STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675971	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Paradigm at the Oak		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one of six residents (Resident #1) reviewed for abuse. The facility failed to ensure Resident #1 had the right to be free from abuse when on 02/07/2026 at approximately 10:00 AM LVN A told Resident #1 to sit right or he was going to fall back, and he would get blood all over the floor and LVN A would have to pick it up. LVN A pushed Resident #1's head forward in the dining room which humiliated him, and LVN A continued to be Resident #1's nurse after the incident and a the day after the incident. The noncompliance was identified as Past Noncompliance. The Immediate Jeopardy (IJ) began on 02/07/2026 and ended on 02/11/2026. The facility had corrected the noncompliance before the survey began. This failure could place the residents in the facility at risk for abuse and neglect. Finding included: Record review of Resident #1's face sheet, dated 02/19/2026, revealed a fifty-one-year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. His admitting diagnoses included bipolar disorder, current episode hypomanic (a distinct period of abnormally elevated, energetic, or irritable mood lasting at least four consecutive days), thrombotic microangiopathy (a life-threatening, rare syndrome characterized by damage to the lining of small blood vessels (endothelial injury), and systemic lupus erythematosus (a chronic, multi-system autoimmune disease where the immune system attacks healthy tissue). Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated 12/16/2025 Quarterly Assessment Section C - Cognitive Patterns revealed a score of 12 indicating moderate cognitive issues. Record review of Resident #1's care plan revealed a focus dated 11/05/2025 of Resident #1 is depended on staff for meeting emotional, intellectual, physical, and social needs. Record review of a text message dated 02/07/2026 at 10:00 AM from MT A to the Administrator reflected MT A said she would be writing a grievance about LVN A due to an incident that occurred at breakfast. The Administrator asked what happened. MT A responded that LVN A was arguing with Resident #1 about him going to his room then made a threat that, she couldnt [sic]wait till he was off of parole so she could show him what a nurse about. Resident #1 told MT A that LVN A tapped him on the back of the head in the dining room. MT A wrote that she knew LVN A was mad because Resident #1 told LVN A quit talking to herself. The Administrator said okay, and thanks for letting her know.Record review of employment document for LVN A reflected employment termination date 02/12/2026 for disciplinary action. During an interview on 02/18/2026 at 1:26 PM MT A said she reported the incident that occurred on 02/07/2026 between LVN A and Resident #1 by text to the Administrator. MT A said she heard LVN A ask Resident #1 where he was going and told him she was tired of him going back and forth. MT A said she heard Resident #1 tell LVN A that she had whole conversations by herself. MT A said she heard LVN A tell Resident #1, I cannot wait until your parole release because then I can show you what a nurse is about. MT A said Resident #1 told her that LVN A popped him (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	on the back of the head. MT A said that LVN A worked the rest of her shift that day. MT A said that Resident #1 told her he was scared to ask LVN A for anything for the rest of the day. MT A said she reported the incident to the Administrator between 9:30 AM and 10:00 AM on 02/07/2026. MT A said that the Administrator replied to MT A's text message that notified the Administrator about the incident that she would take care of it. MT A said the Administrator did not come to the facility that day. MT A said that LVN A worked the rest of her shift on Saturday 02/07/2026 and her shift on 02/08/2026. During an interview on 02/18/2026 at 3:25 PM Resident #1 said he had a problem with LVN A. He said she was, very opened mouthed. Resident #1 said LVN A would tell him she was tired of giving him his 2:00 PM pill all the time. He said he was in the dining room and LVN A told him to sit right or he was going to fall back, and he would get blood all over the floor and LVN A would have to pick it up; and then she hit the back of his head. He said it did not hurt but made him feel like, she could take over him and made him feel stupid. Resident #1 said other residents saw LVN A hit him, but he did not remember their names. Resident #1 said LVN A did not hit him hard, but it made his head go forward. During an interview on 02/18/2026 at 4:34 PM the DON said LVN A could be argumentative and that LVN A was on the clock and worked for 2 days after the allegations between Resident #1 and LVN A were reported to the Administrator. He said that because LVN A continued to work after the allegation of abuse and neglect this could have put residents at risk of abuse and neglect. During an interview on 02/18/2026 at 5:16 PM CNA A said she was in the dining room with Resident #1 and LVN A and she saw LVN A touch the back of his Resident #1's head and his head went forward. CNA A said she looked at CNA C and asked her Did you see that? and CNA C said Yes. CNA A asked Resident #1 if LVN A pushed the back of his head and Resident #1 told her yes. CNA A said she did not hear LVN A say anything to Resident #1. CNA A said it was never okay to touch a resident in that manner, to push their head. She said LVN A did not tell Resident #1 excuse me or that she was sorry. CNA A said LVN A intentionally pushed his head. CNA A said that LVN A pushed Resident #1's head and kept on walking. CNA A said she was trained in abuse and neglect and that the Administrator was the abuse and neglect coordinator. She said MT A told her she reported the incident to the Administrator and that was why she did not report it. CNA A said LVN A disregarded Resident #1. CNA A said she asked Resident #1 if LVN A pushed his head and Resident #1 told her yes. CNA A said that Resident #1 came to her later in the day and said he did not know why LVN A was still at the facility. CNA A said she told Resident #1 it would be handled. During an interview on 02/19/2026 at 8:12 AM with the ADON, she said she learned about Resident #1's allegation with LVN A on Monday, 02/09/2026. The ADON said she did not know who witnessed the incident. The ADON said she assessed Resident #1 from head to toe and there were no findings of visible discoloration. Prior to the incident, the ADON said she heard from the staff that LVN A was easily agitated. The ADON said the incident was an allegation of abuse and neglect and allegations of abuse and neglect should be reported immediately. She said LVN A was not suspended at the time of the incident. The ADON said a possible negative effect of not suspending LVN A was that residents were subject to the same thing happening to them, either to Resident #1 again or another resident. She said the Administrator was the abuse and neglect coordinator. The ADON said when she spoke with Resident #1 when she assessed him on 02/09/2026 he said he did not want to say anything because he did not want to get anyone in trouble, but he confirmed that LVN A did push the back of his head. Resident #1 said it was not a hard slap but like a little pop. The ADON said Resident #1 told her that during the weekend he did not feel safe and was afraid to ask LVN A for his PRN medication. During an interview on 02/19/2026 at 8:42 AM Resident #1 said after the incident with LVN A he stayed out of her way and avoided her because he did not want to deal with her. Resident #1 said she (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	made him feel uncomfortable and he was worried she might be verbally inappropriate to him again. During an interview on 02/19/2026 at 8:47 AM with CNA C, she said LVN A was behind Resident #1 and she saw LVN A push Resident #1's head forward. She said it was not a full force push, but they should not play with residents by pushing their heads. She said she had been trained in abuse and neglect a million times. She said the Administrator was the abuse and neglect coordinator and abuse and neglect should be reported immediately. CNA C said MT A reported the incident to the Administrator. CNA C said LVN A continued to work that weekend and LVN A was Resident #1's nurse that weekend. During an interview on 02/19/2026 at 12:00 PM Resident #1 said he did not feel comfortable asking for his pain medications from LVN A and he said he was in pain. He said he did not have anyone else to get his pills from because LVN A was his nurse that weekend. He said he felt very very uncomfortable, like he had to beg for his pills and did not want to put up with her crap when he asked for his pills. Resident #1 said when LVN A hit his head in front of people in the dining room it humiliated him. He said he was not fearful, but he did isolate himself a little bit that weekend and was psychologically a little uncomfortable. During an interview on 02/19/2026 at 12:40 PM with the Administrator, she said she received a report of an allegation of abuse and neglect on 02/07/2026 and she did not report it to HHS until Monday 02/09/2026. The Administrator said it was an error on her part not to have reported the incident. She did not report the incident because she thought it was a personal issue between MT A and LVN A and she misjudged. The Administrator said she wanted to investigate the incident to find out what it was before she reported it. The Administrator said she now knew that they were to report the incident and not try to get the facts first. She said she now knew she should have immediately suspended LVN A and reported to HHS immediately. She said the possible negative effect of not immediately suspending LVN A immediately was that the residents could have been subjected to additional abuse. During an interview on 02/19/2026 at 12:40 PM with the RDO, he said he received a call on Monday 02/09/2026 about a text that was sent to the Administrator of the facility on 02/07/2026 involving allegations of abuse and neglect. The RDO said matters of personal relationships between staff could not be taken into consideration when the allegation involved resident abuse or neglect. The RDO said the event should have been immediately reported to HHS in accordance with the facility and state guidelines. The RDO said the facility had a responsibility to protect the residents and remove a possible threat of abuse and neglect and in this case, LVN A was the threat, and she should have been removed by suspending her employment. During an interview on 02/20/2026 at 8:05 AM the ADON said she was not aware of the incident that involved Resident #1 or LVN A until Monday, 02/09/2026. She said both she and the DON should have been contacted about the incident by the Administrator when the Administrator learned of the incident from MT A. The ADON said LVN A should have been suspended that day, immediately pending investigation. She said because there was an allegation of abuse LVN A needed to be removed from the facility to protect the residents from possible further abuse. She said the facility policy was that for any possible allegation of abuse by a staff member, that staff member should be suspended until the investigation was completed. She said she had no doubt that Resident #1 was telling the truth about LVN A putting her hand on his head and pushing his head forward. She said she did not know why the Administrator did not take the steps and report the incident. The ADON said they should not make assumptions about what happened when abuse was reported. She said they were supposed to report incidents of abuse and neglect within two hours of learning about it. She said the facility was the residents' home and they needed to be kept from abuse and neglect. The ADON said the facility abuse and neglect policies were not implemented. During an interview on 02/20/2026 at 9:13 AM the Administrator said allegations of abuse and neglect were supposed to be (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	reported to HHS immediately. The Administrator said the facility policies on reporting and investigating abuse and neglect were not followed. The Administrator said on Monday 02/09/2026 she spoke with Resident #1 about the incident with LVN A that occurred on 02/07/2026 and he said what happened made him uncomfortable. The Administrator said she was not aware that Resident #1 told the ADON that he felt uncomfortable asking for his PRN medications because LVN A was his nurse for the rest of her shift on 02/07/2026 and on 02/08/2026. The Administrator said LVN A should not have continued to be his nurse because there could have been potential danger to Resident #1 and maybe other residents for possible further abuse. During an interview on 02/20/2026 at 12:08 PM with the RNC, she said on Monday 02/09/2026 the Administrator called her and told her about the allegation of abuse and neglect that occurred on Saturday 02/07/2026. The RNC said initially she thought that the incident was not reported to the Administrator by the staff then she learned that the incident was reported to the Administrator by the staff and the Administrator did not report it to HHS. The RNC told the Administrator that the allegation should have been reported to HHS immediately. The RNC told her to inform the DON of the incident and to suspend LVN A immediately. The RNC said the Administrator did not report the allegation of abuse and neglect in a timely manner to HHS and she did not follow facility procedures. The RNC said anything that puts resident in harm both mentally and physical should be reported immediately. The RNC said Resident #1 could have had psychosocial harm. She said that Resident #1 could have feared approaching the nurse. The RNC said she understood that the incident humiliated him. The RNC said the Administrator did not report because of lack of experience. The RNC said the Administrator said there was history of MT A and LVN A not getting along so the Administrator thought there was nothing to the alleged allegations. The RNC said the process for any allegation of abuse and neglect was to report the allegation to HHS, suspend any staff who might be involved in allegations of abuse, and then investigate. Record review of facility policy and procedure on Abuse, Neglect and Exploitation dated October 2024 reflected definition abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychological well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled by technology. Willful, as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Record review on 02/18/2026 of an in-service dated 02/09/2026 by the ROD to the Administrator regarding the facility and HHS policies and procedures on self-reporting allegations of abuse and neglect including expectations for promptly identifying, disclosing, and investigating alleged allegations of abuse and neglect. The in-service included the facility and HHS policies and procedures on self-reporting allegations of abuse and neglect including expectations for promptly identifying and disclosing alleged allegations of abuse and neglect. The in-service included the suspension of any employees alleged to have been involved in the abuse, neglect, or exploitation of residents. The in-service discussed when to report any and all allegations of suspected abuse, neglect, or exploitation, when to suspend any staff member(s) involved in allegations of abuse, neglect, or exploitation and when to begin and how to investigate allegations of abuse, neglect, or exploitation. Record review on 02/18/2026 of an in-service to all facility staff dated 02/09/2026 through 02/11/2026 revealed staff were educated on the facility policy and procedure on Abuse, Neglect and Exploitation including the elements of training, prevention, identification, investigation, protection, and (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	reporting/response. Record review on 02/18/2026 of Resident #1's skin observation dated 02/09/2026 by the ADON revealed no redness, discoloration, or skin tears noted. Record review on 02/18/2026 of Resident #1's pain assessment dated [DATE] by DON of pain assessment revealed pain assessment was secondary to Lupus, no headache noted. Record review on 02/18/2026 of Resident #1's neurological assessments every 30 minutes dated 02/09/2026 through 02/11/2026. Record review on 02/18/2026 of an in-service dated 02/09/2026 through 02/11/2026 revealed all staff were educated on the expectations for maintaining professional boundaries, preserving resident dignity, and preventing behaviors that may be perceived as disrespectful, demeaning, or emotionally harmful. Record review on 02/18/2026 of the Resident Safe Survey Questionnaire Alert/Oriented dated 02/10/2026. Record review of statements from MT A dated 02/09/2026, LVN A dated 02/09/2026, CNA A dated 02/10/2026, and Resident #1 dated 02/09/2026. During an interview on 02/19/2026 at 4:39 PM with LVN B, she said she attended an in-service on 02/10/2026 on abuse and neglect and gave an example of hitting a resident or cursing at a resident as examples of abuse and neglect. She said allegations of abuse and neglect should be reported immediately. She said allegations of abuse and neglect should be reported to the Administrator who was the abuse and neglect coordinator. During an interview on 02/19/2026 at 4:43 PM with CNA F, she said she received training on 02/10/2026 on abuse and neglect. She said abuse could be physical, verbal, sexual and mental. She said exploiting residents was also abuse. She said abuse should be immediately reported to the facility Administrator. She said the Administrator was the abuse and neglect coordinator. During an interview on 02/19/2026 at 4:45 PM with CNA G, she said she was trained in abuse and neglect on 02/10/2026. She said abuse could be physical, mental, or sexual. She said taking a call light away from a resident was a form of abuse. She said abuse should be reported to the Administrator because the Administrator was the abuse and neglect coordinator.

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its written policies and procedures to prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 1 (Resident #1) of 6 residents reviewed for abuse and neglect. The facility failed to remove LVN A from duty and she continued to work with Resident #1 after witnessed abuse was reported to the administrator. The noncompliance was identified as Past Noncompliance. The Immediate Jeopardy (IJ) began on 02/07/2026 and ended on 02/11/2026. The facility had corrected the noncompliance before the survey began. This failure could place the residents in the facility at risk for physical, mental, and/or psychosocial harm and lack of timely reporting of incidents.Finding included: Record review of Resident #1's face sheet, dated 02/19/2026, revealed a fifty-one-year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. His admitting diagnoses included bipolar disorder, current episode hypomanic (a distinct period of abnormally elevated, energetic, or irritable mood lasting at least four consecutive days), thrombotic microangiopathy (a life-threatening, rare syndrome characterized by damage to the lining of small blood vessels (endothelial injury), and systemic lupus erythematosus (a chronic, multi-system autoimmune disease where the immune system attacks healthy tissue). Record review of Resident #1's care plan revealed a focus dated 11/05/2025 of Resident #1 is depended on staff for meeting emotional, intellectual, physical, and social needs. Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated 12/16/2025 Quarterly Assessment Section C - Cognitive Patterns revealed a score of 12 indicating moderate cognitive issues. Record review of text message dated 02/07/2026 at 10:00 AM from MT A to the Administrator reflected MT A said she would be writing a grievance on LVN A due to an incident that occurred at breakfast. The Administrator asked what happened. MT A responded LVN A was arguing with Resident #1 about him going to his room then made a threat that, she couldnt [sic] wait till he was off of parole so she could show him what a nurse about. Resident #1 told MT A that LVN A tapped him in the back of the head in the dining room. MT A wrote that she knew LVN A was mad because Resident #1 told LVN A quit talking to herself. The Administrator said okay, thanks for letting me know.Record review of employment document for LVN A reflected employment termination date 02/12/2026 for disciplinary action. During an interview on 02/18/2026 at 1:26 PM MT A said she reported the incident that occurred on 02/07/2026 between LVN A and Resident #1 by text to the Administrator. MT A said she heard LVN A ask Resident #1 where he was going and told him she was tired of him going back and forth. MT A said she heard Resident #1 tell LVN A that she had whole conversations by herself. MT A said she heard LVN A tell Resident #1, I cannot wait until your parole release because then I can show you what a nurse is about. MT A said Resident #1 told her that LVN A popped him in the back of the head. MT A said that LVN A worked the rest of her shift that day. MT A said that Resident #1 told her he was scared to ask LVN A for anything for the rest of the day. MT A said she reported the incident to the Administrator between 9:30 AM and 10:00 AM on 02/07/2026. MT A said that the Administrator replied to MT A's text message that notified the Administrator about the incident that she would take care of it. MT A said the Administrator did not come to the facility that day. MT A said that LVN A worked the rest of her shift on Saturday 02/07/2026 and her shift on 02/08/2026. During an interview on 02/18/2026 at 3:25 PM Resident #1 said he had a problem with LVN A. He said she was, very opened mouthed. Resident #1 said LVN A would tell him she was tired of giving him his 2:00 PM pill all the time. He said he was in the dining room and LVN A told him to sit right or he was going to fall back, and he would get blood all over the floor and LVN A would have to pick it up and then she hit the back of his head. He said (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	it did not hurt but made him feel like, she could take over him and made him feel stupid. Resident #1 said other residents saw LVN A hit him, but he did not remember their names. Resident #1 said LVN A did not hit him hard, but it made his head go forward. During an interview on 02/18/2026 at 4:34 PM the DON said LVN A could be argumentative and that LVN A was on the clock and worked for 2 days after the allegations between Resident #1 and LVN A were reported to the Administrator. He said that because LVN A continued to work after the allegation of abuse and neglect this could have put residents at risk of abuse and neglect. During an interview on 02/18/2026 at 5:16 PM CNA A said she was in the dining room with Resident #1 and LVN A and she saw LVN A touch the back of his Resident #1's head and his head went forward. CNA A said she looked at CNA C and asked her did you see that and CNA C said yes. CNA A asked Resident #1 if LVN A pushed the back of his head and Resident #1 told her yes. CNA A said she did not hear LVN A say anything to Resident #1. CNA A said it was never okay to touch a resident in that manner, to push their head. She said LVN A did not tell Resident #1 excuse me or she was sorry. CNA A said LVN A intentionally pushed his head. CNA A said that LVN A pushed Resident #1's head and kept on walking. CNA A said she was trained in abuse and neglect and that the Administrator was the abuse and neglect coordinator. She said MT A told her she reported the incident to the Administrator and that was why she did not report it. CNA A said LVN A disregarded Resident #1. CNA A said she asked Resident #1 if LVN A pushed his head and Resident #1 told her yes. CNA A said that Resident #1 came to her later in the day and said he did not know why LVN A was still at the facility. CNA A said she told Resident #1 it would be handled. During an interview on 02/19/2026 at 8:12 AM with the ADON she said she learned about Resident #1's allegation with LVN A on Monday, 02/09/2026. The ADON said she did not know who witnessed the incident. The ADON said she assessed Resident #1 from head to toe and there were no findings of visible discoloration. Prior to the incident, the ADON said she heard from the staff that LVN A was easily agitated. The ADON said the incident was an allegation of abuse and neglect and allegations of abuse and neglect should be reported immediately. She said LVN A was not suspended at the time of the incident. The ADON said a possible negative effect of not suspending LVN A was that residents were subject to the same thing happening to them, either to Resident #1 again or another resident. She said the Administrator was the abuse and neglect coordinator. The ADON said when she spoke with Resident #1 when she assessed him on 02/09/2026 he said he did not want to say anything because he did not want to get anyone in trouble, but he confirmed that LVN A did push the back of his head. Resident #1 said it was not a hard slap but like a little pop. The ADON said Resident #1 told her that during the weekend he did not feel safe and was afraid to ask LVN A for his PRN medication. During an interview on 02/19/2026 at 8:42 AM Resident #1 said after the incident with LVN A he stayed out of her way and avoided her because he did not want to deal with her. Resident #1 said she made him feel uncomfortable and he was worried she might be verbally inappropriate to him again. During an interview on 02/19/2026 at 8:47 AM with CNA C she said LVN A was behind Resident #1 and she saw LVN A push Resident #1's head forward. She said it was not a full force push, but you should not play with residents by pushing their heads. She said she had been trained in abuse and neglect a million times. She said the Administrator was the abuse and neglect coordinator and abuse and neglect should be reported immediately. CNA C said MT A reported the incident to the Administrator. CNA C said LVN A continued to work that weekend and LVN A was Resident #1's nurse that weekend. During an interview on 02/19/2026 at 12:00 PM Resident #1 said he did not feel comfortable asking for his pain medications from LVN A and he said he was in pain. He said he did not have anyone else to get his pills from because LVN A was his nurse that weekend. He said he felt very uncomfortable, like he had to beg for his pills and did not want to put up with her crap (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675971	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

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

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	when he asked for his pills. Resident #1 said when LVN A hit his head in front of people in the dining room it humiliated him. He said he was not fearful, but he did isolate himself a little bit that weekend and was psychologically a little uncomfortable. During an interview on 02/19/2026 at 12:40 PM with the Administrator she said she received a report of an allegation of abuse and neglect on 02/07/2026 and she did not report it to HHS until Monday 02/09/2026. The Administrator said it was an error on her part not to have reported the incident. She did not report the incident because she thought it was a personal issue between MT A and LVN A and she misjudged. The Administrator said she wanted to investigate the incident to find out what it was before she reported it. The Administrator said she now knows that you report the incident and not try to get the facts first. She said she now knows she should have immediately suspended LVN A and reported to HHS immediately. She said the possible negative effect of not immediately suspending LVN A immediately was that the residents could have been subjected to additional abuse. During an interview on 02/19/2026 at 12:40 PM with the RDO he said he received a call on Monday 02/09/2026 about a text that was sent to the Administrator of the facility on 02/07/2026 involving allegations of abuse and neglect. The RDO said matters of personal relationships between staff cannot be taken into consideration when the allegation involved resident abuse or neglect. The RDO said the event should have been immediately reported to HHS in accordance with the facility and state guidelines. The RDO said the facility had a responsibility to protect the residents and remove a possible threat of abuse and neglect and, in this case, LVN A was the threat, and she should have been removed by suspending her employment. During an interview on 02/20/2026 at 8:05 AM the ADON said she was not aware of the incident that involved Resident #1 or LVN A until Monday, 02/09/2026. She said both she and the DON should have been contacted about the incident by the Administrator when the Administrator learned of the incident from MT A. The ADON said LVN A should have been suspended that day, immediately pending investigation. She said because there was an allegation of abuse LVN A needed to be removed from the facility to protect the residents from possible further abuse. She said the facility policy was that for any possible allegation of abuse by a staff member, that staff member should be suspended until the investigation was completed. She said she had no doubt that Resident #1 was telling the truth about LVN A putting her hand on his head and pushing his head forward. She said she did not know why the Administrator did not take the steps and report the incident. The ADON said you do not make assumptions about what happened when abuse was reported. She said you were supposed to report incidents of abuse and neglect within two hours of learning about it. She said the facility was the residents' home and they needed to be kept from abuse and neglect. The ADON said the facility abuse and neglect policies were not implemented. During an interview on 02/20/2026 at 9:13 AM the Administrator said allegations of abuse and neglect are supposed to be reported to HHS immediately. The Administrator said the facility policies on reporting and investigating abuse and neglect were not followed. The Administrator said on Monday 02/09/2026 she spoke with Resident #1 about the incident with LVN A that occurred on 02/07/2026 and he said what happened made him uncomfortable. The Administrator said she was not aware that Resident #1 told the ADON that he felt uncomfortable asking for his PRN medications because LVN A she was his nurse for the rest of her shift on 02/07/2026 and on 02/08/2026. The Administrator said LVN A should not have continued to be his nurse because there could have been potential danger to Resident #1 and maybe other residents for possible further abuse. During an interview on 02/20/2026 at 12:08 PM with the RNC she said on Monday 02/09/2026 the Administrator called her and told her about the allegation of abuse and neglect that occurred on Saturday 02/07/2026. The RNC said initially she thought that the incident was not reported to the Administrator by the staff then she learned that the incident was (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	reported to the Administrator by the staff and the Administrator did not report it to HHS. The RNC told the Administrator that the allegation should have been reported to HHS immediately. The RNC told her to inform the DON of the incident and to suspend LVN A immediately. The RNC said the Administrator did not report the allegation of abuse and neglect in a timely manner to HHS and she did not follow facility procedures. The RNC said anything that puts resident in harm both mentally and physical should be reported immediately. The RNC said Resident #1 could have had psychosocial harm. She said that Resident #1 could have feared approaching the nurse. The RNC said she understood that the incident humiliated him. The RNC said the Administrator did not report because of lack of experience. The RNC said the Administrator said there was history of MT A and LVN A not getting along so the Administrator thought there was nothing to the alleged allegations. The RNC said the process for any allegation of abuse and neglect was to report the allegation to HHS, suspend any staff who might be involved in allegations of abuse, and then investigate. Record review on 02/18/2026 of in-service dated 02/09/2026 by the ROD to the Administrator regarding the facility and HHS policies and procedures on self-reporting allegations of abuse and neglect including expectations for promptly identifying, disclosing, and investigating alleged allegations of abuse and neglect. The in-service included the facility and HHS policies and procedures on self-reporting allegations of abuse and neglect including expectations for promptly identifying and disclosing alleged allegations of abuse and neglect. The in-service included the suspension of any employees alleged to have been involved in the abuse, neglect, or exploitation of residents. The in-service discussed when to report any and all allegations of suspected abuse, neglect, or exploitation, when to suspend any staff member(s) involved in allegations of abuse, neglect, or exploitation and when to begin and how to investigate allegations of abuse, neglect, or exploitation. Record review on 02/18/2026 of in-service to all facility staff dated 02/09/2026 through 02/11/2026 on facility policy and procedure on Abuse, Neglect and Exploitation including the elements of training, prevention, identification, investigation, protection, and reporting/response. Record review on 02/18/2026 of Resident #1 skin observation dated 02/09/2026 by ADON that reflected no redness, discoloration, or skin tears noted. Record review on 02/18/2026 of Resident #1 pain assessment dated [DATE] by DON of pain assessment that reflected pain assessment was secondary to Lupus, no headache noted. Record review on 02/18/2026 of Resident #1 neurological assessments every 30 minutes dated 02/09/2026 through 02/11/2026. Record review on 02/18/2026 of in-service dated 02/08/2026 through 02/11/2026 to all staff on reinforcement of expectations for maintain professional boundaries, preserving resident dignity, and preventing behaviors that may be perceived as disrespectful, demeaning, or emotionally harmful. Record review on 02/18/2026 of Resident Safe Survey Questionnaire Alert/Oriented dated 02/10/2026. Record review of statements from MT A dated 02/09/2026, LVN A dated 02/09/2026, CNA A dated 02/10/2026, and Resident #1 dated 02/09/2026.During an interview on 02/19/2026 at 4:39 PM with LVN B she said attended an in-service on 02/10/2026 on abuse and neglect and gave an example of hitting a resident or cursing at a resident as examples of abuse and neglect. She said allegations of abuse and neglect should be reported immediately. She said allegations of abuse and neglect should be reported to the Administrator who was the abuse and neglect coordinator. During an interview on 02/19/2026 at 4:43 PM with CNA F she said she received training on 02/10/2026 on abuse and neglect. She said abuse can be physical, verbal, sexual and mental. She said exploiting residents was also abuse. She said abused should be immediately reported to the facility Administrator. She said the Administrator was the abuse and neglect coordinator. During an interview on 02/19/2026 at 4:45 PM with CNA G she said she was trained in abuse and neglect on 02/10/2026. She said abuse can be physical, mental, or sexual. She said taking a call light away from a resident (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	was a form of abuse. She said abuse should be reported to the Administrator because the Administrator was the abuse and neglect coordinator. Record review of facility policy and procedure on Abuse, Neglect and Exploitation dated October 2024 reflected - Protection: Immediate response: any employee alleged to be involved in an instance(s) of abuse and/or neglect will be interviewed and suspended pending investigation and will not be permitted to return to work unless and until such allegations of abuse/neglect are unsubstantiated or it is determined that no residents are in danger with the employee's return to work.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events caused the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the State Survey Agency in accordance with State law through established procedures for 1 of 6 residents (Resident #1) reviewed for reporting allegations of abuse. The facility failed to report physical and verbal abuse to the State Agency within 2 hours when, on 02/07/2026, it was reported to Administrator by MT A that LVN A made a threat to Resident #1 and tapped Resident #1 in the back of the head. The noncompliance was identified as Past Noncompliance. The Immediate Jeopardy (IJ) began on 02/07/2026 and ended on 02/11/2026. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Finding included: Record review of Resident #1's face sheet, dated 02/19/2026, revealed a fifty-one-year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. His admitting diagnoses included bipolar disorder, current episode hypomanic (a distinct period of abnormally elevated, energetic, or irritable mood lasting at least four consecutive days), thrombotic microangiopathy (a life-threatening, rare syndrome characterized by damage to the lining of small blood vessels (endothelial injury), and systemic lupus erythematosus (a chronic, multi-system autoimmune disease where the immune system attacks healthy tissue). Record review of Resident #1's care plan revealed a focus dated 11/05/2025 of Resident #1 is depended on staff for meeting emotional, intellectual, physical, and social needs. Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated 12/16/2025 Quarterly Assessment Section C - Cognitive Patterns revealed a score of 12 indicating moderate cognitive issues. Record review of text message dated 02/07/2026 at 10:00 AM from MT A to the Administrator reflected MT A said she would be writing a grievance on LVN A due to an incident that occurred at breakfast. The Administrator asked what happened. MT A responded LVN A was arguing with Resident #1 about him going to his room then made a threat that, she couldnt wait till he was off of parole so she could show him what a nurse about. Resident #1 told MT A that LVN A tapped him in the back of the head in the dining room. MT A wrote that she knew LVN A was mad because Resident #1 told LVN A quit talking to herself. The Administrator said okay, thanks for letting me know.Record review of employment document for LVN A reflected employment termination date 02/12/2026 for disciplinary action. During an interview on 02/18/2026 at 1:26 PM MT A said she reported the incident that occurred on 02/07/2026 between LVN A and Resident #1 by text to the Administrator. MT A said she heard LVN A ask Resident #1 where he was going and told him she was tired of him going back and forth. MT A said she heard Resident #1 tell LVN A that she had whole conversations by herself. MT A said she heard LVN A tell Resident #1, I cannot wait until your parole release because then I can show you what a nurse is about. MT A said Resident #1 told her that LVN A popped him in the back of the head. MT A said that LVN A worked the rest of her shift that day. MT A said that Resident #1 told her he was scared to ask LVN A for anything for the rest of the day. MT A said she reported the incident to the Administrator between 9:30 AM and 10:00 AM on 02/07/2026. MT A said that the Administrator replied to MT A's text message that notified the Administrator about the incident that she would take care of it. MT A said the Administrator did not come to the facility that day. MT A said that LVN A worked the rest of her shift on (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Saturday 02/07/2026 and her shift on 02/08/2026. During an interview on 02/18/2026 at 3:25 PM Resident #1 said he had a problem with LVN A. He said she was, very opened mouthed. Resident #1 said LVN A would tell him she was tired of giving him his 2:00 PM pill all the time. He said he was in the dining room and LVN A told him to sit right or he was going to fall back, and he would get blood all over the floor and LVN A would have to pick it up and then she hit the back of his head. He said it did not hurt but made him feel like, she could take over him and made him feel stupid. Resident #1 said other residents saw LVN A hit him, but he did not remember their names. Resident #1 said LVN A did not hit him hard, but it made his head go forward. During an interview on 02/18/2026 at 4:34 PM the DON said LVN A could be argumentative and that LVN A was on the clock and worked for 2 days after the allegations between Resident #1 and LVN A were reported to the Administrator. He said that because LVN A continued to work after the allegation of abuse and neglect this could have put residents at risk of abuse and neglect. During an interview on 02/18/2026 at 5:16 PM CNA A said she was in the dining room with Resident #1 and LVN A and she saw LVN A touch the back of his Resident #1's head and his head went forward. CNA A said she looked at CNA C and asked her did you see that and CNA C said yes. CNA A asked Resident #1 if LVN A pushed the back of his head and Resident #1 told her yes. CNA A said she did not hear LVN A say anything to Resident #1. CNA A said it was never okay to touch a resident in that manner, to push their head. She said LVN A did not tell Resident #1 excuse me or she was sorry. CNA A said LVN A intentionally pushed his head. CNA A said that LVN A pushed Resident #1's head and kept on walking. CNA A said she was trained in abuse and neglect and that the Administrator was the abuse and neglect coordinator. She said MT A told her she reported the incident to the Administrator and that was why she did not report it. CNA A said LVN A disregarded Resident #1. CNA A said she asked Resident #1 if LVN A pushed his head and Resident #1 told her yes. CNA A said that Resident #1 came to her later in the day and said he did not know why LVN A was still at the facility. CNA A said she told Resident #1 it would be handled. During an interview on 02/19/2026 at 8:12 AM with the ADON she said she learned about Resident #1's allegation with LVN A on Monday, 02/09/2026. The ADON said she did not know who witnessed the incident. The ADON said she assessed Resident #1 from head to toe and there were no findings of visible discoloration. Prior to the incident, the ADON said she heard from the staff that LVN A was easily agitated. The ADON said the incident was an allegation of abuse and neglect and allegations of abuse and neglect should be reported immediately. She said LVN A was not suspended at the time of the incident. The ADON said a possible negative effect of not suspending LVN A was that residents were subject to the same thing happening to them, either to Resident #1 again or another resident. She said the Administrator was the abuse and neglect coordinator. The ADON said when she spoke with Resident #1 when she assessed him on 02/09/2026 he said he did not want to say anything because he did not want to get anyone in trouble, but he confirmed that LVN A did push the back of his head. Resident #1 said it was not a hard slap but like a little pop. The ADON said Resident #1 told her that during the weekend he did not feel safe and was afraid to ask LVN A for his PRN medication. During an interview on 02/19/2026 at 8:42 AM Resident #1 said after the incident with LVN A he stayed out of her way and avoided her because he did not want to deal with her. Resident #1 said she made him feel uncomfortable and he was worried she might be verbally inappropriate to him again. During an interview on 02/19/2026 at 8:47 AM with CNA C she said LVN A was behind Resident #1 and she saw LVN A push Resident #1's head forward. She said it was not a full force push, but you should not play with residents by pushing their heads. She said she had been trained in abuse and neglect a million times. She said the Administrator was the abuse and neglect coordinator and abuse and neglect should be reported immediately. CNA C said MT A reported the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident to the Administrator. CNA C said LVN A continued to work that weekend and LVN A was Resident #1's nurse that weekend. During an interview on 02/19/2026 at 12:00 PM Resident #1 said he did not feel comfortable asking for his pain medications from LVN A and he said he was in pain. He said he did not have anyone else to get his pills from because LVN A was his nurse that weekend. He said he felt very very uncomfortable, like he had to beg for his pills and did not want to put up with her crap when he asked for his pills. Resident #1 said when LVN A hit his head in front of people in the dining room it humiliated him. He said he was not fearful, but he did isolate himself a little bit that weekend and was psychologically a little uncomfortable. During an interview on 02/19/2026 at 12:40 PM with the Administrator she said she received a report of an allegation of abuse and neglect on 02/07/2026 and she did not report it to HHS until Monday 02/09/2026. The Administrator said it was an error on her part not to have reported the incident. She did not report the incident because she thought it was a personal issue between MT A and LVN A and she misjudged. The Administrator said she wanted to investigate the incident to find out what it was before she reported it. The Administrator said she now knows that you report the incident and not try to get the facts first. She said she now knows she should have immediately suspended LVN A and reported to HHS immediately. She said the possible negative effect of not immediately suspending LVN A immediately was that the residents could have been subjected to additional abuse. During an interview on 02/19/2026 at 12:40 PM with the RDO he said he received a call on Monday 02/09/2026 about a text that was sent to the Administrator of the facility on 02/07/2026 involving allegations of abuse and neglect. The RDO said matters of personal relationships between staff cannot be taken into consideration when the allegation involved resident abuse or neglect. The RDO said the event should have been immediately reported to HHS in accordance with the facility and state guidelines. The RDO said the facility had a responsibility to protect the residents and remove a possible threat of abuse and neglect and, in this case, LVN A was the threat, and she should have been removed by suspending her employment. During an interview on 02/20/2026 at 8:05 AM the ADON said she was not aware of the incident that involved Resident #1 or LVN A until Monday, 02/09/2026. She said both she and the DON should have been contacted about the incident by the Administrator when the Administrator learned of the incident from MT A. The ADON said LVN A should have been suspended that day, immediately pending investigation. She said because there was an allegation of abuse LVN A needed to be removed from the facility to protect the residents from possible further abuse. She said the facility policy was that for any possible allegation of abuse by a staff member, that staff member should be suspended until the investigation was completed. She said she had no doubt that Resident #1 was telling the truth about LVN A putting her hand on his head and pushing his head forward. She said she did not know why the Administrator did not take the steps and report the incident. The ADON said you do not make assumptions about what happened when abuse was reported. She said you were supposed to report incidents of abuse and neglect within two hours of learning about it. She said the facility was the residents' home and they needed to be kept from abuse and neglect. The ADON said the facility abuse and neglect policies were not implemented. During an interview on 02/20/2026 at 9:13 AM the Administrator said allegations of abuse and neglect are supposed to be reported to HHS immediately. The Administrator said the facility policies on reporting and investigating abuse and neglect were not followed. The Administrator said on Monday 02/09/2026 she spoke with Resident #1 about the incident with LVN A that occurred on 02/07/2026 and he said what happened made him uncomfortable. The Administrator said she was not aware that Resident #1 told the ADON that he felt uncomfortable asking for his PRN medications because LVN A she was his nurse for the rest of her shift on 02/07/2026 and on 02/08/2026. The Administrator said LVN A should not (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have continued to be his nurse because there could have been potential danger to Resident #1 and maybe other residents for possible further abuse. During an interview on 02/20/2026 at 12:08 PM with the RNC she said on Monday 02/09/2026 the Administrator called her and told her about the allegation of abuse and neglect that occurred on Saturday 02/07/2026. The RNC said initially she thought that the incident was not reported to the Administrator by the staff then she learned that the incident was reported to the Administrator by the staff and the Administrator did not report it to HHS. The RNC told the Administrator that the allegation should have been reported to HHS immediately. The RNC told her to inform the DON of the incident and to suspend LVN A immediately. The RNC said the Administrator did not report the allegation of abuse and neglect in a timely manner to HHS and she did not follow facility procedures. The RNC said anything that puts resident in harm both mentally and physical should be reported immediately. The RNC said Resident #1 could have had psychosocial harm. She said that Resident #1 could have feared approaching the nurse. The RNC said she understood that the incident humiliated him. The RNC said the Administrator did not report because of lack of experience. The RNC said the Administrator said there was history of MT A and LVN A not getting along so the Administrator thought there was nothing to the alleged allegations. The RNC said the process for any allegation of abuse and neglect was to report the allegation to HHS, suspend any staff who might be involved in allegations of abuse, and then investigate. Record review on 02/18/2026 of in-service dated 02/09/2026 by the ROD to the Administrator regarding the facility and HHS policies and procedures on self-reporting allegations of abuse and neglect including expectations for promptly identifying, disclosing, and investigating alleged allegations of abuse and neglect. The in-service included the facility and HHS policies and procedures on self-reporting allegations of abuse and neglect including expectations for promptly identifying and disclosing alleged allegations of abuse and neglect. The in-service included the suspension of any employees alleged to have been involved in the abuse, neglect, or exploitation of residents. The in-service discussed when to report any and all allegations of suspected abuse, neglect, or exploitation, when to suspend any staff member(s) involved in allegations of abuse, neglect, or exploitation and when to begin and how to investigate allegations of abuse, neglect, or exploitation. Record review on 02/18/2026 of in-service to all facility staff dated 02/09/2026 through 02/11/2026 on facility policy and procedure on Abuse, Neglect and Exploitation including the elements of training, prevention, identification, investigation, protection, and reporting/response. Record review on 02/18/2026 of Resident #1 skin observation dated 02/09/2026 by ADON that reflected no redness, discoloration, or skin tears noted. Record review on 02/18/2026 of Resident #1 pain assessment dated [DATE] by DON of pain assessment that reflected pain assessment was secondary to Lupus, no headache noted. Record review on 02/18/2026 of Resident #1 neurological assessments every 30 minutes dated 02/09/2026 through 02/11/2026. Record review on 02/18/2026 of in-service to all staff dated 02/09/2-26 through 02/11/2026 on reinforcement of expectations for maintain professional boundaries, preserving resident dignity, and preventing behaviors that may be perceived as disrespectful, demeaning, or emotionally harmful. Record review 0on 02/18/2026 of Resident Safe Survey Questionnaire Alert/Oriented dated 02/10/2026. Record review of statements from MT A dated 02/09/2026, LVN A dated 02/09/2026, CNA A dated 02/10/2026, and Resident #1 dated 02/09/2026.During an interview on 02/19/2026 at 4:39 PM with LVN D she said attended an in-service on 02/10/2026 on abuse and neglect and gave an example of hitting a resident or cursing at a resident as examples of abuse and neglect. She said allegations of abuse and neglect should be reported immediately. She said allegations of abuse and neglect should be reported to the Administrator who was the abuse and neglect coordinator. During an interview on 02/19/2026 at 4:43 PM with CNA F she said she received training on (continued on next page)

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	02/20/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/10/2026 on abuse and neglect. She said abuse can be physical, verbal, sexual and mental. She said exploiting residents was also abuse. She said abused should be immediately reported to the facility Administrator. She said the Administrator was the abuse and neglect coordinator. During an interview on 02/19/2026 at 4:45 PM with CNA G she said she was trained in abuse and neglect on 02/10/2026. She said abuse can be physical, mental, or sexual. She said taking a call light away from a resident was a form of abuse. She said abuse should be reported to the Administrator because the Administrator was the abuse and neglect coordinator. Record review of facility policy and procedure on Abuse, Neglect and Exploitation dated October 2024 reflected report abuse (with or without serious bodily injury) immediately, but not later than two hours after the incident occurs or is suspected.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675971	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Paradigm at the Oak		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to have evidence that all allegations of abuse, neglect, or mistreatment were thoroughly investigated and documented for 1 of 6 residents (Resident #1) reviewed for abuse and neglect. The facility failed to have evidence that a thorough investigation was conducted following the allegation that on 02/07/2026 LVN A spoke tapped Resident #1 in the back of the head. The noncompliance was identified as Past Noncompliance. The Immediate Jeopardy (IJ) began on 02/07/2026 and ended on 02/11/2026. The facility had corrected the noncompliance before the survey began. This deficient practice could place residents at risk for abuse and neglect by not investigating injuries of unknown origin.Finding included: Record review of Resident #1's face sheet, dated 02/19/2026, revealed a fifty-one-year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. His admitting diagnoses included bipolar disorder, current episode hypomanic (a distinct period of abnormally elevated, energetic, or irritable mood lasting at least four consecutive days), thrombotic microangiopathy (a life-threatening, rare syndrome characterized by damage to the lining of small blood vessels (endothelial injury), and systemic lupus erythematosus (a chronic, multi-system autoimmune disease where the immune system attacks healthy tissue). Record review of Resident #1's care plan revealed a focus dated 11/05/2025 of Resident #1 is depended on staff for meeting emotional, intellectual, physical, and social needs. Record review of Resident #1's MDS (clinical assessment to determine resident's strength and needs) dated 12/16/2025 Quarterly Assessment Section C - Cognitive Patterns revealed a score of 12 indicating moderate cognitive issues. Record review of text message dated 02/07/2026 at 10:00 AM from MT A to the Administrator reflected MT A said she would be writing a grievance on LVN A due to an incident that occurred at breakfast. The Administrator asked what happened. MT A responded LVN A was arguing with Resident #1 about him going to his room then made a threat that, she couldnt [sic] wait till he was off of parole so she could show him what a nurse about. Resident #1 told MT A that LVN A tapped him in the back of the head in the dining room. MT A wrote that she knew LVN A was mad because Resident #1 told LVN A quit talking to herself. The Administrator said okay, thanks for letting me know.Record review of employment document for LVN A reflected employment termination date 02/12/2026 for disciplinary action. During an interview on 02/18/2026 at 1:26 PM MT A said she reported the incident that occurred on 02/07/2026 between LVN A and Resident #1 by text to the Administrator. MT A said she heard LVN A ask Resident #1 where he was going and told him she was tired of him going back and forth. MT A said she heard Resident #1 tell LVN A that she had whole conversations by herself. MT A said she heard LVN A tell Resident #1, I cannot wait until your parole release because then I can show you what a nurse is about. MT A said Resident #1 told her that LVN A popped him in the back of the head. MT A said that LVN A worked the rest of her shift that day. MT A said that Resident #1 told her he was scared to ask LVN A for anything for the rest of the day. MT A said she reported the incident to the Administrator between 9:30 AM and 10:00 AM on 02/07/2026. MT A said that the Administrator replied to MT A's text message that notified the Administrator about the incident that she would take care of it. MT A said the Administrator did not come to the facility that day. MT A said that LVN A worked the rest of her shift on Saturday 02/07/2026 and her shift on 02/08/2026. During an interview on 02/18/2026 at 3:25 PM Resident #1 said he had a problem with LVN A. He said she was, very opened mouthed. Resident #1 said LVN A would tell him she was tired of giving him his 2:00 PM pill all the time. He said he was in the dining room and LVN A told him to sit right or he was going to fall back, and he would get blood all over the floor and LVN A would have to pick it up and then she hit the back of his head. He said it did not hurt but made him feel like, she could take over him and (continued on next page)

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

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	made him feel stupid. Resident #1 said other residents saw LVN A hit him, but he did not remember their names. Resident #1 said LVN A did not hit him hard, but it made his head go forward. During an interview on 02/18/2026 at 4:34 PM the DON said LVN A could be argumentative and that LVN A was on the clock and worked for 2 days after the allegations between Resident #1 and LVN A were reported to the Administrator. He said that because LVN A continued to work after the allegation of abuse and neglect this could have put residents at risk of abuse and neglect. During an interview on 02/18/2026 at 5:16 PM CNA A said she was in the dining room with Resident #1 and LVN A and she saw LVN A touch the back of his Resident #1's head and his head went forward. CNA A said she looked at CNA C and asked her did you see that and CNA C said yes. CNA A asked Resident #1 if LVN A pushed the back of his head and Resident #1 told her yes. CNA A said she did not hear LVN A say anything to Resident #1. CNA A said it was never okay to touch a resident in that manner, to push thir head. She said LVN A did not tell Resident #1 excuse me or she was sorry. CNA A said LVN A intentionally pushed his head. CNA A said that LVN A pushed Resident #1's head and kept on walking. CNA A said she was trained in abuse and neglect and that the Administrator was the abuse and neglect coordinator. She said MT A told her she reported the incident to the Administrator and that was why she did not report it. CNA A said LVN A disregarded Resident #1. CNA A said she asked Resident #1 if LVN A pushed his head and Resident #1 told her yes. CNA A said that Resident #1 came to her later in the day and said he did not know why LVN A was still at the facility. CNA A said she told Resident #1 it would be handled. During an interview on 02/19/2026 at 8:12 AM with the ADON she said she learned about Resident #1's allegation with LVN A on Monday, 02/09/2026. The ADON said she did not know who witnessed the incident. The ADON said she assessed Resident #1 from head to toe and there were no findings of visible discoloration. Prior to the incident, the ADON said she heard from the staff that LVN A was easily agitated. The ADON said the incident was an allegation of abuse and neglect and allegations of abuse and neglect should be reported immediately. She said LVN A was not suspended at the time of the incident. The ADON said a possible negative effect of not suspending LVN A was that residents were subject to the same thing happening to them, either to Resident #1 again or another resident. She said the Administrator was the abuse and neglect coordinator. The ADON said when she spoke with Resident #1 when she assessed him on 02/09/2026 he said he did not want to say anything because he did not want to get anyone in trouble, but he confirmed that LVN A did push the back of his head. Resident #1 said it was not a hard slap but like a little pop. The ADON said Resident #1 told her that during the weekend he did not feel safe and was afraid to ask LVN A for his PRN medication. During an interview on 02/19/2026 at 8:42 AM Resident #1 said after the incident with LVN A he stayed out of her way and avoided her because he did not want to deal with her. Resident #1 said she made him feel uncomfortable and he was worried she might be verbally inappropriate to him again. During an interview on 02/19/2026 at 8:47 AM with CNA C she said LVN A was behind Resident #1 and she saw LVN A push Resident #1's head forward. She said it was not a full force push, but you should not play with residents by pushing their heads. She said she had been trained in abuse and neglect a million times. She said the Administrator was the abuse and neglect coordinator and abuse and neglect should be reported immediately. CNA C said MT A reported the incident to the Administrator. CNA C said LVN A continued to work that weekend and LVN A was Resident #1's nurse that weekend. During an interview on 02/19/2026 at 12:00 PM Resident #1 said he did not feel comfortable asking for his pain medications from LVN A and he said he was in pain. He said he did not have anyone else to get his pills from because LVN A was his nurse that weekend. He said he felt very uncomfortable, like he had to beg for his pills and did not want to put up with her crap when he asked for his pills. Resident #1 said when LVN A hit his head (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	in front of people in the dining room it humiliated him. He said he was not fearful, but he did isolate himself a little bit that weekend and was psychologically a little uncomfortable. During an interview on 02/19/2026 at 12:40 PM with the Administrator she said she received a report of an allegation of abuse and neglect on 02/07/2026 and she did not report it to HHS until Monday 02/09/2026. The Administrator said it was an error on her part not to have reported the incident. She did not report the incident because she thought it was a personal issue between MT A and LVN A and she misjudged. The Administrator said she wanted to investigate the incident to find out what it was before she reported it. The Administrator said she now knows that you report the incident and not try to get the facts first. She said she now knows she should have immediately suspended LVN A and reported to HHS immediately. She said the possible negative effect of not immediately suspending LVN A immediately was that the residents could have been subjected to additional abuse. During an interview on 02/19/2026 at 12:40 PM with the RDO he said he received a call on Monday 02/09/2026 about a text that was sent to the Administrator of the facility on 02/07/2026 involving allegations of abuse and neglect. The RDO said matters of personal relationships between staff cannot be taken into consideration when the allegation involved resident abuse or neglect. The RDO said the event should have been immediately reported to HHS in accordance with the facility and state guidelines. The RDO said the facility had a responsibility to protect the residents and remove a possible threat of abuse and neglect and, in this case, LVN A was the threat, and she should have been removed by suspending her employment. During an interview on 02/20/2026 at 8:05 AM the ADON said she was not aware of the incident that involved Resident #1 or LVN A until Monday, 02/09/2026. She said both she and the DON should have been contacted about the incident by the Administrator when the Administrator learned of the incident from MT A. The ADON said LVN A should have been suspended that day, immediately pending investigation. She said because there was an allegation of abuse LVN A needed to be removed from the facility to protect the residents from possible further abuse. She said the facility policy was that for any possible allegation of abuse by a staff member, that staff member should be suspended until the investigation was completed. She said she had no doubt that Resident #1 was telling the truth about LVN A putting her hand on his head and pushing his head forward. She said she did not know why the Administrator did not take the steps and report the incident. The ADON said you do not make assumptions about what happened when abuse was reported. She said you were supposed to report incidents of abuse and neglect within two hours of learning about it. She said the facility was the residents' home and they needed to be kept from abuse and neglect. The ADON said the facility abuse and neglect policies were not implemented. During an interview on 02/20/2026 at 9:13 AM the Administrator said allegations of abuse and neglect are supposed to be reported to HHS immediately. The Administrator said the facility policies on reporting and investigating abuse and neglect were not followed. The Administrator said on Monday 02/09/2026 she spoke with Resident #1 about the incident with LVN A that occurred on 02/07/2026 and he said what happened made him uncomfortable. The Administrator said she was not aware that Resident #1 told the ADON that he felt uncomfortable asking for his PRN medications because LVN A she was his nurse for the rest of her shift on 02/07/2026 and on 02/08/2026. The Administrator said LVN A should not have continued to be his nurse because there could have been potential danger to Resident #1 and maybe other residents for possible further abuse. During an interview on 02/20/2026 at 12:08 PM with the RNC she said on Monday 02/09/2026 the Administrator called her and told her about the allegation of abuse and neglect that occurred on Saturday 02/07/2026. The RNC said initially she thought that the incident was not reported to the Administrator by the staff then she learned that the incident was reported to the Administrator by the staff and the Administrator did not (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	report it to HHS. The RNC told the Administrator that the allegation should have been reported to HHS immediately. The RNC told her to inform the DON of the incident and to suspend LVN A immediately. The RNC said the Administrator did not report the allegation of abuse and neglect in a timely manner to HHS and she did not follow facility procedures. The RNC said anything that puts resident in harm both mentally and physical should be reported immediately. The RNC said Resident #1 could have had psychosocial harm. She said that Resident #1 could have feared approaching the nurse. The RNC said she understood that the incident humiliated him. The RNC said the Administrator did not report because of lack of experience. The RNC said the Administrator said there was history of MT A and LVN A not getting along so the Administrator thought there was nothing to the alleged allegations. The RNC said the process for any allegation of abuse and neglect was to report the allegation to HHS, suspend any staff who might be involved in allegations of abuse, and then investigate. Record review on 02/18/2026 of in-service dated 02/09/2026 by the ROD to the Administrator regarding the facility and HHS policies and procedures on self-reporting allegations of abuse and neglect including expectations for promptly identifying, disclosing, and investigating alleged allegations of abuse and neglect. The in-service included the facility and HHS policies and procedures on self-reporting allegations of abuse and neglect including expectations for promptly identifying and disclosing alleged allegations of abuse and neglect. The in-service included the suspension of any employees alleged to have been involved in the abuse, neglect, or exploitation of residents. The in-service discussed when to report any and all allegations of suspected abuse, neglect, or exploitation, when to suspend any staff member(s) involved in allegations of abuse, neglect, or exploitation and when to begin and how to investigate allegations of abuse, neglect, or exploitation. Record review on 02/18/2026 of in-service to all facility staff dated 02/09/2026 through 02/11/2026 on facility policy and procedure on Abuse, Neglect and Exploitation including the elements of training, prevention, identification, investigation, protection, and reporting/response. Record review on 02/18/2026 of Resident #1 skin observation dated 02/09/2026 by ADON that reflected no redness, discoloration, or skin tears noted. Record review on 02/18/2026 of Resident #1 pain assessment dated [DATE] by DON of pain assessment that reflected pain assessment was secondary to Lupus, no headache noted. Record review on 02/18/2026 of Resident #1 neurological assessments every 30 minutes dated 02/09/2026 through 02/11/2026. Record review on 02/18/2026 of in-service to all staff dated 02/09/2026 through 02/11/2026 on reinforcement of expectations for maintain professional boundaries, preserving resident dignity, and preventing behaviors that may be perceived as disrespectful, demeaning, or emotionally harmful. Record review 0on 02/18/2026 of Resident Safe Survey Questionnaire Alert/Oriented dated 02/10/2026. Record review of statements from MT A dated 02/09/2026, LVN A dated 02/09/2026, CNA A dated 02/10/2026, and Resident #1 dated 02/09/2026.During an interview on 02/19/2026 at 4:39 PM with LVN B she said attended an in-service on 02/10/2026 on abuse and neglect and gave an example of hitting a resident or cursing at a resident as examples of abuse and neglect. She said allegations of abuse and neglect should be reported immediately. She said allegations of abuse and neglect should be reported to the Administrator who was the abuse and neglect coordinator. During an interview on 02/19/2026 at 4:43 PM with CNA F she said she received training on 02/10/2026 on abuse and neglect. She said abuse can be physical, verbal, sexual and mental. She said exploiting residents was also abuse. She said abused should be immediately reported to the facility Administrator. She said the Administrator was the abuse and neglect coordinator. During an interview on 02/19/2026 at 4:45 PM with CNA G she said she was trained in abuse and neglect on 02/10/2026. She said abuse can be physical, mental, or sexual. She said taking a call light away from a resident was a form of abuse. She said abuse should be reported to the (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Administrator because the Administrator was the abuse and neglect coordinator. Record review of facility policy and procedure on Abuse, Neglect and Exploitation dated October 2024 reflected the facility will conduct a timely investigation of any alleged abuse or neglect exploitation, mistreatment, injuries of unknown origin, or misappropriation of resident property. The investigation should include gathering evidence, interviewing witnesses, conducting surveys as indicated, reviewing medical records, and examining any relevant documentation. The facility will record all investigation findings, interviews, and actions taken. The facility will assess the evidence gathered to review and determine the extent and nature of the allegations. Investigative findings will be documented on appropriate state forms as accessible.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure residents received adequate supervision, to the extent possible for 1 of 8 residents (Resident #2) reviewed for safety. The facility failed to ensure Resident #2 followed the facility safe smoking policy when on 12/14/2026 and additional unknown dates staff smelled cigarette smoke in Resident #2's room.on 01/31/2026 staff members observed two packages of cigarettes in Resident #2's roomon unknown dates CNAs observed Resident #2 with lighters. These failures could place residents at risk for avoidable accidents and injuries.Findings included: Record review of Resident #2's face sheet, dated 02/19/2026, revealed a thirty-seven-year-old male who was admitted to the facility on [DATE]. His admitting diagnoses included paraplegia (impairment or loss of motor and sensory function in the lower extremities), anxiety disorder, and major depressive disorder. Record review of Resident #2's MDS (clinical assessment to determine resident's strength and needs) dated 12/14/2025 Quarterly Assessment Section C - Cognitive Patterns revealed a score of 15 indicating no cognitive issues. Record review of Resident #2's care plan revealed a focus dated 11/17/2025 Resident #2 was noncompliant with smoking rules and vapes found in his bed. Record review of Resident #2's signed Resident Smoking Behavior Contract dated 09/12/2025 reflected, The resident agrees to the following terms and conditions: I will follow the objectives set forth in this contract. This Contract has been developed with my input and it reflects my best interests. As a responsible adult, I understand that failure to comply with the obligations of this contract will be dealt with accordingly. If I disregard the facilities smoking safety regulations, I'm aware that the facility will suspend or revoke my smoking privileges. I recognize that continued failure to honor the smoking policy will jeopardize my ability to remain in this facility. Record review of Resident #2's progress note dated 12/14/2025 by the DON reflected, smell of Smoke highly suggestive of Cannabis From his room noted, police confiscated some substance on Voluntary Surrender by Resident Record review of Resident #2's progress note dated 01/31/2026 by LVN B reflected CNA (name of CNA not identified) called LVN B to Resident #2's room and LVN B observed 2 packs of cigarettes in his room and LVN B asked if Resident #2 could give them to her because he was not allowed to have them. Resident #2 brought LVN B a pack of cigarettes. LVN B informed Resident #2 that that was not what she observed, and Resident #2 tried to convince LVN B that was all he had. LVN B informed the DON and ADON. Record review of Resident #2's progress noted dated 02/14/2026 by LVN B reflected it was reported to LVN B that Resident #2 was outside behind laundry building smoking. LVN B went behind the building and Resident #2 was noted smoking cigarettes. Redirected the resident back into the building and reeducated the resident on the smoking The DON was notified. Record review of Resident #2's progress note dated 02/01/2026 by agency nurse reflected Resident #2 came to the nurses' station at approximately 2:00 PM and stated he did not smoke at the 1:00 PM smoke break. Agency nurse asked CNA (name of CNA not identified) if Resident #2 smoked at 1:00 PM. CNA (name of CNA not identified) confirmed that Resident #2 smoked at 1:00 PM and Resident #2pulled a black lighter out of his sock and lit the cigarette and smoked the cigarette. During an interview on 02/19/2026 at 12:18 PM the DON said he thought Resident #2 was smoking in his room because staff have smelled smoke in Resident #2's room. The DON said Resident #2 had a lighter in his possession and when staff entered Resident #2's room and smelled cigarette smoke Resident #2 had the window open. The DON said Resident #2 had a smoking contract. The DON was highly concerned about Resident #2 smoking in his room. During an interview on 02/19/2026 at 12:40 pm with the Administrator she said there was a concern that Resident #2 was smoking in his room. She said the DON told her that about the concern of Resident #2 smoking in his room, (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but she did not know Resident #2 was seen with a lighter. She said that Resident #2 went to store all the time and could buy whatever he wanted to. During an interview on 02/19/2026 at 4:29 PM with LVN D she said she was told Resident #2 had a lighter and cigarettes and was outside in the laundry room smoking unattended outside of smoking times. She said she told the DON about Resident #2 having the lighter. She said Resident #2 could burn the building down and blow them all up. LVN D said she had not seen Resident #2 smoking in his room, but she was very much concerned that Resident #2 was smoking in his room. During an interview on 02/19/2026 at 4:35 PM with CNA E she said she had smelled cigarette smoke in Resident #2's room but she did not ask him about it. She said she saw a black lighter under Resident #2's wheelchair cushion but did not ask him about it. CNA E said she saw Resident #2 push the lighter under the wheelchair cushion. CNA E said she told the charge nurse about it but did not remember the name of the charge nurse she told. CNA E said that if someone smoked in their room, they could have an accident and something might catch on fire. During an interview on 02/19/2026 at 4:45 PM with CNA G she said she was aware Resident #2 was smoking in his room because he had lighters. CNA G said he was not supposed to have lighters. CNA G said she had smelled cigarette smoke in his room. CNA G said she saw Resident #2 with two different lighters, a black one and a blue one. CNA G said she saw the black lighter about a month ago when he was out on the patio smoking during a non-smoking time. CNA G said she told him the facility did not allow him to have irregular smoke breaks, and he was not supposed to have the lighter. Resident #2 said he was just going to smoke and come right back to the facility. CNA G said she saw Resident #2 with a blue lighter yesterday. CNA G said it was under the cushion in his wheelchair. She said she told an agency nurse that she saw Resident #2 with a lighter, but she did not tell the Administrator or the DON. She said as a CNA she told the nurse if there is an issue and the nurse told the Administrator or the DON. CNA G said if Resident #2 had a lighter he could accidentally burn something while smoking a cigarette or he could burn himself. During an interview on 02/20/2026 at 7:28 AM Resident #2 said he had a smoking contract and he followed it. He said he only smoked during the smoking times and in the allowed smoking space. He said he did not have cigarettes or lighters in his room or on his person. Resident #2 said he realized the facility had smoking rules for the safety of the residents. He said he realized there were residents in his hallway who were on oxygen and it would be dangerous for other residents if he was smoking in his room. During an interview on 02/20/2026 at 8:05 AM with ADON she said she heard that Resident #2 was smoking in his room, but no one has told her they had witnessed Resident #2 smoking in his room. She said she did not see him with a lighter, and no one had reported to her that he had a lighter. She said it was against facility policy for residents to have a lighter in their room. She said it was not okay for residents to have a lighter in their room because they had people who were on oxygen, and it could be a fire hazard. During an interview on 02/20/2026 at 9:41 PM with the PMHNP, she said in her opinion Resident #2 was smoking cigarettes in his room. She said it was dangerous and it could affect more people than him. The PMHNP said if there was a fire she did not know if he could get out of the room without assistance. During an interview on 02/20/2026 at 12:08 PM with the RNC, she said the DON had discussed with her concerns about Resident #2 being non-compliant with the smoking rules. She said Resident #2 was risking other residents if he decided to smoke in the building. She said Resident #2 could burn the building down. She said Resident #2 was not compliant even if they educated him. She said Resident #2 would not cooperate. The RNC said one day he could smoke inside the facility and he could burn the building and Resident #2 was putting residents who were on oxygen at risk. During an interview on 02/20/2026 at 12:47 PM with the DON, he said he was not sure if the Administrator knew that Resident #2 had lighters, but they did discuss the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675971	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concern about Resident #2 smoking in his room. During an interview on 02/20/206 at 2:34 PM with the NP, she said Resident #2 would not tell the truth if he was smoking in his room. The NP said they were at his mercy. She said Resident #2 had a personality disorder of being non-compliant. She said he would look them in the eyes and tell them he was not smoking in his room when he was smoking in his room. During an interview on 02/20/2026 at 3:28 PM with the DON, he said he tried to get Resident #2 discharged from the facility. During an interview on 02/20/2026 at 5:01 PM with a resident who wanted to be anonymous, said Resident #2 told him that he smoked in his room. Record review of policies and procedures on Safe Smoking dated March 2024 reflected the facility was committed to providing a safe, healthy, and comfortable environment for all residents, staff, and visitors. The facility policy is designed to ensure residents are aware of their privilege when it comes to smoking but also following guidelines in which smoking may occur in our setting. This policy applies to facilities that permit smoking (including the use of e-cigarettes/vape pens). The facility may permit smoking for certain individuals at designated times in designated areas based upon the findings of the resident's Smoking -Safety Screen. The Smoking Policy Notification is outlined in the admission Agreement. Residents who desire to smoke will be assessed using the Smoking- Safety Screen, documented in Point Click Care. Assessments will be conducted at the time of admission, quarterly, and at the time any condition or behavioral change impacts their ability to smoke safely. Areas assessed include: cognitive status, visual status, dexterity, can the resident light their own cigarette, does the roommate use oxygen, and adaptive equipment needed. Staff members maintain all smoking materials as appropriate for the residents. Staff members will distribute smoking materials to residents at designated smoking times in the designated smoking area. Smoking and e-cigarette/vape pen use must occur in designated locations that are environmentally separate from resident care areas. These designated locations should be outdoors, safe, and should be outfitted with required safety equipment including: fire Extinguisher, fire/Smoke Blanket, life Safety Approved Ash Tray life Safety Approved Disposal Can, and signage: No Oxygen Use. Recommended Resident Infractions (the facility has the autonomy to put an alternate plan of action to prevent further Infractions). 1st Offense - the facility will initiate a Behavioral Contract with the resident that outlines expectations of the smoking policy and procedure, 2nd offense notice of Involuntary/Immediate Discharge. Discharge procedures are initiated and pursued to completion. Rationale: endangerment to the health and safety of residents, staff members, and visitors.