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	04/02/2026

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, interviews, and record review, the facility failed to ensure results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to survey were readily available to examine for 1 of 1 facility reviewed for resident rights in that: The required documents were not posted in a location readily accessible and visible to all residents, their legal representatives, or family members as required.This failure placed residents of the facility at risk of knowing past and present citations of the facility, and potentially being negatively affected by an area of citation.An observation conducted throughout facility on 03/31/26 at 1:12 PM revealed the survey results were not posted in the lobby or any common areas of the facility nor a sign indicating where the survey results were posted. An observation conducted throughout facility on 04/01/2026 at 8:15 AM revealed that survey results were not posted in the lobby or any common areas of the facility nor a sign indicating where the survey results were posted. During a confidential group interview conducted on an undisclosed date and time of 5 of 12 residents revealed they did not know where or how to access the survey results in the facility. Several of the residents stated they would have liked access to that information. They had not understood or been aware that the survey book existed or that they were able to review the results. In an interview and observation conducted 4/1/2026, at 3:07 PM, the Administrator stated he was unsure of the location of the survey results within the facility, as he had only been in his position for three weeks, and indicated he would need to ask the DON. He acknowledged that the survey results were required to be available. The Administrator led this surveyor to the DON's office to verify the location of the survey results binder, and the DON confirmed it was on the Administrator's desk. The RNC and another staff member then returned to the Administrator's office, where the binder was located on his desk. It was subsequently discussed among those facility staff that the binder would be relocated to the table outside the Administrator's office, with signage posted to notify residents, family members, and visitors of its availability. When asked if the binder was accessible to residents while located on his desk, the Administrator stated it was not, and indicated he was unaware it had been placed there. He stated it had been placed on his desk without his knowledge. The Administrator acknowledged that residents, family members, and visitors should have access to review the survey results. When asked about the potential impact of the binder not being readily accessible, he stated he had not considered the potential harm but acknowledged that access to the survey results could provide residents with assurance that reported complaints are investigated by the state.Interview conducted 4/02/2026, at 10:15 AM, the ACTD stated she worked at the facility for a year and a half. The ACTD was asked about the location of the state survey results binder. She stated that she believed it was located in the administrator's office and was not accessible to everyone. She further stated that she was unaware the survey results binder was required to be accessible to all individuals. She indicated that if a resident or visitor requested the binder, she would have to ask the administrator to retrieve it. The ACTD stated she did not know of any potential harm to residents that could result from not having the survey results binder readily accessible. Review of the facility's Required Posting of Survey Results and Regulatory Notices policy with revision date of January 2026 reflected: Policy The facility will (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ensure that all required survey results, regulatory notices, and enforcement actions are posted in a conspicuous and accessible location for residents, visitors, and the public, in accordance with federal and state regulations. Postings will be current, legible, and maintained for the required timeframes. Procedure Required Documents to be Posted The facility will post the following, as applicable: Most recent standard survey results Complaint survey results (as required) Plans of Correction (POCs) for cited deficiencies Notices of enforcement actions, including: Civil Money Penalties (CMPs) Denial of Payment for New Admissions (DPNA) Directed Plans of Correction State-required notices (if applicable) Posting Location All required postings will be placed in a prominent and accessible location, such as: Main lobby Near reception desk The location must: Be easily visible to the public Not require staff assistance to access Be maintained free of obstruction Timeliness of Posting Survey results and related documents will be posted: Within 72 hours of receipt from the regulatory agency (or per state requirement) Updates (e.g., revised POCs or enforcement notices) will be posted promptly upon receipt. Duration of Posting Survey results and POCs will remain posted for a minimum of: 12 months, or As otherwise required by state regulation.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 2 of 19 residents (Resident #56 and Resident #59) reviewed for resident rights. The facility failed to ensure Resident #56 and Resident #59's room temperatures were maintained at comfortable temperatures (between 71 to 81 degrees) on 03/31/2026 when the temperatures were found to be 67 to 68 degrees. These failures could place residents at risk of being cold, living in an uncomfortable environment, and a diminished quality of life.Findings included: Review of Resident #56's face sheet dated 04/02/2026 reflected an [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses diabetes mellitus (A condition results from insufficient production of insulin, causing high blood sugar.), hypertension (High pressure in the arteries (vessels that carry blood from the heart to the rest of the body) and macular degeneration (an eye disease that affects central vision). Review of Resident #56's quarterly MDS assessment dated [DATE] reflected he was assessed to have a BIMS score of 15 indicating his cognition was intact. Review of Resident #56's comprehensive care plan dated 02/23/2026 reflected a focus area of Resident does not like to get out of bed. Review of Resident #59's face sheet dated 03/25/2026 reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses, hypertension (High pressure in the arteries (vessels that carry blood from the heart to the rest of the body), diabetes mellitus (A condition results from insufficient production of insulin, causing high blood sugar.) and major depressive disorder (A mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts.) Review of Resident #59's admission MDS dated [DATE] reflected that he was assessed to have a BIMS score of 10 indicating moderate cognitive impairment. An observation and interview on 03/31/2026 at 8:57 AM revealed Resident #56 was in his room in bed. He stated his room was cold. Resident #56 was in bed with multiple covers on. An observation and interview on 03/31/2026 at 9:15 AM revealed Resident #59 was in his room in bed. He stated his room was cold. Resident #59 was in bed with multiple covers on. An observation on 03/31/2026 at 9:28 AM revealed Resident #56's room temperature was 68 degrees and was measured using a PDT650 (Digital folding pocket thermometer (designed for professionals who need accurate, portable temperature readings in demanding environments such as HVAC.) An observation on 03/31/2026 at 9:30 AM revealed Resident #56's room temperature was 67 degrees and was measured using the PDT650 thermometer. An observation on 03/31/2026 at 9:32 AM revealed the air conditioning control box in the hall outside of Residents #56 (room [ROOM NUMBER]) and #59's room (room [ROOM NUMBER]) was set at 68 degrees. The plastic box that covered the control box was missing. An observation and interview on 03/31/2026 at 10:00 am, the DOSS went to the air conditioner control box and stated it should have a cover on it. He stated he did not know who was messing with the air conditioner box, but he would look into it. In an interview on 03/31/2026 at 2:30 PM, the DOSS stated the facility temperatures should be maintained between 72-82 degrees. He stated that the staff must have changed it. He stated he fixed the temperature and put a new cover box on the thermostat and stated he would be monitoring it daily to make sure the thermostats were set to the right temperatures to make sure the residents were comfortable. In an interview on 04/02/2026 at 10:45 AM, the Administrator stated he expected the facility's temperatures to be maintained at the proper range of 71 to 81 degrees to ensure residents' comfort. Review of the facility's policy Dignity: Resident's rights dated June 2019 reflected It is the policy of this facility that the Facility staff will provide the resident with the right to an environment that preserves dignity and contributes to a positive self-image.7) Create a home-like environment for the resident that includes: e. Proper temperature and ventilation.h. Comfortable and safe temperature levels.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in the facility's only kitchen reviewed for food and nutrition services.1. The facility failed to date food and beverages found within the facility's freezers and refrigerator on 03/31/2026.2. The facility failed to date and properly seal food products in facility's freezers and refrigerator on 03/31/2026.These failures could place the residents who ate food from the kitchen at risk of cross contamination, loss of nutritional value, weight loss, and foodborne illness.Findings included:In an observation on 03/31/2026 at 6:49 AM, the facility's three door refrigerator was found to contain three trays of red juice and water that were not covered, labeled or dated. On a shelf was an open, uncovered, and undated can of soda. On two trays, fruit was cut and in bowls that was covered but not labeled or dated. In an observation on 03/31/2026 at 6:52 AM, the facility's three door freezer was found to contain an open undated box, partially opened bag of frozen fish filets that were exposed to air. There was also a partially opened, undated box of green beans that were exposed to the air. In the freezer, there was also an undated, unlabeled, and uncovered bowl of ice cream with a disposable spoon in it. In an interview on 04/02/2026 at 9:53 AM, Dietary Aide C stated that all items in the kitchen were required to be dated and labeled. The dietary aide stated frozen items were supposed to be covered when opened and that if frozen food was exposed to air in the freezer, it could be exposed to airborne issues or cross contamination. She stated employees' personal food should not be in the refrigerator or freezer. In an interview on 04/02/2026, at 9:56 AM, [NAME] A stated that everything in the kitchen was required to be dated and labeled. She stated frozen items were to be sealed when opened, and frozen food that was exposed to air in the freezer could lead to freezer burn. She also said personal food items were not allowed to be kept in kitchen refrigerators according to dietary policy. In an interview on 04/01/2026 at 10:15 AM, the Dietary Manager stated that their policy was to label and date items placed in the refrigerator and freezer. The Dietary Manager stated the trays containing glasses with juice and the cut fruit were placed in the refrigerator just prior to inspection and were dated after observation. The Dietary Manager stated that the plastic bag containing the green beans and the fish fillets should have been dated and sealed after it was opened. The Dietary Manager stated the failure to properly seal bags containing food in the freezers could lead to frost bite and that food could be ruined if not closed and sealed. Review of the facility's policy entitled Nutrition Services Policies and Procedures Revised February 2022, Subject: Safe Food Handling, General Statements: 6. Follow all local, State, and Federal Regulations when handling food. Food / Beverage Prepared and Served by Facility Staff for Patients / Residents: 5. Refrigerated Time / Temperature Control for Safety (TCS) leftover foods are properly covered, labeled and dated and marked with use by date. Foods are placed in shallow containers and immediately put in refrigerator or freezer for rapid cooling. TCS leftovers are discarded after 3 days unless otherwise indicated. Items that cannot be used within 3 days may be placed in the freezer. Leftover pureed food is discarded. Food / Beverage Prepared with Patients / Residents Individually or Groups: 3. All foods removed from the original packaging are stored in a closed container or tightly wrapped package and labeled with the common name of the item and the date it was opened. Food/Beverages for Employee Consumption: 1. All foods and beverages in the facility that belong to employees are stored in employee refrigerators or other designated areas and labeled with the employee's name and the date the item was placed in the facility storge area. 2/ All foods are wrapped or covered to prevent contamination from outside sources. 4. Food and beverages are consumed by employees/contract personnel in designated areas such as breakrooms. Eating and drinking is not permitted in the kitchen, at nursing stations or rehab areas, etc., unless approved for therapeutic intervention.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one of two residents (Resident #7) reviewed for infection control. The facility failed to ensure RN F followed standard precautions during wound care for Resident #7's unstageable right heel pressure ulcer on 04/01/2026 when she failed to perform hand hygiene during wound care. This failure placed residents at risk for developing wound infections, and at risk for healthcare associated cross-contamination and infection.Findings included: Review of Resident #7's face sheet dated 04/01/2026 reflected at [AGE] year-old male admitted to the facility 04/23/2024 with the following diagnoses diabetes mellitus (A condition results from insufficient production of insulin, causing high blood sugar.), chronic obstructive pulmonary disease (a disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough.) and peripheral vascular disease (a condition in which narrowed arteries reduce blood flow to the arms or legs.). Review of Resident #7's quarterly MDS assessment dated [DATE] reflected Resident #7 was assessed to have a BIMS score of 5 indicating severe cognitive impairment. Resident #7 was further assessed to have an unstageable pressure injury Review of Resident #7's comprehensive care plan reflected a focus area 04/24/2024 Enhanced barrier precautions: Resident requires enhanced barrier precautions AEB (as evidence by) open wounds. Further review reflected a focus area dated 10/17/2024 .Resident has the following wounds.2. Pressure ulcer. Interventions included 1. Cleanse with Dakins 0.25%, Primary Dressing Blue Foam Three Times weekly and PRN (as Needed). Apply Betadine to the peri wound where scabbing is present. An observation on 04/01/2026 at 9:35 AM revealed RN F outside of Resident #7's room to prepare supplies for wound care. RN F sanitized her hands using hand sanitizer outside of Resident #7's room and put on gloves. RN F then entered the room. RN F touched the door, the table, and donned her gown. Without changing her gloves, she cut off the old dressing, cleaned the wound, applied the new dressing using the same gloves without hand hygiene. In an interview on 04/01/2026 at 10:45 AM, RN F stated she did sanitize her hands before going into room but did not change her gloves or sanitize her hands during the wound care process. RN F did not answer why she did not sanitize her hands and stated by not performing hand hygiene during wound care, it could cause cross contamination and infection. In an interview on 04/01/2026 at 1:20 PM, the DON stated he expected nursing staff to sanitize their hands prior to wound care and to perform hand hygiene after removing the old dressing, after cleaning the wound, and before putting on the new dressing. The DON further stated, of course, when staff are done providing care to prevent cross contamination or wound infection. Review of the facility's policy Hand Hygiene dated December 2024 reflected It is the policy of The Facility to prioritize hand hygiene as a fundamental practice in preventing the spread of infections. All staff must perform hand hygiene. When to Utilize Hand Hygiene Before/after resident contact, after removing gloves or PPE, After contact with bodily ˆuids, surface, or contaminated equipment. Review of the facility's policy Dressing Change: Wound dated 06/2025 Procedures: NOTE: (Perform Hand Hygiene before and after donning gloves, Hand Wash every 3rd Glove Exchange. 1. Put on gloves; 2. Remove old dressing and packing (if present)3. Remove gloves and perform Hand Hygiene; 4. Put on clean gloves; 5. Cleanse the wound of drainage, debris or dressing/filler residue; 6. Remove gloves and perform Hand Hygiene; 7. Assess the wound (measuring done here according to measuring schedule8. Remove gloves and perform hand hygiene; 9. Put on clean gloves; 10. Pack the dead space of large wounds (if physician order prescribes it); 11. Apply cover dressing-date and initial cover dressing; 12. Remove gloves, discard waste; 13. Perform Hand Hygiene.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure resident was treated with respect and dignity for 1 (Resident #26) of 10 residents reviewed for resident rights.1. The facility failed to ensure Maintenance Tech E knocked on Resident #26's door prior to entry and explained the purpose of the visit before performing work in the room on 03/31/2026.2. The facility failed to ensure HSKP G knocked on Resident #26's door prior to entry on 03/31/2026.The deficient practice could place residents at risk of feeling uncomfortable, embarrassment, and a decreased quality of life.Record Review of Resident #26's MDS Assessment, dated 01/19/2026, reflected he was a [AGE] year-old male, admitted [DATE] with a BIMS score of 01, which indicated severe cognitive impairment. The resident's diagnoses included Generalized Anxiety Disorder (excessive worry about daily events), Other Paraphilias (intense, recurrent sexual interest that causes distress and impairment), Hyperlipidemia (elevated fat levels in blood), and Depression (mood disorder, loss of interest).Observation on 3/31/2026 at 9:28 AM revealed Maintenance Tech E entered Resident #26's room without knocking nor announcing who he was and what task he was going to complete in the room.Observation on 3/31/2026 at 9:34 AM revealed Maintenance Tech E re-entered Resident #26's room without knocking.Observation on 3/31/2026 at 9:36 AM revealed HSKP G entered Resident #26's room without knocking, nor spoke to the resident, and started talking to Maintenance Tech E.Interview conducted on 04/02/2026 at 9:16 AM, with HSKP G revealed she worked at the facility for 1 year. HSKP G stated she was trained on resident rights and dignity. HSKP G acknowledged that she did not knock before entering Resident #26 ?s room on the morning of 03/31/2026, explaining that she was not thinking at the time. She stated that staff should knock on a resident's door before entering, identify themselves, and explain the purpose of their visit. The housekeeper further stated that failing to knock before entering a resident's room could have a negative effect, as it may cause the residents to feel uncomfortable or that their privacy has been violated.Interview conducted on 04/02/2026 at 12:19 PM, with Maintenance Tech E revealed he worked at the facility for 2 years. Maintenance Tech E stated he was trained on dignity and resident rights. He stated he did not recall failing to knock on Resident 26's door. He stated, I do not like being accused of things. After being advised of each observation in which he did not knock, the maintenance tech stated that nine times out of ten he knocks before entering rooms. He stated, in a defensive and rude tone, apparently I was in a rush . He further stated he entered the room to repair a curtain and thought he told the resident what he was going to do. When asked about the potential effect on a resident when staff do not knock before entering, Maintenance Tech E stated, most residents are thankful that I am doing something for them.Record review of the facility's policy Dignity: Resident Rights, Revision date June 2019, stated: Policy: .7) Create a home-like environment for the resident that includes: a. Sufficient space with access to personal living space. d. Staff knock prior to entering room.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide reasonable accommodation of resident needs and preferences for one (Resident #38) of five residents reviewed for resident rights.The facility failed to ensure Resident #38's call light was within reach on 03/31/2026 and 04/02/2026.This failure could place residents at risk of needs and accommodation being unmet.Record Review of Resident #38's quarterly MDS assessment dated [DATE] indicated Resident #38 was a [AGE] year-old male who was last admitted to facility on 02/10/2026 with multiple diagnoses to include Schizoaffective Disorder, Bipolar Type(mental health condition combining psychotic symptoms (hallucinations, delusions) with manic and depressive episodes, blindness right and left eye, Type 2 Diabetes(body resist insulin and fail to maintain normal blood sugars), and depression(sadness, loss of interest). MDS also indicated Resident #38 had a BIMS score of 00 indicating severe cognitive function. Review of Resident #38's care plan dated 03/19/2026 revealed focus Call bell will be attached to a stuff animal, so [Resident #38] can feel for it and ring for help when needed, initiated 02/23/2026 and revised 03/31/2026. Observation and interview conducted 3/31/2026 at 9:23 AM, revealed Resident #38 was on his bed, awake. It was observed that resident's call light was hanging on the wall clamped together, not within reach of Resident #38. When asked if he could reach the call light, Resident #38 responded he had to reach to get the light, and the resident was observed struggling to sit up. Observation and interview conducted 4/02/2026 at 9:03 AM, revealed Resident #38 was on his bed, awake. It was observed that resident's call light was still hanging on the wall clamped together, not within reach of Resident #38. Resident #38 said he could not reach the call light on the wall. He told the surveyor to ask the staff how to press the light. Surveyor pressed the call light, CNA B responded in less than a minute. In an interview conducted 04/02/2026 at 9:04 AM, CNA B reported she had worked at the facility for 15 years. She stated that call lights should always be within reach of residents. However, she explained that Resident #38 was blind and unable to visually locate the call light. She further stated that the call light cord was currently positioned on the wall because the resident frequently twists and turns, creating a risk of becoming entangled in the cord. CNA B reported that Resident#38 yelled out frequently throughout the day, and staff responded by checking on him regularly. She stated she had not observed a stuffed animal attached to the call light with the current system, noting that the call light system was relatively new (implemented approximately one week ago). She indicated that the resident may have had a stuffed animal attached to the previous call light system. CNA B stated she had not reviewed the resident's care plan. She stated a potential risk of harm, was that the resident could be harmed if he does not have access to a functional call light. During a demonstration of the call light, the CNA explained that the new call light system operated via a push-button and would not function if a stuffed animal was attached. She noted that the previous system used a pull-cord design, which may have been compatible with such an adaptation. The CNA concluded that the facility would need to figure out an appropriate solution to ensure the resident has safe and effective access to the call light under the new system. In an interview conducted 04/02/2026 at 12:30 PM, LVN D stated she had been employed at the facility for one month and has received training regarding call light use. She stated call lights should be kept within reach of the resident. LVN D reported she was unaware why Resident #38's call light was hanging on the wall. She further stated she was assigned to the locked unit that day of the interview. LVN D stated she would need to review the resident's care plan to determine if there was a specific reason for the call light placement. She reported awareness that Resident #38 crawls on the floor and acknowledged that having the call light positioned by Resident #38 could present a safety risk because Resident #38 may get tangled in the cord. She reiterated that she would need to verify this information in the care plan. LVN D stated the potential risk of a resident not having access to a call light includes the inability to call for assistance, which could (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	result in falls or unmet needs. In an interview conducted 04/02/2026 at 12:45 PM, The MDS Coordinator stated she has been employed at the facility for seven years. She acknowledged concern regarding Resident #38's call light placement and stated the call light should be within reach of the resident. She reported that the facility recently implemented a new call light system, and the new system would require an adaptive attachment for Resident#38. She stated she felt bad for not addressing it sooner. The MDS Coordinator explained that with the previous call light system, the resident utilized a stuffed animal attachment, which served as a more accessible target for the resident to locate when needing assistance. She stated this adaptation had not yet been implemented with the new system. The MDS Coordinator reported that the interdisciplinary team will need to meet to assess the situation and develop an appropriate solution to ensure the resident has access to the call light. She stated she would follow up with the interdisciplinary team promptly to address the issue. The MDS Coordinator stated the potential risk of not having access to a call light is that the resident may be unable to obtain assistance in a timely manner when needed. In an interview conducted 04/02/2026 at 1:04 PM, the DON stated that during the installation of the new call light system, staff conducted routine rounds on Resident #38. He reported that the resident was monitored with hourly checks, and the resident's room was located next to the nurses' station to allow for frequent observation. The DON stated that as of 03/ 21/2026, staff discontinued documenting rounds on a paper check sheet, but continued documentation in the electronic medical record. He further stated the new call light system was fully installed on 03/26/2026. The DON reported that Resident #38 does not actively search for the call light and instead typically knocked on the wall to gain staff attention. He stated that behavior is the reason the resident's room is located near the nurses' station to facilitate frequent monitoring. The DON stated that they are working on a solution for the light at this moment.In an interview conducted 04/02/2026 at 1:55 PM, the Administrator stated that call lights should always be within reach of all residents and accessible. He acknowledged that failure to provide access to a call light presents a potential risk, as residents may be unable to notify nursing staff of their needs or concerns. The Administrator reported that the facility contacted another facility to obtain an adaptive tap device for the call light. He stated the attachment is expected to arrive today and will be installed on the wall at a lower, more accessible level for Resident #38. In an interview and observation conducted 04/02/2026 at 2:25 PM, the RNC and DON advised the tap call light had arrived at facility and was installed to wall well within reach of Resident #38. The call light was observed in reach by a surveyor, and it worked properly.Review of facility's policy titled Resident Rights revised April 2024 reflected, Policy The facility protects and promotes the rights of each resident. The facility staff will uphold the resident's dignity and individuality, providing care that fosters their quality of life in a respectful environment. ProcedureThe facility provides a clean, safe, comfortable, and home-like environment. The facility provides equal access to quality of care regardless of diagnosis, severity of condition, or payment source. Record review of the facility's policy Dignity: Resident Rights, Revision date June 2019, stated: Policy: .7) Create a home-like environment for the resident that includes a. Sufficient space with access to personal living space; b. Appropriate furnishings and equipment, including access to telephones; f. Appropriate environmental adaptations to help residents with dementia or confusion; and g. Appropriate environment adaptations to help residents with other specific/special needs when indicated and if able to provide.

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	04/02/2026

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all Pre-admission Screening and Resident Review (PASARR) Level I residents with a mental illness was completed correctly and were provided with a PASARR Level II assessment for one (Resident #4) of four residents reviewed for resident assessments. Resident #4's PASARR Level l was not updated to reflect his new diagnoses of PTSD (post-traumatic stress disorder) on 07/09/2025 after he was admitted on [DATE]. This failure could place residents who had a mental illness and/or intellectual or development disabilities at risk for not receiving the appropriate care, and services to meet their needs.Findings included: Review of Resident #4's face sheet dated 04/01/2026 reflected a [AGE] year-old male admitted on [DATE] with the following diagnoses diabetes mellitus (A condition results from insufficient production of insulin, causing high blood sugar.), atherosclerotic heart disease (A condition where the arteries become narrowed and hardened due to buildup of plaque (fats) in the artery wall.), and heart failure (long-term condition in which your heart can't pump blood well enough to meet your body's needs.). Review of Resident #4's annual MDS assessment dated [DATE] reflected he was assessed to have a BIMS score of 12 indicating he had moderate cognitive impairment. Resident #4 was assessed to have PTSD. Review of Resident #4's comprehensive care plan dated 03/03/2026 reflected a focus area of Resident has PTSD and is at risk for violence directed towards self or others. Review of Resident #4's PASRR level 1 screening dated 03/28/2025 reflected Resident #4 was assessed to not have mental illness. In an interview on 04/01/2026 at 1:12 PM, the MDS Coordinator stated she was in charge of doing PASRR assessments. She stated Resident #4 had a diagnosis of PTSD added after he was admitted . The MDS Coordinator stated that she should have redone his PASARR level one so he could get a level two evaluation done to determine if he qualified for benefits. She stated that she would update Resident #4's level one PASARR to include mental illness so he can get a PASARR level two completed. In an interview on 04/01/2026 at 1:20 PM, the DON stated he expected residents to have PASARRs done correctly and if they had a change in diagnoses or an addition of a mental health diagnosis, the Residents PASARRs are updated to ensure they are getting the services they need. Review of the facility's policies and procedures PASRR dated 01/2025 reflected This policy ensures compliance with federal and Texas Health and Human Services Commission (HHSC) regulations regarding the Preadmission Screening and Resident Review (PASRR) process. The goal is to identify individuals with Mental Illness (Ml}, Intellectual Disability (ID}, or Developmental Disability/Related Conditions (DD/RC) and ensure appropriate placement and specialized services. The PASRR Level I (Pll) Screening Form is designed to identify individuals who are suspected of having mental illness (MI), intellectual disability {ID), or a developmental disability (DD).

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	04/02/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide bedrooms that measured at least 80 square feet per resident in multiple resident bedrooms for 3 of 7 resident rooms (rooms [ROOM NUMBER]) reviewed for environment.The facility failed to ensure resident bedrooms rooms, 25, 26, and 27 measured at least 80 square feet per resident.This failure could place residents at risk by limiting the amount of resident care equipment and personal belongings that could be accommodated in the resident's room. This may restrict the resident's' ability to move about the room freely and could negatively affect the residents' quality of life.Observations conducted on 3/31/26 during the initial pool screening beginning at 6:00 AM revealed 3 resident rooms did not have the required amount of living space for each resident.An observation conducted 4/02/2026 at 8:45 AM revealed the following measurements of resident room dimensions for the room size waiver:1. room [ROOM NUMBER] (2-person room - 2 residents in room) -144 sq ft./ 2 residents = 72 sq ft./resident2. room [ROOM NUMBER] (2-person room - 2 residents in room) -144 sq ft./ 2 residents = 72 sq ft./resident3. room [ROOM NUMBER] (2-person room - 2 residents in room) -144 sq ft./ 2 residents = 72 sq ft./residentAn interview conducted with the DOSS on 4/02/2026 at 10:04 AM, revealed he was not aware of the specific square footage requirements for residents' rooms. He stated he was recently been informed on 3/31/2026 that a waiver was previously granted for the rooms. The DOSS indicated that he believed several rooms may not meet the required square footage. He further stated the room-related issues had typically been handled by the administrator. He reported that he was not aware of any potential harm unless a resident were to voice a complaint.An interview conducted with the ADM on 4/02/2026 at 1:52 PM, revealed he had been at the facility for approximately three weeks, and was not aware the resident rooms did not meet the regulatory room size requirements. The Administrator stated he located documentation that indicated a request for a room size waiver was submitted previously; however, he was unable to determine the status of that request. The Administrator stated he would request a room size waiver again. Record review of the room roster provided by the facility on 03/31/2026 revealed 6 residents lived in rooms [ROOM NUMBER].A facility policy was requested for room sizes. It was not provided before exit.