

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Paradigm at the Pines		STREET ADDRESS, CITY, STATE, ZIP CODE 705 Hwy 418 W Silsbee, TX 77656	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interviews and record review, the facility failed to consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility for 16 out of 16 anonymous residents during a confidential meeting who were reviewed for resident rights. The facility failed to ensure the resident council food grievances were promptly resolved. This failure could place residents at risk for a decreased quality of life. The findings included: Record review of the Resident Council Meeting Minutes, dated 09/11/25, reflected New Business. C. Dietary - see form. The dietary form attached to the resident council minutes reflected .seasons food good.residents would like fried and boiled eggs, wheat bread for diabetics, toast is being made too hard. Record review of the Resident Council Meeting Minutes, dated 10/09/25, reflected New Business. C. Dietary - see form. The dietary form attached to the resident council minutes reflected .Chili on 10/07/25 was way too spicy (hot).residents requesting fried eggs, not scrambled. Record review of the Resident Council Meeting Minutes, dated 11/13/25, reflected New Business. C. Dietary - see form. The dietary form attached to the resident council minutes reflected certain residents were receiving fried eggs, and some still were not receiving fried eggs. The form reflected New Administrator was made aware of ?Menu at a Glance' on Thursday morning and about residents asking for real fried chicken, cottage cheese, and fried fish fillet. During a confidential interview on an undisclosed date and time, there were 16 Anonymous residents who attended the confidential interview. All 16 Anonymous residents indicated they felt their grievances about the food were not addressed or resolved promptly. The anonymous residents stated the food quality was terrible. They said the food was bland, cold, and they were served the same things over and over. All 16 anonymous residents agreed the food was discussed during every resident council meeting, and they felt like the food has not gotten any better. During an interview on 12/10/25 beginning at 1:21 PM, the AD stated she normally facilitated the resident council meetings at the residents' request. She said the food was a constant issue discussed in resident council meetings. She said she attempted to offer solutions such as education and purchasing specific food items or spices for the Bingo carts. The AD stated the previous administrator had talked about a spice rack for the dining room, but that had not been implemented. The AD stated none of the residents had asked for the spice rack. The AD stated every Thursday the Dietary Manager held a Menu at a Glance meeting so residents were able to voice their concerns. She said it was important to ensure the resident council concerns were addressed promptly so the residents felt like they had a voice and were able to make decisions for themselves. During an interview on 12/10/25 beginning at 2:22 PM, the Administrator stated the AD was responsible for facilitating the resident council meetings. He stated he had only been invited to one resident council meeting, and the food was discussed as a concern. He said a grievance form was completed and he felt like it was addressed. The Administrator stated there were general complaints about seasoning, but the facility erred on the cautions of less seasoning. He said it was hard to please everyone when it came to food complaints. He stated the dietary staff followed the recipes from the dietitian. He stated it was important to ensure resident council concerns were addressed so the residents felt like they had a voice. During an interview on 12/10/25 beginning at 3:11 PM, the Administrator stated he felt like the facility attempted to address (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident council concerns by completing grievance forms. He said he wanted it to be noted that the previous Dietary Manager had been replaced within the last 60 days. Record review of the Resident Council policy, revised June 2019, reflected The Nutrition/Culinary Services Director/Designee receives a copy of the Council meeting minutes and responds in writing to concerns identified and actions taken. A separate food committee can be formed at the discretion of the facility. The food committee reviews menus, makes menu suggestions, and helps plan meals for special events and holidays.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for 8 of 16 residents (Resident #15, Resident #20, Resident #24, Resident #27, Resident #37, Resident #38, Resident #48 and Resident #49) reviewed for food and nutrition services. 1. The facility failed to ensure residents received food that tasted good. 2. The facility failed to ensure residents received food with an appetizing appearance, texture, and appropriate temperature. These failures could place residents at risk of weight loss, altered nutritional status and diminished quality of life. 1. Record review of a face sheet, dated 12/08/25, revealed Resident #15 was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including major depressive disorder (a serious mood disorder causing persistent sadness, loss of interest, and impaired daily functioning, stemming from a mix of genetic, biological, environmental, and psychological factors), anxiety and depression. Record review of a quarterly MDS assessment, dated 10/29/25, revealed Resident #15 was understood and understood others. The MDS revealed Resident #15 had a BIMS score of 15, which indicated intact cognition. During an interview on 12/08/25 at 8:59 a.m., Resident #15 said the food was too salty when one person cooked and when another person cooked they don't know what salt is. She said the facility did not serve gravy and the meat was so dry. During an observation and an interview on 12/08/25 at 12:07 p.m., Resident #15 was in bed with her meal tray in front of her. She removed the cover from the plate, and she said, it does not smell good and looks horrible. She tasted the chicken dish. She said it had no flavor. She said the tortillas in the chicken casserole were tough. She said the cornbread looked under baked. She said it was warm. She tasted the cornbread. She said, it could have cooked a few more minutes. She tasted the green beans and said they were bland. She said she was not excited about the diced peaches. She said they served a lot of canned fruits. She tasted the peaches and said they tasted like canned peaches. She said she was just tired of canned fruits. She tasted the iced tea and said, it could be stronger. It is very watery. She said watery tea was a common thing. During an interview on 12/10/25 at 8:29 a.m., Resident #15 said this morning (12/08/25) her scrambled eggs were dry. She said she preferred fried eggs over easy. She said she was able to get them for a few months. She said now she was told by staff that she could only have fried eggs on fried egg day. She said she did not even know when fried egg day was and she felt she should be able to have fried eggs if she wanted them. She said she had been getting them until two weeks ago. She said at lunch, on 12/09/25, the Shepherd's Pie had no flavor, and her honey dew melon was not ripe. She said the facility were wasting their money buying honey dew melons because it was never good. She said sometimes food was burned on the bottom. 2. Record review of a face sheet, dated 12/08/25, revealed Resident #20 was a [AGE] year-old male and who was admitted to the facility on [DATE] with diagnoses including major depressive disorder (persistent sadness or loss of interest, significant changes in sleep/appetite, fatigue, feelings of worthlessness, difficulty concentrating, and thoughts of death or suicide, lasting nearly every day for at least two weeks and affecting daily life), dysphagia (difficulty swallowing), and anxiety disorder. Record review of an annual MDS assessment, dated 11/23/25, revealed Resident #20 was understood and understood others. The MDS revealed Resident #20 had a BIMS score of 11, which indicated the resident had moderately impaired cognition. During an interview on 12/08/25 at 9:25 a.m., Resident #20 said the food was terrible. He said some days it was too salty and sometimes not salty enough. He said the pancakes were hard on the morning of 12/08/25. During an observation on 12/08/25 at 11:32 a.m., Resident #20 was served his lunch tray. The cornbread appeared pale in color and looked under cooked. During an observation and an interview on 12/08/25 at 11:42 a.m., Resident #20 said there was a piece of plastic in his peaches. There was a small piece of plastic lying on the table near his plate. Staff offered him more peaches. He said he did not want them or anything else. 3. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a face sheet, dated 12/08/25, revealed Resident #24 was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing), anxiety, and major depressive disorder (persistent sadness or loss of interest, significant changes in sleep/appetite, fatigue, feelings of worthlessness, difficulty concentrating, and thoughts of death or suicide, lasting nearly every day for at least two weeks and affecting daily life). Record review of a quarterly MDS assessment, dated 09/05/25, revealed Resident #24 was usually understood and usually understood others. The MDS revealed Resident #24 had a BIMS score of 09, which indicated the resident had moderately impaired cognition. During an interview on 12/08/25 at 8:42 a.m., Resident #24 said the food was bad. She said the food did not taste good. She said the food was too salty. 4. Record review of a face sheet, dated 12/08/25, revealed Resident #27 was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including depressive episodes, anxiety disorder, and muscle weakness. Record review of a quarterly MDS assessment, dated 10/31/25, revealed Resident #27 was understood and understood others. The MDS revealed Resident #27 had a BIMS score of 13, which indicated the resident had intact cognition. During an interview on 12/08/25 at 9:12 a.m., Resident #27 said the food did not taste good. She said the food was either too salty or not salty enough. She said this morning (12/08/25) they served rubber pancakes. She said the pancakes were hard. 5. Record review of a face sheet, dated 12/08/25, revealed Resident #37 was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including generalized anxiety disorder, heart failure, and depression. Record review of a MDS assessment, dated 11/17/25, revealed Resident #37 was understood and understood others. The MDS revealed Resident #37 had a BIMS score of 14, which indicated the resident had intact cognition. During an interview on 12/08/25 at 8:34 a.m., Resident #37 said the food was cold and tasted like slop. 6. Record review of a face sheet, dated 12/08/25, revealed Resident #38 was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including stroke (when the blood supply to part of the brain is blocked or reduced), depressive episodes, and major depressive disorder (persistent sadness or loss of interest, significant changes in sleep/appetite, fatigue, feelings of worthlessness, difficulty concentrating, and thoughts of death or suicide, lasting nearly every day for at least two weeks and affecting daily life). Record review of a MDS assessment, dated 11/22/25, revealed Resident #38 was usually understood and usually understood others. The MDS revealed Resident #38 had a BIMS score of 12 which indicated the resident had moderately impaired cognition. During an interview on 12/08/25 at 9:25 a.m., Resident #38 said the eggs were cold and the food tasted like poop. 7. Record review of face sheet, dated 12/08/25, revealed Resident #48 was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses including recurrent depressive disorder, anxiety and muscle weakness. Record review of MDS assessment, dated 11/23/25, revealed Resident #48 was understood and understood others. The MDS revealed Resident #48 had a BIMS score of 14, which indicated the resident had intact cognition. During an interview on 12/08/25 at 11:40 a.m., Resident #48 said the food was not good. She said she did not like the lunch (on 12/08/25) and would not eat it. She said she did not want a substitute. She said the food was horrible. 8. Record review of a face sheet, dated 12/08/25, revealed Resident #49 was a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including anxiety disorder, heart failure, and protein-calorie malnutrition. Record review of a MDS assessment, dated 07/10/25, revealed Resident #49 was understood and understood others. The MDS revealed Resident #49 had a BIMS score of 14, which indicated the resident had intact cognition. During an interview on 12/08/25 at 9:20 a.m., Resident #49 said the morning of 12/08/25 he was served cold eggs and hard pancakes. He said sometimes the food was too salty. During an observation and interview on 12/09/25 at 12:12 p.m., a lunch meal tray was sampled with three state surveyors and the Dietician. The tray consisted of Shepherd's Pie, carrots in butter, biscuit, honey dew melon, and diced canned peaches. The Dietician said she could taste the potatoes, meat, and vegetables in the Shepherd's Pie. The surveyors' observation was that the potatoes in Shepherd's Pie were bland with not much flavor. (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The honey dew melon was crunchy and hard. The biscuit was warm, but was slightly dry and crumbly, the peaches tasted like canned peaches. The Dietician said fruit was served as a dessert for almost every meal. During an interview on 12/09/25 at 2:12 p.m., the Dietician said typically there was a fruit as a dessert on the menu every day. She said if the Dietary Manager had a complaint, they should educate their cook and make sure they were following recipes. Then they should follow up with the residents to see how they felt about the food. She said a resident who did not like their food could cause them to have a poor outlook. During an interview on 12/09/25 at 2:56 p.m., the Dietary Manager said she did notice the pancakes served on 12/08/25 were hard. She said they were pre-cooked, and she discussed with staff that next time they just needed to be re-heated. She said she made food rounds every Thursday. She said she heard complaints about the food being too salty. She said she discussed food complaints with her staff when she heard them. She said she educated staff. She said she had not completed any written in-services. She said she had just verbally educated the staff. She said the menu was new. She said she tried to find what the residents actually liked and what they wanted. She said she did not want any resident to get sick or lose weight. During an interview on 12/10/25 at 9:10 a.m., CNA A said she heard food complaints. She said she heard things like the food was never good, there were small portions, the grits were watery, and the food did not look appetizing. She said when she heard complaints, she reported it to the nurse or DON. She said when she went to the kitchen, she went to ask them for something else. She said there were other options available in the kitchen. She said a resident who did not like the food could make them frustrated and not want to eat at all. During an interview on 12/10/25 at 9:25 a.m., RN B said she heard food complaints from the residents. She said, they just don't like it, they did not get enough and they were not children. She said she reported food complaints to the kitchen all the time. She said some residents complained about small portions. She said residents who did not like their food could cause malnutrition, unhealed wounds, not getting enough protein, and grouchiness. During an interview on 12/10/25 at 9:36 a.m., the DON said if she heard a food complaint, she would ask if she could get the resident something else. She said she wanted them to eat. She said she then let the dietary staff know about the complaints. She said she heard the food was bland. She said she reported this to the Dietary Manager. She said she bought burgers for residents. She said she heard complaints about small portions. She said she was told they were using the right scoops. She said residents could ask for seconds. She said a resident who did not like their food could cause them not to eat, get depressed, or lose weight. During an interview on 12/10/25 at 9:48 a.m., the Administrator said he made rounds during the week and observed meals during the day. He said they started menu at a glance where the Dietary Manager went over the menu with the resident council. The Dietary Manager went over the next week's menu with the residents. He said sometimes changes could be made as long as it kept the nutritional value. He said he heard no recent complaints. He said a few months ago they made adjustments as they could. He said dietary staff followed the recipes. He said residents not liking their food could cause general discomfort and stress. Record review of a Resident Council Concern Follow-Up Form, dated 10/09/25 at 2:00 p.m., indicated Chili on 10/07/25 was way to spicy (hot). The action taken indicated, I will re-educate the staff on seasoning use. To make sure they follow the recipe and reading the preference. The form was signed by the Administrator on 10/09/25. Record review of a Concern Form, dated 11/10/25, indicated the Dietary Manager was the staff receiving the grievance. The summary of the grievance was the resident doesn't like the chicken over fried rice & (and) spicy. The steps taken were the Dietary Manager talked to the cook and resident. The resolution indicated, I will re-educate staff and make sure we have Asian soy sauce we been use. Record review of a Meal Quality facility policy, last revised 06/2019, indicated .Meals are served attractively and at the correct temperature to enhance patient/resident acceptance and provide a pleasant homelike dining experience. serve foods that meet the patient's/resident's individual food preferences.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 3 hallways (D Hall) and 1 of 1 (Resident #16) reviewed for infection control practices. 1. The facility failed to ensure LVN E performed hand hygiene between each meal tray while passing the lunch meal trays on 12/08/25. 2. The facility failed to ensure CNA D changed her gloves and performed hand hygiene during Resident #16's incontinent care on 12/09/25. These failures could place residents at risk for cross contamination and an increased risk of infection, or the spread of infection. The findings included: 1. During an observation on 12/08/25 between 11:17 AM and 11:25 AM, LVN E checked the meal trays on D Hall and started passing them. LVN E passed the meal tray to room D1, set up the tray and exited the room; LVN E passed the meal tray to room D3, set up the tray and exited the room; LVN E passed the meal tray to room D10, set up the tray and exited the room; LVN E passed the meal tray to room D4, she moved the covered and rearranged items on the bedside table, she set up the tray and exited the room; LVN E passed the meal tray to room D6, set up the tray and exited the room; LVN E passed the meal tray to room D8, set up the tray and exited the room; LVN E passed the meal tray to room D9, she moved the blankets, readjusted the bed, setup the tray, then left the room. LVN E did not sanitize her hands or perform hand hygiene between each meal tray. During an interview on 12/08/25 beginning at 11:28 AM, LVN E stated she normally sanitized her hands between each resident's room when she passed meal trays. LVN E stated she did not have her hand sanitizer in her pocket, and the facility just added the sanitizer pumps in the hallway, so she forgot to use them. She stated she was also nervous because this was her first experience with a health inspection. LVN E stated it was important to ensure hand hygiene was performed during meal services to prevent contamination and the spread of infection. 2. Record review of the face sheet, dated 12/10/25, reflected Resident #16 was a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of chronic respiratory failure (long-term condition in which the lungs cannot adequately exchange oxygen and carbon dioxide, leading to decreased oxygen levels and increased carbon dioxide levels in the body) and morbid obesity (a body mass index higher than 40). Record review of the quarterly MDS assessment, dated 10/22/25, reflected Resident #16 had clear speech, was understood by others, and was able to understand others. Resident #16's BIMS score was 1, which indicated severe cognitive impairment. Resident #16 had inattention and disorganized thinking, which came and went. The MDS reflected Resident #16 had physical, verbal, and other behaviors 1 to 3 days during the look-back period. Resident #16 was usually dependent on staff for toileting hygiene. Resident #16 was always incontinent of bladder. The MDS reflected Resident #16 had no active infections within the last 30 days. Record review of the comprehensive care plan, dated 10/10/25, reflected Resident #16 had bladder incontinence related to weakness mobility deficits. The interventions included: educate the resident and responsible party/family on proper perineal hygiene practices, monitor resident for signs or symptoms of UTI, perform routine rounding to include incontinence care and brief changes, and report any changes in skin integrity to the charge nurse. During an observation on 12/09/25 beginning at 3:50 PM, CNA D washed her hands and applied an isolation gown and gloves. She set up her supplies and started incontinent care. She cleaned Resident #16 from the front, rinsed, and dried. CNA D turned Resident #16 to the back and cleaned, rinsed, and dried. CNA D adjusted Resident #16's covers, then removed her gloves. CNA D used the same pair of gloves and did not perform hand hygiene during the whole incontinent care observation. During an interview on 12/10/25 beginning at 12:50 PM, CNA D stated she normally worked Resident #16's hallway. CNA D stated she should have changed her gloves and performed hand hygiene when she went from the front to the back and before she went from dirty to clean. She said she should have (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removed her gloves before touching anything that was clean. She stated she was checked off on incontinent care and usually did it correctly. She stated she was just nervous because the state surveyor was observing her. She stated it was important to ensure infection control practices were followed during incontinent care to prevent bacterial contamination. During an interview on 12/10/25 beginning at 2:03 PM, the DON stated she expected staff to ensure hand hygiene was performed during meals when trays were passed and during incontinent care when going from dirty to clean, and from the front to the back. The DON said she expected staff to ensure their gloves were changed when they were soiled. She said nursing management was responsible for ensuring infection control practices were followed during mealtimes and incontinent care. She stated it was important to follow infection control procedures to prevent harm or sickness from infections. During an interview on 12/10/25 beginning at 2:22 PM, the Administrator stated he expected the staff to ensure infection control policies and procedures were followed. He stated the infection control preventionist was responsible for monitoring to ensure the staff followed infection control practices. The Administrator stated it was important to ensure infection control policies and procedures were followed to stop the spread of infection. Record review of the Perineal Care policy, revised December 2023, reflected the facility will provide perineal care in a manner that maintains privacy, reduces the risk of infection, and promotes skin integrity.preparation.wash hands thoroughly and apply gloves. applying clean brief. remove soiled gloves and dispose of them properly, perform hand hygiene thoroughly, apply new clean gloves. Record review of the Infection Control Program policy, revised June 2024, reflected the facility is dedicated to maintaining a safe and healthy environment by implementing an effective infection control program that adheres to state and federal regulations and follows evidence-based practices recommended by the CDC. The policy did not specifically address hand washing or hand hygiene.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident had the right to a safe, clean, and comfortable homelike environment for 1 of 16 residents (Resident #40) reviewed for physical environment. The facility failed to ensure Resident #40's room was cleaned and in good repair. This failure could place residents at risk for a decreased quality of life and an unsanitary environment. The findings included: Record review of the face sheet, dated 12/09/25, reflected Resident #40 was an [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of cancer of the tongue. Record review of the MDS tab in the electronic charting system, reflected Resident #40's admission MDS assessment was in progress and had not been completed yet. Record review of the baseline care plan, initiated on 12/02/25, reflected Resident #40 was new to the nursing facility and required adjustment. Record review of the nursing progress notes, dated between 12/01/25 and 12/10/25, reflected Resident #40 was alert, and oriented to person, place, time, and her situation. There were no cognitive concerns documented. During an interview and observation on 12/09/25 beginning at 11:34 AM, Resident #40 stated the toilet in her bathroom was constantly running. She said every time she washed her hands; her shirt became wet from the spray of the faucet. She said her window was opened on Saturday and it was filthy. She said her walls had missing paints. The state surveyor observed Resident #40's back wall beside her bed had a small area with missing paint and deep gouges in the sheetrock near the floor. The blinds were open; they were warped and appeared wavy. The window was slightly raised. There was a thick layer of brown gritty substance and dark brown gritty clumps between the outside screen and window. The state surveyor turned on the faucet in the bathroom and the state surveyors name badge became wet. The toilet was running. Resident #40 said she reported the issues to staff but stated no one tried to fix it yet. Resident #40 stated it made her feel disappointed with the facility because things were not completed the way she did them at her own home. During an interview on 12/10/25 beginning at 12:58 AM, CNA F stated Resident #40 reported her toilet was running, but she jiggled the handle, and it stopped. CNA F stated she instructed Resident #40 to jiggle the handle. CNA F stated she did not notice Resident #40's walls, blinds, windowsill, or the faucet spray. CNA F stated if issues with the room maintenance were reported or observed she would have notified the Director of Support Services verbally. CNA F stated it was important to ensure the room was cleaned and in good condition to ensure a sanitary and homelike environment was maintained. During an interview on 12/10/25 beginning at 1:12 PM, the Treatment Nurse stated she was also the unit manager for Resident #40's hallway. She stated Resident #40 had not reported any concerns about her room, toilet, or faucet to her knowledge. She said there was an electronic system that created work orders for environmental, or maintenance issues and the staff would also verbally notify the Director of Support Services. The Treatment Nurse stated it was important to ensure the rooms were cleaned and in good repair so the residents might feel more at home. During an interview on 12/10/25 beginning at 1:55 PM, the Director of Support Services stated if a resident reported or staff observed an environmental or maintenance concern, they placed it in the electronic system that created a work order. She stated she spoke with Resident #40 on 12/09/25 but had not received any work orders. The Director of Support Services stated Resident #40 reported her sink was messing up and she became wet every time she washed her hands. She said performed rounds on the rooms scheduled to be deep cleaned. She said she looked at things like the walls, the bathrooms, and general cleanliness and repairs needed during the rounds, but did not notice the concerns in Resident #40's room. The Director of Support Services stated rooms were prepared when one resident was discharged and another resident was ready for admission. She stated she usually knew when residents were admitted but did not always know which room they were going into. She said it was important to ensure rooms were cleaned and in good (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	repair for resident safety and to maintain a homelike environment. During an interview on 12/10/25 beginning at 2:22 PM, the Administrator stated Resident #40's family opened the window on the previous weekend, and the facility staff were unaware of the dirt buildup. The Administrator stated that was absolutely not something they would monitor on a regular basis. The Administrator stated he expected the housekeeping staff to follow the room ready checklist but was unsure what that entailed. He stated he expected the checklists, policy, and protocols to have been followed for cleaning rooms, and getting them ready for new residents. The Administrator stated it was important to ensure the rooms were cleaned and in good repair to provide a homelike environment. Record review of the maintenance logs for December 2025, reflected no entries for Resident #40's room. Record review of the Dignity: Resident's Rights for policy, revised June 2019, reflected .create a home-like environment for the resident that includes: .clean, orderly, comfortable, safe environment.		

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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. Based on observation, interview, and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as was possible for 1 of 3 Halls (Hall C) reviewed for accidents and supervision. The facility failed to ensure an unsecured shower room did not contain bath wash, disinfectant, which was labeled Keep out of the reach of children and a package of disposable razors This failure could place residents at risk for accidents that could lead to injuries. Findings include: During an observation on 12/08/2025 at 8:15 a.m., revealed the shower room on C hall was not locked. The shower room contained a plastic cabinet approximately 6 feet tall and was missing 1 of the 2 doors. The cabinet contained 2-6 ounce bottles of body wash and were labeled to keep out of reach of children. There was a package of disposable razors noted in the cabinet. There were no residents, or staff near the shower door at this time. During an observation on 12/08/25 at 9:17 a.m., revealed the doorknob was set to lock, but the door was not latched and pushed opened. The shower room contained a plastic cabinet approximately 6 feet tall and was missing 1 of the 2 doors. The cabinet contained 2- 6-ounce bottles of body wash and labeled to keep out of reach of children. There was a package of disposable razors noted in the cabinet. There was a 32-ounce clear bottle which contained approximately 14 ounces of yellow liquid. The bottle was labeled disinfectant and labeled to keep out of reach of children. During an interview on 12/08/25 at 9:38 a.m., CNA C and CNA D said the shower room was to be locked when not in use. CNA D said the cabinet was not broken on Friday (12/05/25) and they would also lock the cabinet. CNA C and CNA D said the residents could wander in the shower room and get hurt, injured with the chemical or the razors. The CNAs said they were trained in preventing accidents . CNA C and CNA D said they were unsure why the door was not locked and could be just pushed open. During an interview on 12/08/25 at 9:45 a.m., the Director of Support Services said the hall 200's shower door was not latching properly and was not reported to her. She said there was a lock on the cabinet in the shower. The Director of Support Services walked into the shower room and said no one had reported the cabinet door was broken off the cabinet. She said the supplies must be secured to prevent accidents. During an interview on 12/08/25 at 10:00 a.m., the DON said her expectations were when doors were broken to report to the Director of Support Services and herself immediately. The DON said the cabinet must be kept locked unless the staff were giving a shower. Record review of the Policies and Procedures Housekeeping Chemical Storage & Security Policy, dated 2/2022, indicated . the facility ensures all housekeeping chemicals are safely stored and secured to prevent resident, visitor, or unauthorized staff access. Chemicals must remain locked in carts, storage rooms, and closets at all times when not actively in use. 2. Chemical Closets / Storage Rooms All chemical storage areas must remain locked at all times. Only authorized staff may access these areas. After removing or returning supplies, staff must close and secure the door.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident is offered sufficient fluid intake to maintain proper hydration and health for 1 of 16 resident (Resident #39) reviewed for hydration. The facility failed to ensure Resident #39 had a water pitcher at his bedside on 12/08/25, 12/09/25, and 12/10/25. This failure could place residents at risk for decreased quality of care and dehydration. The findings included: Record review of the face sheet, dated 12/10/25, reflected Resident #39 was a [AGE] year-old male who admitted to the facility on [DATE], with diagnoses of rhabdomyolysis (rare and life-threatening condition where your muscles break down and release toxins into your blood and kidneys), heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's need for blood and oxygen), and chronic kidney disease (kidneys are damaged over time, leading to a decline in their ability to filter blood effectively). Record review of the admission MDS assessment, dated 11/08/25, reflected Resident #39 had clear speech, was understood by others, and was able to understand others. Resident #39 had a BIMS score of 5, which indicated severe cognitive impairment. Resident #39 had no behaviors or refusal of care during the look-back period. The MDS reflected Resident #39 usually required supervision or touching assistance with eating, which included liquids. Resident #39 received parenteral/IV feeding while a resident, on admission, and while not a resident. Resident #39 received 500 mL/day or less by IV or tube feeding. Record review of the comprehensive care plan, dated 11/13/25, reflected Resident #39 required regular/thin consistency liquids for nutritional support and was at risk for unplanned weight loss and nutritional complications. The goal was Resident #39 would have adequate nutritional/fluid intake and would be free from unplanned weight loss or other nutritional complications over the next 90 days. The interventions included: assist with eating as indicated. Record review of the comprehensive care plan, dated 11/13/25, reflected Resident #39 had a history of hypertension (high blood pressure). The interventions included: encourage fluid intake within dietary limits. Record review of the comprehensive care plan, dated 11/13/25, reflected Resident #39 had a history of constipation. The interventions included: encourage fluid intake within dietary limits. Record review of Resident #39's physician orders list reflected an order for a Regular diet, regular texture, regular/thin consistency liquids, which was revised on 12/10/25. During an observation and interview on 12/08/25 beginning at 8:54 AM, Resident #39 was sitting up on the side of his bed, facing the window. His bedside table was in reach and did not have a water pitcher on it. He stated the facility staff took his water pitcher out last week and never brought it back. During an observation on 12/09/25 at 8:33 AM, Resident #39 was lying in bed facing the window. There was no water pitcher at the bedside. During an interview on 12/10/25 beginning at 12:50 PM, CNA D stated she did not normally work Resident #39's hall. She said she provided ice water at the beginning of her shift daily and then again toward the end of her shift. She stated if a resident did not have an ice pitcher, she was supposed to have gotten one from dietary. CNA D stated she was unsure if Resident #39 had a water pitcher. She stated some residents did not like the facility water pitchers and preferred to use their own, but she was unfamiliar with Resident #39 and his hall. CNA D stated it was important to ensure the residents had access to water so they could stay hydrated and drink if they were thirsty. During an observation and interview on 12/10/25 beginning at 12:58 PM, CNA F stated she normally worked on Resident #39's hallway. She stated she passed ice water at the beginning of her shift and then as needed throughout the day. She stated she had already passed ice this morning on her hallway, which included Resident #39. She said if a resident did not have a water pitcher, then she would have gotten one from the kitchen. The state surveyor and CNA F went into Resident #39's room and there was no water pitcher. CNA F explained she had not been in Resident #39's room and saw him up wheeling around the facility. CNA F stated she was going to get him a water pitcher after our conversation. CNA F said it was important to ensure Resident #39 had a water pitcher to prevent (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dehydration and UTIs. During an interview on 12/10/25 beginning at 1:12 PM, the Treatment Nurse stated CNAs should have been passing ice at the beginning of their shift and then again toward the end of their shift, since they work 12 hours. She stated night shift frequently picked up all the water pitchers to be washed and then they were replaced in the morning to maintain sanitization. The Treatment Nurse stated she was unaware Resident #39 did not have a water pitcher at his bedside. She stated she would provide education to the facility staff and ensure he got one. The Treatment Nurse stated having a water pitcher at the bedside was important to prevent dehydration, which also helped with the skin and kidney function. During an interview on 12/10/25 beginning at 2:03 PM, the DON stated she expected all the residents to have a water pitcher unless they could not have anything by mouth. The DON stated water pitchers were picked up and cleaned during the night shift at least 3 times a week and then passed back out the next morning. The DON stated the staff were supposed to pass fresh ice water in the morning and in the evening. The DON stated the nurses were responsible for monitoring to ensure ice water pitchers were at the bedside. The DON stated it was important to ensure ice water was at the bedside to ensure the residents stayed hydrated. During an interview on 12/10/25 beginning at 2:22 PM, the Administrator stated he expected the staff to follow the hydration policy. The Administrator stated he was unsure who was responsible for monitoring to ensure water pitchers were at the bedside. He said he needed to review the policy. The Administrator stated it was important to ensure water pitchers were at the bedside to maintain hydration. Record review of the Water Pitchers/Cups policy, revised June 2019, reflected It is the policy of this facility that the staff will clean reusable water pitchers and glasses according to facility practice guidelines. when supplies are available, return the water pitcher, drinking cup, and tray (if applicable) to the resident's room. fill pitcher with ice water. note: if resident is on thickened liquid, no water is placed at the bedside. if the resident is on fluid restriction refer to his/her specific plan of care.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pharmaceutical services including procedures that assured the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident and determined that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for 1 of 3 residents (Resident #46) reviewed for pharmacy services. The facility failed to ensure Resident #46's as needed Tylenol #3 (narcotic pain medication) was signed out in the electronic medical record, when it was given on 12/02/25, 12/04/25, and 12/06/25. This failure could place residents at risk for medication errors and loss of medications through drug diversion. The findings included: Record review of the face sheet, dated 12/10/25, reflected Resident #46 was a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnoses of osteoarthritis (degenerative joint disease characterized by the progressive deterioration of the cartilage around the joints) and pain. Record review of the quarterly MDS assessment, dated 09/30/25, reflected Resident #46 had clear speech, was understood by others, and was able to understand others. Resident #46 had a BIMS score of 11, which indicated moderately impaired cognition. Resident #46 had no behaviors or refusal of care during the look-back period. The MDS reflected Resident #46 received as needed pain medications. Resident #46 stated he had occasional pain that occasionally effected sleep, therapy activities, and normal day-to-day activities. Resident #46 rated his worst pain at a 4 on a 0-10 pain scale. Record review of the comprehensive care plan, last reviewed 08/29/25, reflected Resident #46 complained of pain and was at risk for further episodes of increased pain. The interventions included: utilize numbers scale to assess pain level, observe for signs and symptoms of increased pain, assess resident for possible causes of pain and give pain medications, treatments, and relaxation modalities, check for effectiveness, and monitor for side effects of pain medication and report to the physician if noted. Record review of Resident #46's physician order listed an order for Acetaminophen-Codeine Tablet 300 mg - 30 mg (Tylenol #3, a narcotic pain medication) - Give 1 tablet by mouth every 6 hours as needed for pain, which started on 02/12/25. Record review of the Controlled Drug Administration Record for Resident #46's Tylenol #3 reflected the following:1. On 12/02/25 at 4 PM, one tablet was given by LVN G.2. On 12/04/25 at 8 PM, one tablet was given by LVN H.3. On 12/06/25 at 8 AM, one tablet was given by LVN G. Record review of the MAR, dated December 2025, reflected Resident #46's Tylenol #3 was not signed out on 12/02/25, 12/04/25, or 12/06/25. During an interview on 12/08/25 beginning at 1:26 PM, Resident #46 stated he had Tylenol #3 prescribed as needed every six hours for pain if he needed it. He stated that he normally received his pain medication when he requested it. During an interview on 12/10/25 beginning at 9:31 AM, the DON stated the process for administering narcotic medications included signing off the medication on the electronic MAR and the narcotic count sheet. She said she expected the nurses to give the medication and then document they gave the medication. She said the facility had a process for monitoring the nurses to ensure they were signing off on the MAR, but she and the ADON were working the floor, so monitoring was not completed. She stated it was important to ensure the nurses were signing out narcotic pain medications on the electronic MAR to prove they did not take the drug and to ensure residents were not in pain. During an interview on 12/10/25 beginning at 1:29 PM, LVN G stated when a resident complained of pain, she first performed a pain assessment and asked the resident to rate the pain. LVN G stated if the resident requested medication for pain, it should have been signed out on the narcotic count sheet, and then the electronic MAR. LVN G stated she did not always sign out Resident #46's narcotic pain medication administration in both places. She said by the time she got to the computer to sign the medication out, she got distracted and forgot. She stated it was important to ensure narcotic pain medications were accurately reconciled to prevent Resident #46 from receiving (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	too many pills and to ensure an accurate record was kept. During an attempted telephone interview on 12/10/25 at 1:43 PM, LVN H did not answer the phone, and no return call was received before exiting the facility. During an interview on 12/10/25 beginning at 2:22 PM, the Administrator stated he expected staff to ensure narcotic pain medications were signed out as they were given. The Administrator stated the nursing management was responsible for monitoring to ensure narcotic pain medications were reconciled appropriately. He said it was important to ensure narcotic pain medications were reconciled appropriately for proper medication administration. Record review of the Medication Administration and Management policy, revised June 2019, reflected .Authorized licensed or certified/permitted medication aide or by state regulatory guidelines staff must understand. the '8 Rights' for administering medication.6) the right charting. medications are prepared, administered, and recorded by the same authorized medical/licensed staff. the authorized licensed or certified/permitted medication aide or by the state regulatory guidelines staff member documents that the medication is given in the correct slot of MAR, before going to the next patient/resident.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident received and the facility provided food that accommodated the resident allergies, intolerances and preferences 1 of 16 residents (Resident #19) reviewed for food and nutrition services. The facility failed to ensure Resident #19's food preferences and listed food allergy were honored. This failure could place residents at risk for dissatisfaction, poor intake, and/or weight loss. Record review of a face sheet, dated 12/08/25, revealed Resident #19 was [AGE] years old and admitted to the facility on [DATE] with diagnoses including dementia, paranoid schizophrenia (a disorder with a common presentation where paranoia, intense delusions [like persecution], and vivid hallucinations [often auditory] dominate, while other cognitive functions remain relatively intact), and major depressive disorder (a serious mood disorder causing persistent sadness, loss of interest, and impaired daily functioning, stemming from a mix of genetic, biological, environmental, and psychological factors). Record review of a quarterly MDS assessment, dated 09/05/25, indicated Resident #19 was understood and understood others. The MDS indicated Resident #19 had a BIMS of 13, which indicated her cognition was intact. The MDS indicated Resident #19 required setup or clean-up assistance with eating. Record review of Care Plan, last revised 09/28/25, indicated Resident #19 was at risk for allergic reaction due to allergies to eggs and yeast. There was an intervention to review diet for food allergies. Record review of an Order Summary, dated 12/08/25, for Resident #19 indicated an order for a regular diet with regular texture. The orders did not indicate any food allergies. Record review of the Electronic Medical Record for Resident #19, accessed 12/08/25 - 12/10/25, indicated allergies of egg and yeast. Record review of a Progress Note for Resident #19 dated 12/09/25 at 10:15 a.m., indicated Spoke with RP (representative) and he verified that (Resident #19) is not allergic to eggs or yeast. He told us she will think she is allergic to stuff and tell you, but she was not allergic to anything that he knew of. The Progress Note was signed by the DON. During an interview on 12/08/25 at 9:08 a.m., Resident #19 said she could not eat eggs and the kitchen kept sending her eggs. During an observation and interview on 12/09/25 at 8:18 a.m., Resident #19 was sitting on the side of her bed with her breakfast tray in front of her. She said there were eggs on her tray. She said she was served eggs every morning. She said she was told not to eat eggs or yeast. She said she had not had a reaction, and she just did not eat the eggs. There were scrambled eggs on her plate with sausage mixed in. The meal ticket on her tray indicated the resident was served egg and sausage casserole and did not indicate an egg allergy. She said she was told as a child that if she ate eggs, it would kill her. She said she was just eating the cereal on her tray and that was all she wanted. During an interview on 12/09/25 at 2:12 p.m., the Dietician said she would expect adequate communication between nursing staff and dietary concerning allergies and preferences. She said typically upon admission preferences were obtained. She said the dietary manager sometimes rounded in the dining room to obtain preferences and they liked to see preferences obtained quarterly from each resident. She said the outcome of a resident being served a food they were allergic to could be a number of things. During an interview on 12/09/25 at 2:56 p.m., the Dietary Manager said when a resident admitted to the facility nurses were supposed to send a paper to dietary listing allergies and food preferences. She said she also visited each new resident to discuss food allergies and food preferences. She said Resident #19 was admitted 2 years ago and her dietary card had not been updated. She said she talked to Resident #19, and she did not have an actual allergy to eggs but did not want to be served eggs. She said residents being served food they had an allergy to, could cause itching or difficulty breathing. During an interview on 12/10/25 at 9:10 a.m., CNA A said Resident #19 had been served eggs. She said they found out she was truly not allergic, but it was charted that she was. She said the resident had told her she was hoodooed (hexed) when she was a child and could (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not eat eggs. CNA A said she told the kitchen in the past, but eggs were still served. She said Resident #19 did not want eggs on her plate. She said in the past Resident #19 had eaten fried eggs and had no reaction. She said Resident #19 did not eat cheese either. She said there were just foods Resident #19 did not like. During an interview on 12/10/25 at 9:25 a.m., RN B said Resident #19 just did not like eggs. She said it depended on how the eggs were served to her. RN B said it had to do with her religion and her beliefs. She said if Resident #19 did not want eggs she should not be served eggs. She said all she had to do was tell them and they would get her something else. She said she never told the kitchen Resident #19 was served eggs because she had not made her complaint known to her. During an interview on 12/10/25 at 9:36 a.m., the DON said if Resident #19 did not want eggs, she did not want them. She said the only time she should be served eggs was when she asked for them. She said there were times she asked for them. She said she spoke to Resident #19's family member and he said she was not allergic to eggs. She said food preferences not being honored could cause residents to not want to eat their food and lose weight. She said a resident with an actual allergy could be caused harm if served the food they were allergic to. During an interview on 12/10/25 at 9:48 a.m., the Administrator said he expected staff to not serve food a resident was allergic to or food the resident preferred not to have. He said the Dietary Managers addressed food preferences on admission. He said allergic reactions could have a wide range from mild discomfort to a rash. He said a residents' food preference, not being honored, could lead to emotional discomfort. Record review of a Food Allergies facility policy, last revised 06/2019, indicated, .Patients/residents with food allergies will be provided with safe food/fluids, and appropriate substitutions to maintain their health. identified food allergies are documented in the medical record and communicated to the appropriate departments and personnel. the diet order must include the primary diet order and a listing of all known food allergies. When food allergies are listed as part of the diet order the Nutrition/Culinary Services Director, dietitian, or designee will interview the patient/resident to clearly identify and confirm all food allergies. The words allergic to may be printed on the meal ticket using dietary notes. Record review of a Meal Quality facility policy, last revised 06/2019, indicated, .serve foods that meet the patient's/resident's individual food preferences.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER Paradigm at the Pines		STREET ADDRESS, CITY, STATE, ZIP CODE 705 Hwy 418 W Silsbee, TX 77656	
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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to establish policies, in accordance with applicable, Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents for 1 of 2 residents (Resident #5) reviewed for smoking and smoking policy. The facility failed to complete a quarterly smoking assessment for Resident #5 per facility policy. This failure could place residents at risk of an unsafe smoking environment and injury. Findings included: Record review of Resident #5's smoking - safety screen indicated the last and only assessment was completed on 04/16/24 and indicated she was a safe smoker. Record review of Resident #5's admission record, dated 12/10/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnose which included dementia (decline in memory, judgment and thinking), bipolar (extreme mood swings) and seizures (temporary disruption of brain activity). Record review of the facility's, undated, Smokers list provided by the facility, identified Resident #5 as a smoker. Record review of Resident #5's comprehensive MDS assessment, dated 04/03/24, indicated a [AGE] year-old female. Resident #5's BIMS score was 15, which indicated she was intact with cognition. She used tobacco. Record review of Resident #5's care plan, dated 09/17/25, indicated she was a tobacco smoker and was at risk for injury. Resident #5 was a smoker and had the potential for injury related to smoking. The care plan indicated smoking assessment was completed on 04/16/24 deemed her safe smoker. Staff were to provide adequate supervision as indicated. Routinely complete Safe Smoking risk assessments to assess for safe smoking status, supervision required, and any assistive devices needed Safe Smoking will occur during designated safe smoking times and in the designated safe smoking areas safe to smoke with supervision. During an interview and observation on 12/08/25 at 12:30 p.m., Resident #5 was sitting outside with a staff member, and she was smoking without assistance. During an interview on 12/09/25 at 1:00 p.m., the DON said she and the management team were responsible for completing the smoking assessment every quarterly review. She said the electronic system would alert her when assessments were due. She said the only smoking assessment was completed on 04/16/24 in Resident #5's electronic records. She said the assessments had to be completed quarterly in case the residents required more assistance with smoking to prevent accidents. She said the electronic system did not alert her the assessment needed to be completed. Record review of the facility's Policies and Procedures Safe Smoking, dated March 2024 . Residents who desire to smoke will be assessed using the safe smoking screen, document in (electronic record). Assessments will be conducted at admission and quarterly.		