STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455699	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at the Creek	1405 Valhalla Dr Wharton, TX 77488

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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 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, interview, and record review, the facility failed to ensure that each resident received adequate supervision to prevent and accidents for one (Resident # 1) of 5 residents reviewed for supervision. The facility failed to provide adequate supervision to Resident # 1 to prevent injury of unknown origin (a physical injury where the cause or source is not known, or could not be explained, and raises suspicion of abuse or neglect due to the injury's size, location, or circumstances) which resulted in Resident # 1, who is totally dependent on staff for care, having a mildly displaced fracture of the fourth proximal phalanx (the bone closest to the base of a finger) on 5/7/2025 when a family member visited and noted a swollen finger. Resident # 1 did not leave the facility on an outing and only facility staff provided care to Resident # 1. This deficient practice has the potential to affect all residents in the building by causing resident injuries, such as fractures, falls, and even death due to improper supervision. Findings include: Record review of Resident # 1's face sheet, dated 5/13/2025, revealed a [AGE] year-old male who admitted to the facility on [DATE] (original admission date 9/11/2021) with diagnosies: Toxic Encephalopathy (a condition where brain dysfunction occurs due to exposure to toxic substances), Acute Respiratory Failure with Hypoxia (a condition where the lungs fail to adequately deliver oxygen to the blood), Dementia with Psychotic Disturbance (involves the presence of psychotic features like hallucinations and delusions alongside the cognitive decline of dementia),Chronic Obstructive Pulmonary Disease (a group of lung diseases that cause ongoing inflammation and damage to the airways and lungs), Cerebral Infarction (a condition where blood flow to the brain is interrupted, causing brain tissue damage), Sepsis (a life-threatening medical emergency that occurs when the body's response to an infection harms its own tissues and organs), Mood affective Disorder (mental health conditions characterized by persistent or severe disruptions in emotional state), Muscle Wasting and Atrophy (refers to the decrease in size and weakening of muscle tissue), (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	Record review of Resident # 1's Quarterly MDS , dated 4/15/2025, revealed unclear speech, the resident was rarely/never understood, had severely impaired cognition, no response to resident mood interview questions, behavior not exhibited (physical behaviors, directed towards others, verbal, behavioral symptoms directed to others or other behavioral symptoms not directed towards others, no rejection of care, no wandering, no impairment (upper and lower extremities), mobility device wheelchair (manual or electric), total dependence on all ADL's, total dependence on transfer, always incontinent of both bladder and bowel, medically complexed conditions, and non-traumatic brain dysfunction. Record review of Resident # 1's Care Plan, dated 5/13/2025, revealed: ADL Self Care Deficits, date initiated 3/19/2022: Focus-ADL self-care deficits and is at risk for further decline in ADL functioning and injury. Diagnosis: Dementia CVA. Goal: Resident # 1 will be well dressed, groomed, clean, dignity will be maintained and will have no further decline in ADL functioning or injury over the next 90 day-target date 4/28/2025. Interventions/Tasks-provide extensive assistance of (#1-2- of support persons) for transfers, upper/lower body dressing and bed mobility Mood/Behavior, date initiated 7/28/2022 with target date 4/28/2025: Focus: Resident # 1 has a history of alteration in mood or exhibition of behavioral symptoms: Alzheimer's/Dementia's, Anxiety. Resident # 1 is resistive to care and combative with staff and verbally aggressive at times. Goal: Resident # 1 will be met and will be kept clean, dry, and well-groomed daily within the next review date. Resident # 1 dignity will be preserved, quality of life improved by minimizing the risk of agitation, inappropriate behaviors unmet needs and inappropriate behavioral symptoms will be minimized through the next review period. Goal: Allow resident time to calm down and reapproach later, interact in an empathetic and supportive manner. Communication, date initiated 7/28/2022, Focus: Resident # 1 has impaired communication and is at risk for further declined and injury AEB; Minimal difficulty, Rarely/never understood. Sometimes understands others. Goal with target date 4/28/2025: staff will anticipate and meet needs Resident # 1 is not able to effectively communicate over the next 90 days. Interventions/Tasks: Allow time for resident to digest information-do not rush, anticipate and meet all needs every shift, approach in calm manner using eye contact-call resident by name, and use calm clear voice. Use calm clear voice, use simple/direct communication and repeat as necessary (date initiated 12/6/2022). Safety, date initiated 8/14/2024, Focus: Resident # 1 had an actual fall on 8/14/2024 with no injury r/t /Gait/balance problems. Resident # 1 had an actual fall on 8/14/2024 with no injury r/t. Gait/balance problems. Goal with target date 4/28/2025: Resident # 1 will be free from fall through the review date. Interventions/Tasks: 8/14/2024: head to toe assessment completed, no injury, no signs, or symptoms of pain. NP and DON notified. Left message for representative. Neuro checks in progress. Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Fall facility fall protocol. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident # 1's Psychiatry Progress Notes completed by NP B, dated 5/5/2025, revealed [Resident # 1] was dependent for all activities of daily living. [Resident # 1] was seen in the hallway sitting in wheelchair in no apparent distress; awake. Tone: mildly increased tone was noted to right biceps and right forearm muscles specifically, otherwise tone is normal as well in upper and lower body extremities. [Resident # 1] did not have functional ROM in bilateral (pertaining to, involving, or affecting two or both sides) UE or BLE. [Resident # 1] left elbow is limited to about 40 degrees of extension degrees of extension by contracture. His Right elbow can be moved through full ROM, flexion, and extension with passive ROM. All exams were done passive ROM as patient would not follow commands Record review of Resident # 1's Nursing notes, dated 5/7/2025 at 10:55 am, revealed Resident # 1 [Family Member A]was in the facility and brought Resident # 1 to the nurse's station and stated that Resident # 1's fourth right finger was swollen, upon observation noted residents finger with swelling and turning outwards, noted during touch, noted with facial grimacing, received new order for Tylenol 325 mg t tabs tid for 7 days and stat Xray, Family Member A stated no I am taking him to the er. Record review of Resident # 1's Nursing notes, dated 5/7/2025 at 6:40 pm revealed The resident returned from a local hospital. Xray findings revealed a mildly displaced fracture of the fourth proximal phalanx with no evidence of dislocation. There is a adjacent soft tissue swelling and joint space narrowing in the interphalangeal (a hinge joint located between two adjacent phalanges, the bones of the fingers) joints. The NP was notified, and no new orders were given. Impression: Mildly displaced fracture of the fourth proximal phalanx. Osteoarthritis of the hand. Record review of Resident #'1's physician's notes signed by NP A, dated 5/8/2025, revealed [Resident # 1] was a [AGE] year-old male with a PMH of CVA, dementia without behavioral disturbances, impulsiveness, hyperlipidemia, HTN, and anxiety. [Resident # 1]is a long-term resident at a NF. Saw patient for ER follow up for mildly displaced fracture of the right fourth proximal phalanx, patient sitting up in long back wheelchair by dining room; alert, eyes open, but not attempting verbalization; keeps eyes contact; no new behavior changes. Current vital signs stable; BP stable, needs total assist with ADL's; limited movements; incontinent; uses wheelchair assistance; occasional resistance to care, frequently redirected by staff each episode, startles easily, incontinent to bowel and bladder. Needs moderate assist with ADL's. Review of Systems: poor historian, denies any complaints; limited verbalization; unable to assess much; reports from staff reports, records, and observation. Musculoskeletal: generalized limitation of range of motion, no paresthesia's, or numbness. No signs of pain noted to right hand. Plan: all above diagnosis reviewed continue current care, medications reviewed and reconciled. Pain management and follow up plan discussed with patient and staff. Assessments:1) Displaced fracture of distal phalanx of right ring finger, subsequent encounter for fracture with routine healing, 2) Unspecified dementia with behavioral disturbance, 3) Personal history of transient ischemic attack and cerebral infarction without residual deficits, and 4) anxiety disorder. Record review of Resident # 1's hospital Radiology report, dated 5/7/2025, revealed Study- 3 views of the right hand. Findings: mildly displaced fracture of the fourth proximal phalanx. No evidence of dislocation. Adjacent soft tissue swelling. Joint Space narrowing of the interphalangeal joints. Impression: 1) Mildly displaced fracture of the fourth proximal thighs and 2) Osteoarthritis of the hand. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident # 1's hospital records, dated 5/7/2025, in part revealed [Resident # 1] presented to a local hospital on 5/7/2025 at 12:19 pm. History of Present Illness-chief complaint (including nature, duration, location, onset, progression of symptoms): [AGE] year-old male presents to the ED with [family member] for a chief complaint of right-hand 4th digit pain and swelling. Family Member A states she picked him up from nursing home and asked nursing home if patient had a fall. Patient denies fall but states someone hurt him. Resident told Family Member A someone hit him. Review of Systems- Musculoskeletal: System is negative; positive for Arthralgias (pain in one or more joints); negative for back pain, negative for gait problem, negative for joint swelling; positive for Myalgias(muscle pain or soreness); negative for neck pain. Physical Examination: musculoskeletal -4th digit spiral fracture(a type of bone break that occurs when a twisting force is applied to a long bone, often resulting in a break that winds around the bone). Constitutional-Musculoskeletal upper extremities abnormal: right hand tenderness; right deformity of wrist/hand is noted; right wrist/hand triggering. Imaging-independent interpretation shows Xray mildly displaced fracture. Final diagnosis- right finger fracture 4th digit. Record review of the Nursing Facilities policies and procedures on Abuse, Neglect, and Exploitaion, revised 10/24, read in part The Nursing Facility strictly p prohibits abuse, neglect, exploitation or any mistreatment of residents by anyone at the Facility, including staff, residents, volunteers, visitors, and others. This policy includes 7 key components: Screening, Training Prevention, Identification, Investigation, Protection and Reporting/Response. The Administrator or appointed designee serves at the ANE Prohibition Coordinator overseeing the policy and investigations. Interview with hospital staff on 5/13/2025 at 9:00 am, revealed that Resident # 1 was admitted with a swollen finger on right hand. Resident # 1 was found to have spiral fracture and Resident # 1 was unable to state what happened. She stated that Resident # 1 was transported to the emergency room from the nursing facility with a swollen finger on the right hand. She stated that Resident # 1 was found to have a spiral fracture. Interview with Family Member A on 5/13/2025 at 10:30 am she stated that she visited Resident # 1 at the nursing facility on 5/7/2025 at approximately 10:40 am. She stated that she noticed that Resident # 1's right hand was swollen, and it was green. She stated she asked staff at the nursing facility what happened, and no one could tell her what happened. She stated that she drove Resident # 1 to the hospital. She stated that she was told by the hospital staff that Resident # 1 had a spiral fracture. She stated that the physician at the hospital informed her that the type of injury was consistent with someone twisting the resident's finger. She stated that Resident # 1 was total care, and he needed total assistance from the nursing facility staff. She stated that she's concerned that staff did not observe that her Resident # 1's right hand was swollen, and his middle finger was dislocated. She stated that staff provided ADL's that morning and no one noticed anything. Interview with MA A on 5/13/2025 at 12:58 pm she stated on 05/07/25 she administered medication to Resident # 1. She stated she did not know the time. She stated that prior to administering Resident # 1 his medication he checked Resident #1's blood pressure. She stated that Resident # 1's blood pressure was taken on the left hand. She stated that Resident # 1's right hand was not swollen. MA A stated that she crushed Resident # 1's medication and she administered the medication to Resident # 1. MA stated that Resident # 1 is total care and a 2 person assist. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with LVN A on 5/13/2025 at 1:35 pm she stated that Resident #1 was a two-person transfer and total care. She stated she observed Resident # 1 on 5/7/2025 at approximately 6:30 am while making morning rounds. She stated that Resident # 1 was lying in bed and alert, and she did not observe anything wrong with his hands. She stated that she was made aware of Resident # 1's swollen hand when Resident #1's family member mentioned that Resident # 1's hand was swollen on 5/7/2025. She stated she did not know the exact time. She stated that she assessed Resident # 1's right hand. She stated that Resident # 1's hand was swollen. She stated that she did not observe Resident # 1's hand was not discolored or dislocated. She stated that she contacted Resident # 1's NP. She stated that the NP ordered an Xray and Tylenol as needed. She stated that Family Member A stated she did not want to wait for an Xray. She stated Family Member A transported Resident # 1 to the emergency room. She stated that two CNAs assisted with putting Resident # 1 in Family Member A's vehicle. LVN A stated she did not know what how Resident # 1's hand was injured. LVN A stated that Resident # 1's hand possibly was injured while been transferred. She stated that Resident #1 returned from the hospital on 5/7/2025 and he had a splint on his right finger. She stated that Resident # 1 diagnosis was mildly displaced fracture and Osteoarthritis (a degenerative joint disease where the cartilage that cushions the ends of bones in joints wears away over time). Interview with CNA B on 5/13/2025 at 1:57 pm she stated that Resident # 1 is a total care and a 2 person assist. She stated that on 5/7/2025 in the morning she assisted CNA A. She stated that when she arrived Resident # 1 was lying in bed and she assisted CNA A with sitting Resident # 1 up in the bed and transferring Resident # 1 from the bed to the wheelchair. She stated that CNA A was Resident # 1 assigned caregiver. She stated that when she arrived at Resident # 1's room he was dressed and dry. She stated that at the time of the transfer Resident # 1's hand was not swollen. She stated that CNA A rolled Resident # 1 to the dining room in his wheelchair. CNA A stated she was at the nurse's station on 5/7/2025 when Family Member A brought Resident # 1 to the nurse's station and stated that Resident # 1's hand was swollen. CNA B stated that Resident # 1's hand did not hit anything while he was lying in bed. She stated that Resident # 1's hand did not hit anything while being transferred to his wheelchair. CNA B stated that Resident # 1 is total care and a 2 person assist. CNA stated that Resident #1 was compliant with care when she assisted. Interview with CNA A on 5/13/2025 at 2:10 pm she stated she provided care to Resident # 1 on 5/7/2025. CNA A stated that on 5/7/2025 she began her rounds at 6:00 am. She stated that she checked all residents. CNA A stated that once she made her initial rounds she started getting the residents up for breakfast. She stated that on 5/7/2025 she dressed Resident # 1. She stated that she did not change Resident # 1's brief as he was dry. CNA A stated that CNA B assisted with sitting Resident # 1 up in the bed. She stated that CNA B assisted with transferring Resident # 1 to the wheelchair. She stated that she transferred Resident # 1 to the dining area. She stated that Resident # 1's hand was not swollen. CNA A stated she did not know how Resident # 1's hand was injured. She stated while transferring Resident # 1 he did not injure his hand. She denied Resident #'1 hand being caught in the wheelchair wheel while be transported to the dining area. She stated that she was made aware of Resident #1's hand injury when Family Member A brought it to staff attention. She stated that Resident # 1's hand looked normal. She stated that Resident # 1 has arthritis. CNA A stated that she did not shower Resident # 1 as he was bed B and showers were on Tuesday, Thursday, and Saturday. She stated that Resident # 1 was showered on the 5/6/2025 on the second shift. CNA stated that Resident # 1 is total care and a 2 person assist. She stated that Resident # 1 was compliant with care when she assisted on 5/13/2025. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with CNA C on 5/13/2025 at 2:30 pm she stated that Resident # 1 is total care. She stated that on 5/7/2025 she did not provide direct care to Resident # 1. She stated that Resident # 1's hand was swollen, and Family Member A wanted to take him to the hospital. She stated that she assisted CNA A with transferring Resident # 1 to the car. She stated that she did not notice anything wrong with his hands. She stated that she worked with Resident # 1 last week. She stated that when transferring Resident # 1 from wheelchair to bed and vice versa he will attempt to grab staff. She stated that Resident # 1 has a strong grip. CNA C stated Resident # 1 is total care and a 2 person assist. She stated Resident # 1 was compliant when she assisted with transferring him to the car. Interview with NP B on 5/13/2025 at 3:00 pm he stated that he is Resident # 1's NP. He stated he was not aware that Resident # 1 was injured. He stated that he was made aware that Resident # 1's was injured on 5/13/2025 while reviewing Resident # 1's chart. NP B stated that nursing facility most likely contacted NP A as NP A is the consulting NP. NP B stated he is not the consulting NP. NP B stated that Resident # 1 is total care, and he has Dementia. He stated that he visited with Resident # 1 on 5/5/2025 and at the time of this visit there were no noted concerns. He stated that Resident # 1's hands were not swollen. NP B stated that Resident # 1's finger fracture most likely caused from him rolling in the bed because Resident # 1 had poor functional ability of the upper extremities. He is very weak in the upper extremities. He stated that he did not have any evidence that Resident # 1 fell. Interview with NP A on 5/13/2025 at 3:10 pm he stated that on 5/7/2025 he was contacted by the nurse at the nursing facility. He stated that the nurse reported that Resident # 1 had swelling to his right hand. He stated that he ordered an Xray and Tylenol as needed for pain. He stated that later the nurse called and stated that Family Member A did not want to have the Xray at the nursing facility and Family Member A was taking Resident # 1 to the emergency room. NP A stated that Resident # 1 has a diagnosis of Dementia, CVA and Arthritis. He stated that Resident # 1 is total care for ADL's and transferring. He stated that he does not know who Resident # 1 injured his hand. He stated that Resident # 1 hand may have been injured during transfer. NP A stated that Resident # 1 was discharged from the emergency room on 5/7/2025 and was diagnosed with mildly displaced fracture of the right fourth proximal phalanx. NP A stated that he completed his weekly wound and follow up ER visit with Resident # 1 on 5/8/2025. He stated that Resident # 1 has a splint on the fourth phalanx. He stated that Resident # 1 fourth phalanx was swollen and little deviated. He stated that Resident # 1 will remain in the splint. He stated that he ordered Tylenol as needed for pain. Interview with DON on 5/13/2025 at 5:16 pm he stated that Resident # 1 is basically total care for the most part and need assistance with everything. He stated that Resident # 1's finger was fractured. He stated that Resident # 1's finger may have gotten fractured as a result of being caught in a wheelchair or bumped into a door. The DON stated he did not know how Resident # 1's finger was injured. He stated that Resident # 1's Xray displayed that Resident # 1 had a displaced fracture. The DON stated that the hospital reported that Resident # 1 had a spiral finger fracture; however, the hospital Xray revealed Resident # 1 had a displaced finger fracture and not a spiral fracture. The DON stated that a spiral fracture is when the circle around the bone is broken. He stated that this would happen if someone twisted the finger. The DON stated that in the past Resident # 1 had a history of combative behavior. The DON stated that Resident # 1's combative behavior has toned down. On 5/13/2025 at 5:30 pm attempted to contact the hospital physician. The hospital physician was not available. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview with the Administrator on 5/13/2025 at 6:30 pm she stated she learned of Resident # 1's hand injury on 5/7/2025. She stated on 5/7/2025 Family Member A informed LVN A that Resident # 1's hand was swollen. She stated that LVN A assessed Resident # 1 hand and she contacted NP A. She stated that NP A ordered an Xray of Resident # 1 hand. She stated that Family Member A wanted to take Resident # 1 to the emergency room. She stated that Family Member A took Resident # 1 to the emergency room. She stated that Resident # 1 was a 2-person transfer/lift. The Administrator stated she did not know how Resident # 1 hand was injured. She stated that perhaps when staff was moving or pushing Resident # 1 in the wheelchair his hand got caught in the wheel without staff realizing it. Observation on 5/14/2025 at 1:30 pm revealed Resident # 1 lying in bed. Resident # 1 is non-verbal. Resident # 1 had a splint on his finger.