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	08/04/2025

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

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (CR#1) of 6 residents reviewed for comprehensive care in that:-The facility failed to ensure CR#1's care plan interventions had not been updated since 2024 despite recent falls including falls with injury. CR#1 had unwitnessed falls on 07/08/25 and another on 07/10/25. CR#1 was transported to the hospital where she was diagnosed with rib fractures and had a chest tube placed.An Immediate Jeopardy (IJ) situation was identified on 8/1/2025 at 3:30pm. While the IJ was removed on 8/4/2025 at 6:45pm, the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of not having their individual medical, psychological and/or emotional needs met. Findings Included: Record review of CR#1's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. CR#1 had diagnoses which included unspecified psychosis (a mental disorder characterized by a disconnection from reality), insomnia (persistent problems falling and staying asleep), dementia mild with agitation (agitation in dementia refers to a range of behaviors and sometimes aggression by individuals with cognitive decline), cerebral infarction due to embolism (occurs when blood flow to the brain is blocked, causing brain tissue to die) and brief psychotic disorder (a short-term psychotic condition that involves the sudden onset of at least positive psychotic symptom for more than a day but less than a month). Record review CR#1's quarterly MDS, dated [DATE], revealed:Section C500- Brief Interview of Mental Status was coded as 3, which represented severe cognitive impairment.Section GG- Functional Abilities revealed:Mobility devices was coded as Z. NoneGG0130- C. Toileting, E. shower/bath were coded as (3) for partial moderate assistance needed. Upper and lower dressing was coded as (5)- which required setup assistance. Record review of CR#1's care plan, dated 3/23/2024, revealed: Focus: CR#1 has had an actual fall with minor injury. 4/17/24- unwitnessed fall in room-bump on left side of head raised area with bruising.6/18/25: CR#1 found on the floor in her room. Date Initiated: 03/23/2024Goal: CR#1 will be free from further falls and injuries over the next 90 days. Date Initiated: 04/17/2024Target Date: 07/01/2025Interventions: 6/18/25: Head to toe assessment completed, noted bleeding from forehead. NP andDON notified. Transferred to ER for evaluation. Date Initiated: 06/18/2025 Check range of motion twice times daily.Date Initiated: 04/12/2024 Continue interventions on the at-risk plan.Date Initiated: 04/12/2024 Floor mat in place at bedsideDate Initiated: 03/23/2024 For no apparent acute injury, determine and address causative factors of the fall.Date Initiated: 04/12/2024 MD to review for sleep aide 6/18/25Date Initiated: 06/18/2025 Monitor for pain and report to MD if pain is noted.Date Initiated: 05/04/2024 Record review of fall assessments revealed:6/18/2025- Score of 20, she was deemed high risk7/10/2025- Score of 11, she was deemed high risk .Record review of nursing progress note dated 6/18/2025 revealed CR#1 was found in her room bleeding from laceration to left eye. CR#1 was sent out to emergency room due to unwitnessed fall and returned the same day with no new orders.Record review of nursing progress note dated 7/8/2025 revealed RN D noted CR#1 had bruising to her left flank. She was assessed and determined from her grimacing she had pain. SBAR was completed due to the change in condition, PRN Tylenol given, NP and RP notified. Record review of nursing progress note dated 7/10/2025 revealed during room checks CR#1 was heard yelling. Upon entrance CR#1 stated, I fell ma'am. Full assessment, vitals taken, PCP and RP notified. PCP instructed nurse to send CR#1 to ER. Bed was observed to be locked in lowered position, call bell in reach and monitored until EMS arrived.Record review of CR#1's hospital record dated 7/11/2025 revealed she was diagnosed with bruising in various stages, fractures on the left 6th-8th ribs, a mildly displaced fracture to the T11-L-1, and left side pneumothorax with chest tube placed.An observation and interview on 7/14/25 at 11:02 AM, with CR#1 revealed the resident had a sitter provided by the hospital who stated CR#1 was trying to get out of bed and she pulled her chest tube out that was why she was sitting with her. She said someone was sitting with her everyday due to behaviors like trying to get out of bed and yelling. CR#1 was observed with a dark purplish bruise to her left eye. She was asked what happened. She responded she was walking through the door and hit her eye. CR#1 was not interview able. An interview with CR#1's RP on 7/11/2025 at 3:50 PM, she said she was called and told CR#1 must have had a fall and was found with a bloody eye