STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675420	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at the Brazos	2127 Preston St Richmond, TX 77469

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment were reported immediately but no later than 2 hours after the allegation was made, for 1 of 5 residents (CR#1), reviewed for freedom from abuse in that: The facility failed to report to Health and Human Services suspected alleged abuse on CR#1.This failure could put the residents at risk of abuse, allegations of abuse not being reported immediately, and could result in physical and psychosocial harm. The findings included. Record review of provider investigation report revealed the following:Date and Time of the Incident: [DATE] at 6:00 PMDate facility first learned of Incident. [DATE]Date and time facility reported the incident to HHSC - [DATE] at 5:45 PMDate facility fax the investigation report to the state: [DATE]. Record review of CR #1's face sheet indicated the [AGE] year-old female resident was admitted to the facility on [DATE]. Diagnoses included, but not limited to Dementia, mood disturbance, anxiety, hypertension, kidney disease stage 3, muscle weakness, Alzheimer's disease with late onset, cognitive communication disorder, history of falling, and difficulty in walking. Record review of CR #1's MDS dated [DATE] revealed no BIMS score but documented a memory problem with a severe cognitive impairment. Maximally assisted with ADLS, wheelchair dependent with 2 or more persons assisting. Record review of the Care Plan (revised [DATE]) for CR #1 revealed the resident has impaired cognitive function/dementia or impaired thought processes related to Alzheimer's, Dementia, long-term memory loss, Psychotropic drug use, and short-term memory loss. Interview with Resident #26 on [DATE] at 1:15 pm. stated the staff are great, no concerns, only one staff member who was working today was rude to her, but she had been written up. She stated the staff member could not give her pain medicine on time as the doctor has prescribed it. Th resident stated she had pain in my shoulder, back, and leg. But overall, she was fine and satisfied with the services here. Se stated she had not been abused or neglected. She was independent; and did all her stuff by herself. She stated the incident involving CR#1, she reported it to the administrator the next day. What happened was she was playing at a table and CR#1 was sitting in her wheelchair next to her table, she had been sitting there for a long time, CNA A came to get her, she yelled at her to mind my business, she pushed CR#1 too fast to her room. Resident #26 stated she felt she was being abused. I told the administrator about it the next day and when CR#1's RP came she told her about the incident. The resident stated she also told the Ombudsman. They never came until after CR#1 died in the hospital. But CR#1's death was not a result of the abuse. Telephone interview with CR#1's RP on [DATE] at 3:26 p.m., she said CR #1 passed on [DATE] from complications of pneumonia in the hospital. There was an incident that happened at the facility before CR #1 was transferred to the hospital. She stated she did not hear about it until they visited the facility, and one of the residents who always looked after CR #1 told them CNA A abused CR #1 by pushing her so forcefully. The facility did not notify her. She said she was taking CR #1 to change her. She pulled on CR #1, she was screaming, she guesses CNA A was frustrated with CR #1which was why she was forcing on CR #1. The administrator did not tell me about, CR#1's RP stated she asked the administrator, and she was told an investigation was started, but she did not want to tell me until she had finished her investigation, so she would have something to tell. CR #1 stated there was no bruise on CR #1 but was told the incident happened on [DATE] but was notified about it on [DATE]. Interview with Administrator on [DATE] at 1:25 pm. Said CR#1, is no longer in this facility. She had a change in condition and was transferred to the hospital on [DATE] hospital, where she finally died of natural death. On the incident that happened while she was in this facility, I came to work on Monday around noon, a resident by the name resident #26 came to me and told me that a resident was physically abused on Sunday late afternoon by a CNA A. She said that CR#1, was trying to stand up from her wheelchair, and CNA A forcefully pushed her back in the wheelchair. I asked her if she had told any staff, and she said no. I started an investigation immediately and removed the employee from the schedule pending investigation. After investigation, it was undetermined if staff abused the resident. Training on abuse/neglect was done on [DATE], and every month/PRN, last done on [DATE]. Examples of abuse are physical, mental, verbal, financial, and sexual. An example of neglect is not changing the residents or not providing care. She stated that she had not witnessed any abuse before. If there is any suspected abuse, all staff report to her, and she starts an investigation immediately.In another interview with Administrator on [DATE] at 4:57 pm. She said the incident happened on [DATE], knew about it on [DATE] through resident #26, and it was reported to HHSC on [DATE] at 5:45 p.m. She stated that, there was

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for storage, preparation and sanitation. -The facility failed to seal, label the contents of the packages and date when food items were opened in the refrigerator and dry storage. -The facility failed to discard expired cooked food from the walk-in refrigerator.-The facility failed remove a scoop in the flour container. These failures could place residents who received meals and/or snacks from the kitchen at risk for food-borne illness and food contamination if consumed. Findings included: Kitchen Observation on 07/29/25 at 8:15 AM revealed the following: -1 Plastic bag of cooked Spanish rice that was not labeled or dated in the walk-in refrigerator.-1 Plastic bag cooked ham chunks that was not labeled or dated in the walk-in refrigerator.-1 plastic bag of diced tomatoes that was not labeled or dated in the walk-in refrigerator.-15 8oz glasses of orange juice that was not labeled or dated in the walk-in refrigerator.-1 -25 lb box of instant food thickener that was opened, unsealed, and undated in the dry storage area. - 1 plastic bag of opened and [NAME] Crispy cereal that was not labeled or dated in the dry storage area.- 1 opened 5 lb bag of Rotini that was not labeled or dated in the dry storage area.- 1 opened 3-gallon container of vanilla ice cream that was not dated in the walk-in freezer.- 1 container of tomato soup with an expired date of 07/22/25 in the dry storage area.- 20 Liter flour container noted with scoop left in container in the dry storage area. During an interview on 07/29/25 at 8:30 AM, Dietary Aide B said all open items should be labeled and dated. Dietary Aide B said these items should be discarded because the staff does not know when the items were opened. During an interview on 07/31/25 at 4:50 PM, [NAME] E said the kitchen staff was responsible for labeling and dating food items. She said cooked food should be labeled and dated, and it should be discarded after 2-3 days. [NAME] E said the risk of not labeling and dating food was that the residents could get sick, which could lead to food poisoning. During an interview on 07/31/25 at 5:01 PM, the Dietary Manager said the expectation was for all kitchen staff to label and date open items in the refrigerator and in the dry storage areas. She also said the scoop should not be left in the flour container because it could be an infection control concern. The Dietary manager said the risk of unlabeled, unsealed, or outdated food would not be good for residents to consume because serving outdated food could cause harm and lead to food borne illness. During an interview on 07/31/25 at 5:15 PM, the Administrator said she expected the kitchen staff to label and date all foods per policy. She said food without labels or dates should be discarded. She said outdated food can cause harm and the resident can get sick. Record review of the Nutrition Services policy and procedure, dated 08/12/19, reflected, . Food Safety in Receiving and Storage It is the policy of this facility that food will be received and stored by methods to minimize contamination and bacterial growth. Procedures: Receiving Guidelines: 7. Check expiration dates and use-by dates to assure the dates are within acceptable parameters. General food: Place food that is repackaged in a leak-proof, pest-proof, non-absorbent, sanitary container with a tight-fitting lid. Label both the container and its lid with the common name of the contents and the date it was transferred to the new container. It is recommended that food stored in bins (e.g. flour or sugar) be removed from its original packaging . Record review of the Food and Drug Administration Food Code, dated 2022, reflected, 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety .