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	12/31/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 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 interviews and record reviews the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources, are reported immediately but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency in accordance with State law through established procedures for 1 of 5 residents (Resident #1) reviewed for abuse, neglect and exploitation.The facility administrator failed to report to a law enforcement entity or the State Agency of an allegation of misappropriation when a former employee used the [store] account containing Resident #1's debit card information for personal use. This failure had the potential to affect the residents in the facility by placing them at further risk of exploitation and/or misappropriation of resident funds.Record review of Resident #1's admission Record revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included necrotizing fasciitis of the abdominal wall (a bacterial infection destroying skin, fat, and fascia, often from issues like perforated organs or gastrostomy sites), Type 2 diabetes mellitus with diabetic neuropathy (high blood sugar has damaged peripheral nerves, commonly starting in feet/hands with numbness, tingling, burning or pain), major depressive disorder (a serious mood disorder causing persistent sadness, loss of interest, and impacts feelings) and fibromyalgia (a chronic disorder causing widespread musculoskeletal pain, fatigue, sleep problems, and cognitive difficulties). Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating resident was cognitively intact. Record review of Facility Grievance Log on 12/30/25 revealed a concern brought to the charge nurse by Resident #1 about her bank account missing over $300. Resident #1 was directed by the charge nurse to consult the Business Office Manager and Administrator who then conducted an investigation. Record review on 12/30/2025 of document authored by the BOM stated she was contacted by the local bank regarding disputed charges on Resident #1's debit card. It stated, The bank gave me, with Resident #1's permission, the attached documents showing that the disputed items were purchased by A, an ex-employee at [this facility.] The items were then shipped to A's home address. Record review on 12/30/2025 of grievance log showed a list of the disputed items was attached to the Grievance Report and revealed over $312.94 worth of items purchased through the [store] app with the shipping address of ex-employee, A. An interview was conducted with the DON on 12/30/25 at 3:30 pm since the Administrator who conducted the investigation was no longer employed. The DON stated that the Administrator had told her that since the amount was only around $300 and the bank had replaced the money and canceled her debit card, they did not have to report the incident to State and did not call the police. During an interview with the current Administrator on 12/30/25 at 3:50 pm, who had only been in the facility for a week, the Administrator agreed the incident should have been reported since there was no regulation about the amount of money taken or whether the bank refunded the money. During an interview with Resident #1 on 12/31/25 at 10:30 am, resident stated she felt the previous employee had made an honest mistake and accidentally used the card. Resident #1 stated that when she first arrived at the facility, she did not have any clothes and only had the facility hospital gowns to wear. Resident #1 gave her debit card to the employee and asked her to order some clothes for her which was done. Employee A left employment on 08/05/25 and the disputed charges were made in October and November of this year. During a phone interview on 12/31/25 at 11:17 am with ex-employee, A, she stated she was not aware that Resident #1's card was still being used. Ex-employee, A, acknowledged Resident #1 had given her a debit card to purchase clothes when Resident #1 first arrived and due to Resident #1's size it was difficult to find the correct sized clothes locally. Ex-employee, A, stated that she used her family card for herself and the last 4 numbers are similar to Resident #1's card. She stated this was a total accident and said she would call the BOM to see what she needed to do. Record review of Tulip reporting system on 12/30/2025 revealed no self reported incidents related to Resident # 1's misappropriated money was called in. Record review on 12/31/2025 of the facility policy and procedures titled Abuse, Neglect, and Exploitation (ANE) Prohibition dated 10/24 stated:The Nursing Facility strictly prohibits abuse, neglect, exploitation, or any mistreatment or residents by anyone at the Facility, including: staff, residents, volunteers, visitors, and others. Reporting and Response:Do Report: an incident that does not result in serious bodily injury but that involves any of the