STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676040	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm at the Prairies	106 Del Norte Dr El Campo, TX 77437

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from abuse for one (Resident # 1) of 6 residents reviewed for abuse. The Administrator emotionally and verbally abused Resident # 1 when she yelled at the resident and pointed her finger in Resident #1's face bringing Resident #1 to tears. The failure place residents at risk of further abuse and diminished self worth.Findings included:Record review of Resident # 1's face sheet, dated 6/26/2025, revealed a [AGE] year-old male initial admission date, 3/3/2023. Resident # 1 had diagnoses including Cerebral Infarction due to Thrombosis of Unspecified Cerebral Artery (a stroke caused by a blood clot (thrombosis) in an artery supplying the brain), Alzheimer Disease (a progressive brain disorder that gradually impairs memory, thinking skills, and eventually, the ability to carry out the simplest tasks), Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side (common consequences of cerebral infarction, or stroke, affecting one side of the body), Diabetes Mellitus (a group of metabolic diseases characterized by high blood sugar levels), Mood Disorder (a group of mental health conditions characterized by significant and persistent disturbances in a person's emotional state, impacting their ability to function in daily life, Dementia (a general term for a decline in mental ability severe enough to interfere with daily life), Major Depressive Disorder (a serious mental illness characterized by persistent sadness, loss of interest in activities, and other symptoms that significantly interfere with daily life) and Transient Ischemic Attack (TIA) and Cerebral Infarction (A TIA involves a temporary blockage, with symptoms resolving within minutes or hours, while a cerebral infarction (stroke) involves a longer-lasting blockage, leading to tissue damage and potentially permanent disability). Record review of Resident # 1's quarterly MDS assessment, dated 3/1/2025 indicated Resident # 1 had minimal difficulty hearing. Resident # 1 had unclear speech. Resident # 1 was usually understood and usually understood others. Resident # 1's BIMS was a 09 (moderate cognitive impairment). Resident # 1 used a wheelchair. Resident # 1 was independent with toileting hygiene, sit to lying, sit to stand, toilet transfer. Resident # 1 required setup or clean-up assistance with eating, oral hygiene, putting on/taking off footwear. Resident # 1 required supervision or touching assistance with shower/bathe self, upper body dressing, and personal hygiene. Resident # 1 was occasionally incontinent with urinary and bowel.Record review of Resident # 1's Care Plan, revision date 8/9/2023, indicated Resident # 1 had communication impairment; Goal: staff will anticipate and meet needs that Resident # 1 is not able to effectively communicate; Interventions: allow resident time to verbalize his thoughts/needs. Do not rush. Ask him to repeat as needed. Use writing materials if resident is having trouble relaying his thoughts/needs; allow time for resident to digest information-do not rush; approach in a calm manner using eye contact- call resident by name. Resident # 1 had cognitive impairment; Goal- Resident # 1's needs will be met, and dignity maintained; Interventions- allow time for tasks and responses, anticipate and assist with ADL's q shift, and explain all procedures using terms gestures the resident can understand. Resident # 1 had episodes of behaviors and was at risk for further increased episodes and injury; Goal-Resident # 1 will decrease behavioral episodes through behavioral monitoring and interventions; Interventions- encourage to attend social activities of preference, give medication as ordered, monitor and chart behaviors as they occur and report progress /declines to MD; observe for early warning signs of behavior-approach in a calm manner, call by name remove from unwanted stimuli.During an interview and observation with Resident # 1 on 6/26/2025 at 11:10 a.m., Resident # 1 stated he wanted to move into an apartment. He stated that he was at the nurse's station talking to staff when the Administrator approached him and yelled in his face. He stated the Administrator pissed him off when she yelled at him. He stated he told the Administrator to stay away from him. Resident # 1 stated two days ago he was drawing and the Administrator came by his door and he stated that upset him because he told the Administrator to stay away from him. Resident # 1 stated he wanted to leave the facility because the Administrator was rude. Resident # 1 had a stroked, therefore, he had limited verbal skill. Resident # 1 was able to verbally express his frustration.During an interview with MA A on 6/26/2025 at 2:10 p.m., MA A stated a couple of days ago (she could not remember the date) she heard a verbal altercation. She stated that the verbal altercation was extremely loud, and she thought it was two residents. She stated that when she arrived at the nurse's station, she observed Resident # 1 and the Administrator in a verbal altercation. She stated that she did not know what Resident # 1 and the Administrator were arguing about. She stated that the Administrator was loud and disrespectful towards Resident # 1. She stated that Resident # 1 was loud as well, and the Administrator