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	05/06/2026

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 0689 Level of Harm - Minimal harm or potential for 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 each resident's environment remained free of accident hazards for 1 of 6 residents (Resident #2) reviewed for accident hazards.The facility failed to ensure Resident #2 had an adequate assistance device in that his wheelchair brake was inoperable, resulting in a fall on 3/10/26. Resident #2 had been using the wheelchair between 3/10/26 and 5/6/26. This failure could place residents at risk for falls, pain and injuries. Findings included:Record review of Resident #2's admission Record generated on 5/6/26 revealed he was admitted to the facility on [DATE] with diagnosis of osteomyelitis (serious infection of the bone, causing inflammation and pain, often triggered by bacteria or fungi. He was [AGE] years old. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 12, indicating he had moderate cognitive impairment. He used a wheelchair for mobility and required substantial/maximal assistance for chair/bed-to-chair transfers. He weighed 282 pounds. The MDS indicated he did not experience any falls since admission to the facility. Record review of Resident #2's care plan dated 12/5/25 indicated he was at risk for falls and injuries. Interventions included anticipating the resident's needs, encouraging the resident to ask for assistance of staff, encouraging resident to lock wheels prior to transfers and keep frequently used items at the resident's bedside. Record review of Resident #2's nurse progress note dated 3/10/26 at 3:45pm completed by LVN E, it read, cna called for nurse stated (sic) resident on the floor, upon observation noted resident lying on right side in between bed and w/c. resident stated that he was trying to get in bed by himself and the w/c slid from under him and he fell. rom performed to all extremities, no c/o pain or discomfort noted, no visible injuries noted, assisted resident to bed with use of [mechanical] lift and staff x4. Record review of Resident #2's Form Summary Progress Note dated 3/12/26 at 9:18am, the DON documented that an interdisciplinary review of the fall, including circumstances and environmental factors, was completed. The summary stated he was transferring to bed without assistance and there were no environmental or situational factors that contributed to the fall. Educated resident on calling for assistance when transferring- he states he will. In an observation and interview on 5/6/26 at 2:15pm, Resident #2 stated he fell once while self-transferring to his wheelchair from his bed. He said that he did not like his wheelchair because the brakes did not work. He said the wheelchair moved back during the transfer and he fell to the floor hitting his bottom and back, with no injuries or pain. He said the facility staff ordered a wheelchair for him but it was not here yet. He admitted that he transferred himself when he should have asked for staff assistance. Surveyor looked at his wheelchair located next to his bed and observed that the left brake was loose and did not lock the tire. The wheelchair was easily pushed back. In an interview on 5/6/26 at 3:25pm, the Director of Rehabilitation said she attended post-fall IDT meetings where they discussed fall circumstances and look at what they could do to prevent future falls. She said after Resident #2's fall, they evaluated his mattress to see if there were any issues. She said his wheelchair had a broken brake. She said the maintenance staff tried to fix it but was unsuccessful. She said before Resident #2 fell, he complained that his wheelchair was not large enough and had pain in the groin area, so they ordered him a 22-inch chair, but it had not (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 - Minimal harm or potential for actual harm Residents Affected - Few	arrived. She said there was no risk to using a chair with a broken brake because Resident #2 knew it was broken and could not get out of bed without staff assistance. In an interview on 5/6/26 at 4:56pm, LVN E said Resident #2's fall in March 2026; he self-transferred and the resident reported his wheelchair slipped from underneath him. She said maybe it slipped due to his weight but could not remember exactly why the wheelchair slipped. In an interview on 5/6/26 at 5:12pm, the DON said in the IDT post-fall meetings, they discussed why a resident fell and implemented new interventions. After Resident #2's fall, they told him not to not transfer by himself. She stated she was aware his wheelchair's brake was broken and they ordered a new wheelchair for him. When asked if someone should use a wheelchair with a broken brake, the DON said that it was hard to answer, but she knew that Resident #2 was not going to self-transfer. Record review of the facility policy regarding Wheelchair Safety: Use and Maintenance dated 6/2019 read, The Facility promotes patient, resident and staff safety through the appropriate use and maintenance of wheelchairs. Evaluate an educate the patient/resident regarding wheelchair use and safety, including but not limited to:. accident prevention: Tipping and falling are the most common wheelchair accidents which can be caused by: e. Propelling he chair too fast. F. Improper use or failure to use brakes/wheel locking devices. Safety Tips: a. Lock brakes before getting into or out of the wheelchair. resident, patients and staff remove equipment from service that is defective or requires maintenance or repair.