STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675971	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at the Oak	507 West Ave Schulenburg, TX 78956

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 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 record review and interview, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for one (Resident #2) of five residents reviewed for transfer and discharge rights, in that:The facility failed to:1. provide documentation that Resident #2's guardian received sufficient preparation and orientation when Resident #2 was discharged to a facility not within Resident #2's guardian's jurisdiction2. Provide documentation from Resident #2's psychiatric NP that Resident #2 was a danger to himself or other residents3. Provide documentation that the ombudsman was informed of the discharge4. Provide documentation that Resident #2 received a discharge notice.This failure could place residents at risk of not receiving care and services to meet their needs upon discharge.Findings included: Review of Resident #2's face sheet dated 09/11/25 reflected a 49-year-male who was admitted to the facility on [DATE] with diagnoses including neuroleptic induced parkinsonism (Parkinsonism (a general term used to describe a group of neurological disorders that share similar symptoms to Parkinson's disease (a progressive neurodegenerative disorder that affects movement, balance, and coordination) caused by antipsychotic (a class of drugs used to treat psychotic disorders, such as schizophrenia and bipolar disorder) medication), major depressive disorder (a common and debilitating mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), schizoaffective disorder, bipolar type (a mental health condition that combines symptoms of schizophrenia (a serious mental health condition that affects how people think, feel and behave) and bipolar disorder (health condition causes extreme mood swings that include emotional highs, called mania, and lows, known as depression). Resident #2's face sheet reflected his RP was a legal guardian. Review of Resident #2's care plan reflected a focus, dated 08/21/25, of Resident #2 was hit in the face/chest area by a chair thrown by another resident and an intervention dated 08/21/25 of trying to relocate resident to another facility for his safety. Record review of Resident #2's BIMS assessment, dated 08/14/25, reflected a score of 3 indicating severe cognitive impairment. Record review of Resident #2's Psychiatric Assessment, dated 08/21/25, reflected Resident #2 was seen for exacerbation of chronic problem requiring prescription management at staff request for continued unstable symptoms that have shown limited improvement. The DON requested an evaluation s/p patient was on the receiving end of an altercation with another resident on 08/20/25. The patient was allegedly hit by another resident. No apparent injuries. Initially the patient was referred to inpatient behavioral hospital for evaluation but was denied. Patient's guardian seeking alternate placement, medication review requested. Patient seen in the facility ambulating freely on secured unit, was calm, cooperative and was in good spirits.Record review of Resident #2's progress note, dated 08/20/25, by nursing (nurse unknown) reflected on 08/20/25 Resident #2 was hit with a chair by another resident. Record review of Resident #2's progress note, dated 08/20/25, by the previous social worker and current Administrator reflected social worker spoke with Resident #2's guardian and informed her the facility was planning to transfer Resident #2 to an inpatient psych facility. The facility was currently uncertain about how to ensure Resident #2's safety. Therefore, they were relying on the guardian's assistance to find another facility that could better meet his needs. Record review of Resident #2's guardian's note, dated 08/20/25, reflected Received phone call from [former facility social worker current facility Administrator] to inform me that [Resident #2] would be [sic Resident #2] to a behavioral health hospital she stated that another staff member would call her with further information. [former facility social worker current facility Administrator] did state that once [Resident #2] is admitted to the behavioral health hospital that the [facility name] will not take [Resident #2] back due to his behaviors.Record review of Resident #2's guardian's note, dated 08/20/25, subject phone call from [DON] to Resident #2's guardian reflected, Received a phone call from [Don] to confirm that I had received a phone call from a staff prior to his call about the altercation hat [Resident #2] was involved in. I informed [DON] that I had received a phone call from [former social worker and current Administrator] stating that [Resident #2] was in an alteration and that they were looking to send him to a behavioral health hospital. [DON] confirmed that this information was correct, however, [DON] stated that another resident had hit [Resident #2] with a chair due to [Resident #2] provoking him. I asked [DON] why [Resident #2] was being set to the behavioral health hospital due to he was the victim, I stated I understood that [Resident #2] may have provoked the resident I just didn't understand why they would send [Resident #2] out known [sic] that these are some of [Resident #2's]

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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F 0655 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 record reviews and interviews, the facility failed to develop and implement a baseline care plan that included the instructions needed to provide effective and person-centered care of the residents that meet professional standards of quality care for one (Resident #3) of five residents reviewed for baseline care plans. The facility failed to create a baseline care plan for how to transfer Resident #3, a paraplegic, within 48hours of his admission. This failure could place residents at risk of not receiving goals and interventions for their individual needs for person centered care and safe transfers. Findings included:Review of Resident #3's face sheet, dated 09/11/25, reflected a 36-year-male who was admitted to the facility on [DATE] with diagnoses including paraplegia (a condition characterized by the loss of voluntary movement and sensation in both lower limbs, typically resulting from an injury to the spinal cord in the thoracic or lumbar regions), displaced fracture of acromial process, right shoulder, initial encounter for closed fracture (a broken bone (acromion) in the right shoulder where the bone fragments moved from their normal position), displaced fracture of body of scapula, right shoulder, initial encounter for closed fracture (a broken shoulder blade (scapula) on the right side, where the broken pieces have shifted out of their normal alignment), and displaced fracture of acromial process, left shoulder, initial encounter for closed fracture (a broken bone at the acromion (the bony point of the shoulder blade) that was no longer in its normal alignment, on the left side, for which the patient was receiving initial medical care, and the skin was unbroken). Review of Resident #3's care plans reflected no care plan for Resident #3's transfers until 08/13/25. Review of Resident #3's Entry MDS dated [DATE] reflected no functional status and no BIMS score. Record review of Resident #3's occupational therapy daily progress note prior to admission, dated 07/23/25, reflected chair/bed to chair transfer detail, patient unable to provide any effort, helper transferred patient to and from bed to chair (or wheelchair) mechanical lift, two helpers required.Record review Resident #3's Admission/readmission Assessment date 08/05/25 primary diagnosis spinal cord injury (occurs when the spinal cord is damaged, disrupting the communication between the brain and the rest of the body. Range of motion - left upper extremity (refers to the left arm, including the shoulder, upper arm, forearm, wrist, and hand), left lower extremity (refers to the left side of the lower body), and right lower extremity impairment (a permanent functional or anatomical loss or derangement of the right leg, foot, or hip).Record review of Resident #1's Baseline Care Plan assessment, dated 08/06/25, signed by DON reflected - select the mobility status below that most accurately described the resident: bed bound, chair/bed-to-chair transfer - dependent.Record review of Resident #1's Occupational Therapy Treatment Encounter Notes, dated 08/7/2025, reflected skilled interventions focused on transfer training to increase functional task performance, reduce fall risk, and caregiver burden, transferring from edge of bed to wheelchair with maximum assistance with second person for safety due to compromised strength and paraplegia status.Interview on 09/11/2025 at 2:29 pm with the MDS Coordinator reflected that the initial baseline care plan should be completed within 48 hours of the time a resident was admitted to the facility. Because Resident #3's Baseline Care Plan assessment, signed by the DON, stated Resident #3 was dependent upon admission, his transfer status should have been a mechanical lift in his care plan. She said everyone should have known he was a mechanical lift transfer,and the information would have been passed on by word of mouth to the nurses and aides who were responsible for transferring him. She said that Resident #3's transfer status should have been in his care plan within 24 hours of his admission to the facility. She said it was the responsibility of the DON to know the residents' transfer status and to make sure all staff knew the residents' transfer status. She said the possible negative effect of a residents' transfer status not being included in the baseline care plan was that the residents could get hurt if they were inappropriately transferred. Interview on 09/11/25 at 3:13 pm with the DOR reflected on 08/07/25 Resident #3 was evaluated by therapy, and his transfer status was maximum assistance with second person for safety. She said this was what should have been in his care plan for how to transfer him after he was evaluated by therapy when he was admitted to the facility. She said the therapy staff did participate in care plans. She said the MDS Coordinator was responsible for care plans, but they all worked together on the IDT team to communicate for the needs of the residents. She said if there was no care plan, staff would not know how to safely transfer a resident, and the resident could get hurt. Interview on 09/17/25 at 1:36 pm with LVN B reflected she was not sure who was responsible for care plans at the facility but when Resident #3 entered the facility, how to transfer him was missing from his care plan and she did not know if it was included in the

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs for one (Resident #3) of six residents reviewed for pharmacy services.The facility failed to administer Resident #3's Lidocaine Pain Relief External 21 times between 08/08/25 and 09/06/25. This failure could place residents at risk of worsening of their condition, increased risk of falls, pain, and injury. Findings included:Review of Resident #3's face sheet, dated 09/11/25, reflected a 36-year-male who was admitted to the facility on [DATE] with diagnoses including paraplegia (a condition characterized by the loss of voluntary movement and sensation in both lower limbs, typically resulting from an injury to the spinal cord in the thoracic or lumbar regions), displaced fracture of acromial process, right shoulder, initial encounter for closed fracture (a broken bone (acromion) in the right shoulder where the bone fragments have moved from their normal position), displaced fracture of body of scapula, right shoulder, initial encounter for closed fracture (a broken shoulder blade (scapula) on the right side, where the broken pieces have shifted out of their normal alignment), and displaced fracture of acromial process, left shoulder, initial encounter for closed fracture (a broken bone at the acromion (the bony point of the shoulder blade) that is no longer in its normal alignment, on the left side, for which the patient is receiving initial medical care, and the skin is unbroken). Review of Resident #3's care plan focus, dated 08/14/25, reflected pain: [Resident #3] complained of increased pain/discomfort and was at risk for further episodes of increased pain/discomfort and injury.Review of Resident #3's Entry MDS, dated [DATE], reflected no functional status and no BIMS score. Record review of Resident #3's orders Lidocaine Pain Relief External start date 08/07/2025 D/C date 08/28/2025 Patch 4% (Lidocaine) apply to left shoulder topically every 24 hours for pain, remove both patches after 12 hours - remove daily at 7pm.Record review of Resident #3's MAR, dated 08/08/25 through 08/10/25, 08/12/25 through 08/15/25, and 08/19/25 through 08/26/25, reflected number 8 which indicated that further information about the medication administration was in the resident's progress notes.Record review of Resident #3's progress notes dated 08/08/25 through 08/10/25, 08/12/25 through 08/15/25, and 08/19/25 through 08/26/25 reflected no notes specific to the administration of Lidocaine Pain Relief External start date 08/07/2025 D/C date 08/28/2025 Patch 4 % (Lidocaine) apply to left shoulder topically every 24 hours for pain remove both patches after 12 hours - remove daily at 7pm.Record review of Resident #3's orders reflected Lidocaine Pain Relief External start date 08/28/25 (no d/c date) (Lidocaine Pain Relief External Patch 4% apply to left shoulder topically in the evening for pain remove both patches after 12 hours - remove daily at 7pm Record review of Resident #3's [DATE]/01/25 through 09/04/25 reflected number 8which indicated that further information about the medication administration was in the resident's progress notes.Review of Resident #3's MAR, dated 09/05/25, reflected a blank, no staff initials and no check mark.Review of Resident #3's MAR, dated 09/06/26, reflected number 8 which indicated that further information about the medication administration was in the resident's progress notes.Record review of Resident #3's progress notes, dated 09/01/25 through 09/04/25 and 09/06/26 reflected no notes specific to the administration of Lidocaine Pain Relief External start date 08/28/2025 Patch 4 % (Lidocaine) Apply to left shoulder topically every 24 hours for pain remove both patches after 12 hours - remove daily at 7pm.Interview on 09/19/25 at 4:56 pm with the ADON reflected a number 8 in a residents' MAR reflected that the resident did not receive the medication. The ADON reflected it usually means that the facility did not have the medication and there should be a progress note explaining why the resident did not get the medication. She said the process was if the resident did not receive the medication, the person who was to administer the medication informed the nurse, then made a progress note and then inform the NP. She said there should never be a blank space in the MAR because it indicated the medication was not given. She said if Resident #3 did not get his lidocaine pain patch he could have been in pain. She said there was trouble getting the lidocaine patches from the pharmacy and he missed some lidocaine patch administration. She said the nursing staff notified the ADON and the DON if the facility did not have resident medication so it could be obtained. She said it was the responsibility of the medication aide and charge nurse to ensure residents' medication was in the building. She said the lidocaine patches could be purchased at [name of discount store] and they could have gone over there to pick them up. She said the possible negative effect of him not getting the lidocaine patch was pain, but he had several other pain medications he was received. She said Resident #3 was taking tramadol

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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. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to serve foods that were palatable and prepare food by methods that conserve nutritive value, flavor, and appearance for 1 of 1 kitchen observed and five (Resident #1, Resident #3, Resident #4, Resident #5, and Resident #6) of ten residents reviewed.The facility failed to serve warm food to residents.These failures could place residents at risk of decreased food intake, hunger, unwanted weight loss, and diminished quality of life. Findings included:Review of Resident #1's face sheet, dated 09/22/25, reflected a 62-year-male, admitted on [DATE] and readmitted on [DATE] with diagnoses including human immunodeficiency virus [HIV] disease (a virus that attacks the body's immune system), type 2 diabetes mellitus with unspecified complications (a chronic condition in which the body does not use insulin effectively and has not developed any specific complications that can be identified), and bipolar disorder, current episode manic without psychotic features, moderate (periods of manic symptoms, including a prolonged elevated or irritable mood, increased energy, and goal-directed activity, lasting at least a week, without the presence of psychotic features such as delusions or hallucinations. The moderate severity suggests the symptoms are causing significant, but not severe, impairment in daily functioning). Review of Resident #1's care plan reflected focus, dated 09/19/25, Resident #1 was a diabetic and was at risk for fluctuations in blood glucose levels (the amount of sugar (glucose) in the bloodstream), hypo/hyperglycemia (abnormally low or high blood sugar levels) and other complications. Review of Resident #1's Nursing Home Comprehensive MDS, dated [DATE], reflected a BIMS score of 12 indicating moderate cognitive impairment. Review of Resident #3's face sheet, dated 09/11/25, reflected a 36-year-male, admitted on [DATE] with diagnoses including paraplegia (a condition characterized by the loss of voluntary movement and sensation in both lower limbs, typically resulting from an injury to the spinal cord in the thoracic or lumbar regions), displaced fracture of acromial process, right shoulder, initial encounter for closed fracture (a broken bone (acromion) in the right shoulder where the bone fragments have moved from their normal position), displaced fracture of body of scapula, right shoulder, initial encounter for closed fracture (a broken shoulder blade (scapula) on the right side, where the broken pieces have shifted out of their normal alignment), and displaced fracture of acromial process, left shoulder, initial encounter for closed fracture (a broken bone at the acromion (the bony point of the shoulder blade) that is no longer in its normal alignment, on the left side, for which the patient is receiving initial medical care, and the skin is unbroken). Review of Resident #3's care plan, dated 09/01/25, reflected Resident #3 refused meals.Review of Resident #3's Entry MDS, dated [DATE], reflected no functional status and no BIMS score.Review of Resident #4's face sheet, dated 09/11/25, reflected a 63-year-male, admitted on [DATE] and discharged on 08/07/25 with diagnoses including pressure ulcer of sacral region, unstageable (a full-thickness wound located on the bony prominence at the top of the buttocks (sacrum) that cannot be accurately staged due to the presence of thick, non-removable layers of necrotic tissue), paraplegia (a condition characterized by the loss of voluntary movement and sensation in both lower limbs, typically resulting from an injury to the spinal cord in the thoracic or lumbar regions), and unspecified protein-calorie malnutrition (a condition where a person does not consume enough protein and calories to meet their nutritional needs).Review of Resident #4's care plan reflected focus, dated 07/02/25, Resident #4 was a diabetic and was at risk for fluctuations in blood glucose levels, hypo/hyperglycemia, and other complications. Review of Resident #4's discharge MDS, dated [DATE], reflected no BIMS assessment. Review of Resident #4's BIMS assessment, dated 06/30/25, reflected a BIMS score of 13 indicating cognitively intact.Review of Resident #5'sface sheet, dated 09/17/25, reflected a 72-year-male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (a chronic metabolic disorder characterized by high blood sugar levels that persist over time due to underlying condition with diabetic chronic kidney disease (occurs when a primary disease causes diabetes, which then leads to kidney damage), chronic kidney disease (a condition where the kidneys gradually lose their ability to filter waste products from the blood), and parkinsonism (a general term used to describe a group of neurological disorders that share similar symptoms to Parkinson's disease (a progressive neurological disorder that affects movement, balance, and coordination)Review of Resident #5's care plan reflected focus, dated 04/22/25, Resident #5 was a diabetic and was at risk for fluctuations in blood glucose levels, hypo/hyperglycemia, and other complications. Review of Resident #5's Quarterly MDS, dated [DATE], reflected a BIMS score of 9 indicating moderate cognitive impairment.Review

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an effective pest control program was implemented so the facility was free of pests and rodents for 1 of 1 facility reviewed for pest control observed and four (Resident #1, Resident #3, Resident #6, and Resident #7) of seven residents reviewed.The facility failed to keep roaches and rodents out of resident rooms, the facility kitchen, facility common areas, and rest rooms.These failures placed residents at risk of infection, feelings of fear, anxiety, disgust, helplessness, shame, and a diminished quality of life.Findings included:Review of Resident #1's face sheet dated 09/22/25 reflected a 62-year-male who was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including human immunodeficiency virus [HIV] disease (a virus that attacks the body's immune system), type 2 diabetes mellitus with unspecified complications (a chronic condition in which the body does not use insulin effectively and has not developed any specific complications that can be identified), and bipolar disorder, current episode manic without psychotic features, moderate (periods of manic symptoms, including a prolonged elevated or irritable mood, increased energy, and goal-directed activity, lasting at least a week, without the presence of psychotic features such as delusions or hallucinations. The moderate severity suggests the symptoms were causing significant, but not severe, impairment in daily functioning). Review of Resident #1's care plan reflected focus revised 09/19/25 reflected Resident #1 was a diabetic and at risk for fluctuations in blood glucose levels (the amount of sugar (glucose) in the bloodstream), hypo/hyperglycemia (abnormally low or high blood sugar levels) and other complications.Review of Resident #1's Nursing Home Comprehensive MDS, dated [DATE], reflected a BIMS score of 12 indicating moderate cognitive impairment.Review of Resident #3's face sheet, dated 09/11/25, reflected a 36-year-male who was admitted to the facility on [DATE] with diagnoses including paraplegia (a condition characterized by the loss of voluntary movement and sensation in both lower limbs, typically resulting from an injury to the spinal cord in the thoracic or lumbar regions), displaced fracture of acromial process, right shoulder, initial encounter for closed fracture (a broken bone (acromion) in the right shoulder where the bone fragments have moved from their normal position), displaced fracture of body of scapula, right shoulder, initial encounter for closed fracture (a broken shoulder blade (scapula) on the right side, where the broken pieces have shifted out of their normal alignment), and displaced fracture of acromial process, left shoulder, initial encounter for closed fracture (a broken bone at the acromion (the bony point of the shoulder blade) that is no longer in its normal alignment, on the left side, for which the patient is receiving initial medical care, and the skin is unbroken). Review of Resident #3's care plan focus, dated 08/13/25, reflected [mechanical lift] for transfers with staff to use [mechanical lift] x2 aides for transfers.Review of Resident #3's Entry MDS, dated [DATE] reflected no functional status and no BIMS score.Review of Resident #6's face sheet, dated 09/17/25, reflected a 71-year-male who was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (nkhhc) (a serious complication of type 2 diabetes characterized by extremely high blood sugar levels (hyperglycemia) without the presence of ketones (molecules produced by the liver from fat, serving as an alternative energy source when glucose is unavailable, and they are a sign of fat breakdown in the body) in the blood) and heart failure (occurs when the heart muscle does not pump blood as well as it should).Review of Resident #6's care plan reflected focus, dated 04/22/25, was a diabetic and at risk for fluctuations in blood glucose levels, hypo/hyperglycemia and other complications. Review of Resident #6's Quarterly MDS, dated [DATE], reflected a BIMS score of 10 indicating moderate cognitive impairment.Review of Resident #7's face sheet, dated 09/17/25, reflected a 51-year-male who was admitted to the facility on [DATE] with diagnoses including type 1 diabetes mellitus (an autoimmune disorder where the body's immune system mistakenly attacks and destroys the insulin-producing beta cells in the pancreas) with unspecified diabetic retinopathy with macular edema (medical diagnosis for a person with Type 1 diabetes whose eyesight was affected by a combination of two related eye conditions), major depressive disorder (a common and debilitating mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), and malignant neoplasm of bladder (bladder cancer). Review of Resident #7's care plan reflected focus, dated 04/03/25, was a risk for falls and injuries.Review of Resident #7's Quarterly MDS, dated [DATE], reflected a BIMS score of 15 indicating no cognitive impairment.Observation on 09/17/2025 at 11:11 am of a live roach in the rest room across from Resident #5 and Resident #6s' room Observation 09/17/25 at 12:34