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	05/22/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure each resident was free from abuse for 1 of 16 residents (Resident #1) reviewed for abuse. Resident #2 was physically abusive to Resident #1 on 3/5/26 when he punched her with a closed fist in the head after which Resident #1 was observed crying and upset. The noncompliance was identified as past noncompliance (PNC). The noncompliance began on 3/5/26 and ended on 3/6/26. The facility corrected the noncompliance before the survey began. These failures placed residents, who resided in the facility, at risk of abuse, pain and emotional distress. The findings included: Resident #1 Record review of Resident #1's admission Record generated on 5/22/26 revealed she was admitted to the facility on [DATE] and had diagnoses of dementia (an umbrella term for a decline in mental ability-such as memory, thinking, and reasoning-severe enough to interfere with daily life), schizophrenia (a chronic brain disorder that disrupts how a person interprets reality. It presents as a combination of hallucinations, delusions, and disorganized thinking), Parkinson's disease (develops when brain cells responsible for producing dopamine die, leading to tremors, muscle stiffness, slow movement, and balance issues) and type II diabetes type (a chronic condition where your body becomes resistant to insulin or cannot produce enough of it). She was [AGE] years old. Record review of Resident #1's annual MDS assessment dated [DATE] revealed she had a BIMS of 7, indicating she had severe cognitive impairment. The assessment indicated that she used a wheelchair for mobility. Record review of Resident #1's Change of Condition progress note dated 3/5/26 revealed Resident #1 was hit by a fist on the right posterior (back or rear) side of her head. Record review of Resident #1's Nursing Note dated 3/5/26 at 1:34pm, LVN A documented that she asked Resident #1 what happened and she said, he was trying to get my coffee, and he hit me in the head ma. LVN A assessed the resident and determined there were no visible injuries and gave Resident #1 two tablets of Tylenol 325mg for pain rated at a 4 .on a numerical scale. The resident was sent to the emergency room for evaluation. Record review of Resident #1's acute hospital records dated 3/5/26 revealed she arrived to the hospital with a complaint of assault/trauma and received patient education regarding physical assault. In an observation and attempted interview on 5/20/26 at 9:45am, Resident #1 was seated in her room in a wheelchair. She could not recall being involved in an altercation with another resident. In an interview on 5/22/26 at 11:29am, when asked how Resident #1 would feel if she were hit by someone at the facility, Resident #1's family member said she would be mad if she were hit. The family member stated Resident #1 may not remember the incident but would remember the way they made her feel. The family member said Resident #1 could state if she liked another person or not. Resident #2 Record review of Resident #2's admission Record generated on 5/22/26 revealed he was admitted to the facility on [DATE] and had diagnoses of dementia with psychotic disturbance, anxiety disorder (a group of treatable mental health conditions that cause persistent, excessive fear or worry that is out of proportion to the situation), paranoid schizophrenia (a chronic mental health disorder characterized by intense paranoia, including delusions of persecution and auditory hallucinations), and schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia, (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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	like hallucinations or delusions, with a mood disorder, such as depression or bipolar disorder). He was [AGE] years old. He was discharged from the facility on 3/6/26. Record review of Resident #2's care plan dated 5/15/25 revealed he had the potential to be physically aggressive related to diagnoses of dementia and schizophrenia and had a history of being physically aggressive with other residents on 8/31/25, 9/4/25 and 2/9/25. Interventions included, administer medications as ordered. Monitor/document for side effects and effectiveness.Analyze times of day, places, circumstances, triggers and what de-escalates behavior and document. assess and address for contributing sensory deficits. assess and anticipate resident's needs. encourage activity attendance. when the resident becomes agitated: Intervene before agitation escalates, guide away from source of distress; engage calmly in conversation, if response is aggressive, staff to walk calmly away and approach later. Record review of Resident #2's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 3, indicating he had severe cognitive impairment. The assessment indicated he required supervision or touching assistance for walking and transfers from chair/bed-to-chair and did not use a mobility device. Record review of Resident #2's Change of Condition progress note dated 3/5/26 at 1:07pm, LVN A documented the following: Resident sitting at table stated, ?she tried to seal (sic) my coffee; she is a liar and a thief.' When this nurse asked him what happen (sic), and what was wrong. (sic) Resident asked if he wanted to leave the dining room, he stated ?no.' Nurse redirected resident accepted redirect (sic) and is calm at this time. Other resident involved already moved from altercation prior to nurse entering the unit. Record review of Resident #2's nurse progress note dated 3/6/26 at 10:07am revealed LVN B documented that the DON and Administrator informed the nurse to send resident to the emergency room for further evaluation due to recent physical aggression and increased behaviors. Record review of the Provider Investigation Report dated 3/12/26, under Investigation Summary, it was determined that Resident #2 and another resident were arguing and the Activity Assistant redirected the other resident to his room. Resident #2 turned to Resident #1 and tried to grab her coffee, then Resident #2 grabbed Resident #1's hair. In an interview on 5/22/26 at 9:55am, the Activity Assistant stated on the day of the incident between Resident #1 and Resident #2, Resident #2 was fussing with Resident #3 verbally in the dining room in the memory care unit. She said she removed Resident #3 from the room. She said she could not remember what she saw when she returned to the dining room and said the incident had already happened. She said CNA B was in the dining room when she left. In an interview on 5/22/26 at 10:02am, CNA A said she did not see the incident between Resident #1 and Resident #2, but she was present in the memory care unit. She said after the altercation, Resident #1 was crying and upset and said she was going to file charges. In an interview on 5/22/26 at 10:10am, CNA B, when asked about the incident between Resident #1 and Resident #2, she said she was in the dining room in the mc unit and saw Resident #2 trying to fight with Resident #3 and they were swinging at each other. She said the Activity Director removed Resident #3 from the room. CNA B said, all of a sudden, (Resident #2) went over there and hit (Resident #1). She said she heard Resident #2 hollering, and she ran over to them and that is when Resident #2 hit Resident #1 with a closed fist to the side of her head. She said she removed Resident #2 from the room and reported it to the DON and Administrator. She said Resident #1 was crying. Record review of the facility policy and procedure regarding Abuse, Neglect and Exploitation Prohibition dated 4/2024 stated, The Nursing Facility strictly prohibits abuse, neglect, exploitation, or any mistreatment of residents by anyone at the Facility, including: staff, residents, volunteers, visitors, and others. The facility took the following action to correct the non-compliance on 3/6/26: Record review of Resident #2's progress note dated 3/6/26 at 11:27am revealed Resident #2 returned from the acute care hospital and was placed on one-on-one supervision (continuous patient observation to ensure the safety of at-risk individuals) and behavioral monitoring. Record review of Resident #2's progress note dated 3/6/26 at 2:30pm revealed Resident #2 was accepted to a local behavioral hospital and left the facility using the facility's transportation van. Record review of Resident #2's progress note dated 3/6/26 at 4:42pm revealed Social Services Personnel spoke to (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #2's responsible party about resident's behavior and 30-day discharge notice. Record review of an Education In-service Attendance Record dated 3/5/26 revealed nursing facility staff were educated on the topic of abuse, neglect, resident-to-resident altercations and behavioral support. Interviews with facility staff, including CNA C, CNA D, CNA E, CNA F, LVN B, Activity Assistant, Staffing Coordinator, and LVN C between 5/20/26 and 5/22/26 revealed they could state what to do if they became aware of an allegation of abuse, neglect and resident-to-resident altercations.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on interviews and record reviews, the facility failed to have evidence that the alleged violation was thoroughly investigated in response to allegations of abuse or neglect for 7 of 16 residents reviewed for freedom from abuse and neglect (Residents #1, #4, #5, #6, #7, #9, and #11). The Administrator failed to have evidence that an alleged violation of an injury of unknown origin was thoroughly investigated and included witness statements from staff members when Resident #4 was found to have a fractured toe on 2/26/26. The Administrator failed to have evidence that an alleged violation of abuse was thoroughly investigated and included witness statements from staff members when Resident #1 was hit in the head by Resident #2 on 3/5/26. The Administrator failed to have evidence that an alleged violation of abuse was thoroughly investigated and included witness statements from staff members when there was an allegation that Resident #5 and Resident #6 kicked each other and Resident #6 spilled coffee on Resident #5 on 3/22/26. The Administrator failed to have evidence that an alleged violation of an injury of unknown origin was thoroughly investigated and included witness statements from staff members when Resident #9 was found to have swelling and bruising to his left 4th finger on 3/25/26. An x-ray determined that he had a small bony fragment in the volar middle phalangeal base (the middle bone of your finger). The Administrator failed to have evidence that an alleged violation of abuse was thoroughly investigated and included witness statements from staff members when there was an allegation that Resident #8 hit Resident #7 in the eye on 3/26/26. The Administrator failed to have evidence that an alleged violation of abuse was thoroughly investigated and included witness statements from staff members when there was an allegation that Resident #10 scratched Resident #11 after a verbal altercation on 4/21/26. This failure could place residents at risk for further abuse and neglect and could place the residents at risk of harm. Findings included: Record review of a provider investigation report, HHSC Form 3613-A, dated 3/6/26 indicated Resident #4 had an injury of unknown origin. An assessment on 2/26/26 at 11:45am revealed Resident #4 had swelling on his toe. The Investigation Summary section stated Attach additional sheets, including but not limited to interview summaries with all parties involved in the incident, clinical records, lab and imaging reports. The section was completed and stated, This resident has serious vascular issues which have led him to have several toes amputated, one of which was done recently. Resident has no safety awareness but will propel himself around the facility at times will (sic) bump into objects, walls, and even people. Despite education and redirection resident will still be found moving about the facility. It does appear that this was accidental with the resident's feet being in a more fragile state at this time. The Investigation Findings section of the report stated unfounded. The report was signed by the Administrator. Attached to the investigation report were Resident #4's medical records but did not include any interview summaries or witness statements. Record review of a provider investigation report, HHSC Form 3613-A, dated 3/12/26 indicated on 3/4/26 at 12:50pm in the secure unit dining room, a CNA reported a resident-to-resident incident. The Alleged Perpetrator section was blank. CNA B and the Activity Assistant were listed as witnesses. LVN A assessed Resident #1 on 3/5/26 at 1:45pm and found she had some of her hair pulled out by the aggressor and was sent to the emergency room to rule out internal injuries. The Investigation Summary section stated Attach additional sheets, including but not limited to interview summaries with all parties involved in the incident, clinical records, lab and imaging reports. The section was completed and stated, [Resident #2] and a third resident, were starting to argue when the activities assistant redirected the third resident to his room. [Resident #2] then turned to [Resident #1] and tried to grab her coffee. [Resident #1] refused to give up her coffee so [Resident #2 grabbed her hair and pulled it. The CNA on the unit tried to intervene before contact but was unable to reach him in time. The Investigation Findings section of the report stated unfounded. The report was signed by the Administrator. Attached to the investigation report were Resident #1 and Resident #2's medical records but did not include any interview summaries or witness statements. In an (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 5/22/26 at 10:10am, CNA B, when asked about the incident between Resident #1 and Resident #2, she said she was in the dining room in the mc unit and saw Resident #2 trying to fight with Resident #3 and they were swinging at each other. She said the Activity Director removed Resident #3 from the room. CNA B said, all of a sudden, (Resident #2) went over there and hit (Resident #1). She said she heard Resident #2 hollering, and she ran over to them and that is when Resident #2 hit Resident #1 with a closed fist to the side of her head. Record review of a provider investigation report, HHSC Form 3613-A, dated 3/29/26 indicated on 3/22/26 at 10:30am, a staff member reported a resident-to-resident altercation that occurred in the hallway. The staff member was not identified. Resident #5 was listed as the alleged perpetrator and did not indicate how the alleged perpetrator was identified. No witnesses were listed. LVN C assessed Resident #5 and Resident #6 and found no injuries. The Investigation Summary section stated Attach additional sheets, including but not limited to interview summaries with all parties involved in the incident, clinical records, lab and imaging reports. The section was completed and stated, [Resident #5] was coming out of the shower when the other was in the hallway just outside the shower. One resident asked the other to move out of the way however it was unclear if this request was heard. Both residents started arguing and then escalated to kicking each other that is when [Resident #6] threw his coffee at [Resident #5]. They were separated and redirected to their respective rooms. [Resident #6] ended up having some seizure activity and was sent out for observation. He was diagnosed with a UTI (a common bacterial infection in the urinary system) and he came back to the facility. Administrator spoke with [Resident #6] and he stated he doesn't know why he acted out and he acknowledged that was not the way he normally acts. It is thought that the UTI contributed to the out of character behavior and the seizures for [Resident #6]. The Investigation Findings section of the report stated unfounded. The report was signed by the Administrator. Attached to the investigation report were Resident #5 and Resident #6's medical records but did not include any interview summaries or witness statements. In an interview on 5/21/26 at 3:00pm, when asked about the incident between Resident #5 and Resident #6, CNA E said she did not witness the incident but saw they were arguing. She said she was in the shower room changing or showering another resident. She said when she left the shower room, she saw Resident #6 had a cup in his hand and Resident #5's shirt was wet. In an interview on 5/21/26 at 3:30pm, when asked about the incident between Resident #5 and Resident #6, CNA F said she did not witness the incident but saw them arguing. She said she was in the shower room with another resident when she left and saw Residents #5 and #6 in the hallway. She said she noticed Resident #5's shirt was wet. She said Resident #5 was kicking at her (CNA F), but not intentionally. Record review of a provider investigation report, HHSC Form 3613-A, dated 4/2/26, indicated on 3/26/26 at 2:30pm, a CNA reported a resident-to-resident incident that occurred in the hallway. The CNA was not identified. Resident #8 was listed as the alleged perpetrator and was identified by description. There were no witnesses listed. Under the assessment section, it stated an assessment was completed on 3/26/26 at 2:45pm, but did not state who completed the assessment. Description of assessment stated, [Resident #7], the receiver of the aggression, reported that [Resident #8] hit him in the eye. [Resident #8] admitted to hitting [Resident #7]. The Investigation Summary section stated Attach additional sheets, including but not limited to interview summaries with all parties involved in the incident, clinical records, lab and imaging reports. The section was completed and stated, [Resident #8] was in the hall trying to get around [Resident #7]. [Resident #8] asked [Resident #7] to move out of the way, and it seems that [Resident #7] possibly did not hear [Resident #8] ask him to move. [Resident #8], according to [Resident #7] pushed past him and simultaneously hit [Resident #7] in the eye. [Resident #7] was assessed for injury and there was none. The Investigation Findings section of the report stated unfounded. The report was signed by the Administrator. Attached to the investigation report were Resident #7 and Resident #8's medical records but did not include any interview summaries or witness statements. Record review of a provider investigation report, HHSC Form 3613-A, dated (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/2/26, indicated on 3/25/26, a staff member reported an injury of unknown origin. The staff member was not identified. There were no witnesses listed. An assessment was completed by LVN C on 3/25/26 at 12:30pm and found Resident #9 had swelling to his left 4th finger and the area was purple in color. The Investigation Summary section stated Attach additional sheets, including but not limited to interview summaries with all parties involved in the incident, clinical records, lab and imaging reports. The section was completed and stated, This resident has been rolling around the facility at times without having any safety awareness. Resident is non verbal and unable to say if he bumped into anything. Initial x-ray showed that there was no dislocation or fracture, yet also said that the volar middle phalangeal base small bony fragment is visualized. The resident was send (sic) out to [local emergency room] for clarification. Second x-ray corroborated appearance of small foreign body. Resident was noted in both reports to have osteoporatic (sic) bones and degenerative changes. The Investigation Findings section of the report stated unfounded. The report was signed by the Administrator. Attached to the investigation report were Resident #9's medical records but did not include any interview summaries or witness statements. Record review of a provider investigation report, HHSC Form 3613-A, dated 4/28/26 indicated on 4/21/26 at 12:00pm, a nurse reported a resident-to-resident incident that occurred in the dining room. Resident #10 was listed as the alleged perpetrator. There were no witnesses listed. An assessment was completed by LVN C on 4/21/26 at 12:15pm and found Resident #11 sustained a skin tear to her left forearm. The Investigation Summary section stated Attach additional sheets, including but not limited to interview summaries with all parties involved in the incident, clinical records, lab and imaging reports. The section was completed and stated, Both ladies arrived into the dining room in anticipation of lunch, when the nurse heard the two ladies arguing. Nurse went to go (sic) into the dining room and noted another nurse was already separating the ladies. During the argument, [Resident #10] struck out at [Resident #11] which resulted in a superficial skin tear. The Investigation Findings section of the report stated unfounded. The report was signed by the Administrator. Attached to the investigation report were Resident #10 and 11's medical records but did not include any interview summaries or witness statements. In an interview on 5/21/26 at 3:30pm, when asked about the incident between Resident #10 and Resident #11, CNA F said she was in the dining room and heard and saw Resident #10 and Resident #11 cussing at each other. She said she did not witness any physical contact. She said the residents were at the dining room table, and someone was trying to tell the other one something, and they started yelling at each other. In an interview on 5/22/26 at 3:00pm, when asked about the incident between Resident #10 and Resident #11, LVN said she was at the nurse's station and could hear Resident #10 and #11 starting to fight verbally. She said she went into the dining room and when the staff were separating the two residents, she saw Resident #10 scratch Resident #11. In an interview on 5/22/26 at 1:07pm, the Administrator stated to complete an investigation of an allegation of abuse or neglect, she spoke to staff and started in-servicing right away. She said if the allegation was a resident-to-resident altercation, she would make sure the residents were separated and start one-to-one supervision to make sure they were safe. She said she interviewed residents to see what happened and put together a story. She said the staff reported who the witnesses were and they would identify the alleged perpetrator. She said for injuries of unknown origin, she determined what happened before the incident and goes off what was documented in the chart. She stated for the incident regarding Resident #10 and #11, she went off what LVN C witnessed. She said she did not remember talking to other staff about the incident. She said there were no witness statements for the incident regarding Resident #8 and #9. She said she could not remember who she spoke to and/or who was present during the incident. She said she remembered that Resident #8 was furious after it happened and he was generally truthful and would not have made it up. She said regarding the injury of unknown origin for Resident #4, she used the results of the x-ray to determine the injury and then determined there was no suspicion of abuse or neglect. She said she spoke to staff who worked with Resident #4 prior to discovery of the injury. She said they looked at his record to determine what (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	happened prior to injury, including to determine if he had any falls. She said there were no incidents reported. She said that when completing the HHSC Form 3613-A, selecting unconfirmed under Investigation Findings indicated that the facility did not abuse or neglect the resident. She said a finding of unconfirmed did not mean that a resident-to-resident altercation occurred, but that the facility did not cause abuse or neglect. Record review of the HHSC website at https://www.hhs.texas.gov/regulations/forms/3000-3999/form-3613-a-snf-nf-icfiid-alf-dahs-including-iss-provide accessed on 6/2/26 at 1:37pm revealed the instructions for completing Form 3613-A for skilled nursing facilities and nursing facilities. The Instructions were last updated 4/2024. The instructions read, .Investigation Summary - Summarize the provider's investigative procedures concisely, factually and objectively. Summarize the investigator's analysis of supporting documents, such as interviews, witness statements, injury reports, diagrams, life satisfaction surveys, observations and other appropriate evidence. Clearly state the investigator's conclusion about the allegation and any contributing facility practice(s) and the investigator's recommendation(s). Summarize how the investigator arrived at these conclusions and recommendation(s). Include the name(s) and position(s) of the investigator(s).Facility Investigation Findings - Check the term that best describes the facility's investigation.Confirmed: The allegation is supported by the strength of the evidence that best concurs with reason and probability, for example, the facts are more probably one way than another.Unconfirmed: It is reasonable to conclude the allegation did not occur or is unlikely to have occurred.Inconclusive: There is insufficient evidence to support or refute the allegation.Unfounded: The allegation is untrue or patently without factual basis. Record review of the facility policy and procedure regarding Abuse, Neglect and Exploitation Prohibition dated 4/2024 stated, .Investigation. The Facility will conduct a timely investigation of any alleged abuse/neglect, exploitation, mistreatment, injuries of unknown origin, or misappropriation of resident property. The investigation should include: gathering evidence, interviewing witnesses, conducting surveys as indicated, reviewing medical records, and examining any relevant documentation. The Facility will record all investigation findings, interviews, and actions taken. The Facility will assess gathered evidence to review and determine the extent and nature of the allegation. Investigative findings will be documented on appropriate state forms as applicable.