Three fans were observed to be circulating air in the room. Resident #1 stated the room frequently becomes so hot that she sweats profusely in spite of the fans. She said the room had been intermittently hot since she admitted to the facility. She had reported the temperature to the nursing staff, and they provided the additional fans for cooling. She stated that the temperature of the room at the time was warm and slightly uncomfortable. Resident #2 stated the room felt warm and that she wished it was cooler. In an observation and interview on 9/6/2025 at 1:17 PM, the same room had a recorded temperature of 80.2 degrees F. The temperature recorded next to the air conditioning vent above the door measured 80.1 degrees F. Resident #1 stated she felt hot and was uncomfortable. In an observation on 9/6/2025 at 1:18 PM, the temperature at the nurse's station in the hallway of Residents' #1 and #2 room was recorded at 79.4 degrees F. The air conditioning control panel next to the nurse's station was observed to be set at 72 degrees F. In an interview with the ADON on 9/6/2025 at 1:17 PM, she stated she was unaware that Residents #1 and #2 had ongoing discomfort related to the temperature of their room. She was aware of ongoing issues with the air conditioning in that area of the building and stated the air conditioning had been worked on recently. She stated the air conditioning was set to cool at 72 degrees F and maintained by the Maint. Dir., but she would relocate both residents to a cooler area of the facility. In an interview on 9/6/2025 at 1:53 PM, LVN A stated the hallway in front of Resident #1 and #2's room frequently became very hot as well as their room. She had reported the issue to the ADON in August, when both residents admitted to the facility, but stated nothing had been done to correct the temperature. She reported no adverse effects of the warm temperature to either resident other than discomfort. In an observation and interview on 9/6/2025 at 2:52 PM, the Maint. Dir. was observed on a ladder working in the ceiling in the hallway in front of the room shared by Residents #1 and #2. He stated he was not aware of any issues with the air conditioning in that hallway, and the air conditioning unit had been replaced earlier in the year. He then said the staff had notified him previously that some of the rooms in the same hallway were hot, but he found no issues when he checked the temperatures of the rooms. He stated he came to the facility that day after being notified by the ADON that the room was hot, and he found that an area of the air conditioning duct was dislodged, but he had been able to repair it. In an observation and interview on 9/6/2025 at 2:59 PM, Residents #1 and #2 were observed to have been relocated to a room across the hall from their original, shared room. The temperature in the room was measured at 72.9 degrees F near Resident #2's bed and 64.5 degrees F next to the air conditioning vent above the doorway. Residents #1 and #2 both stated they felt better and more comfortable, and they were satisfied with the temperature of the room. In an interview with the Admin. on 9/6/2025 at 3:25 PM, she stated she was unaware of the ongoing discomfort of Residents #1 and #2 with the temperature in the room. She was not sure how the residents obtained the fans in their room. She stated the potential harm to residents who had an uncomfortable temperature in their rooms was discomfort. Record review of the facility policy titled Dignity: Residents' Right for revised 6/2019, reflected the following: 7) Create a home-like environment for the resident that includes .e. proper temperature and ventilation.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was stored in accordance with professional food standards for food service safety for 1 of 2 residents (Resident #1) reviewed for food storage. The facility failed to ensure Resident #1's personal refrigerator was maintained at proper temperature and the food was dated and labeled appropriately for September 2025. This failure could lead to food-borne illness and decreased quality life of residents. Findings included:Record review of Resident #1's face sheet dated 9/6/2025 reflected a [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included schizophrenia (a mental health disorder in which a person has difficulty distinguishing their own thoughts/delusions from reality), depression, and generalized anxiety disorder. Record review of Resident #1's admission MDS, submitted 8/14/2025, reflected a BIMS score of 15, indicating intact cognition. In an observation and interview on 9/6/2025 at 9:55 AM, Resident #1 was observed to have a small, personal refrigerator in her room containing several items of fruit, open containers of ketchup and mayonnaise, and a partially empty container of lunch meat. All items felt warm to the touch. The temperature of the refrigerator was recorded as 75.3 degrees F. Resident #1 stated someone used to check the temperature of the refrigerator, but it had not been checked lately and did not contain a thermometer. She stated her family had visited recently and provided groceries. She denied any gastro-intestinal illness related to food intake. In an observation and interview on 9/6/2025 at 1:17 PM, the ADON stated the night nursing staff was responsible for monitoring the temperature logs of residents' personal refrigerators. A binder containing the temperature logs was observed, but it did not contain a temperature log of Resident #1's refrigerator for September 2025. She was unsure of the facility's policy regarding labeling and dating the food contained in residents' personal fridges. She said the staff will clean the personal refrigerators approximately once a week to ensure there is no expired food inside. In an interview with the Admin on 9/6/2025 at 3:25 PM, she stated she was the person responsible for the temperature log of Resident #1's personal refrigerator as she was the Resident Ambassador for the room. She stated she had not performed a check of Resident #1's refrigerator temperature in September. She was unsure what the proper range was for food storage. She was unsure of the facility policy regarding food labeling/dating for personal food. She reported the potential harm to residents of having improperly stored food was sickness. Record review of the facility policy titled Resident Refrigerators revised 9/2024, reflected the following: All food items must be labeled with the resident's name and date of placement.Perishable items must be discarded after 3 days unless otherwise directed by dietary services.Temperature must be maintained at or below 41 degrees F.